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Special Theme Issue on Internal Medicine

Upcoming Issues of *Virtual Mentor*

February: Quality of Life and Clinical Decision Making
March: Ethics in Adolescent Medicine
April: Professional Self-Regulation

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Introduction

Special Theme Issue on Internal Medicine

Introduction to a special theme issue on internal medicine with interactive educational modules for internal medicine residents.

This special issue of *Virtual Mentor* consists entirely of clinical cases for exploring the challenges to professionalism that confront internal medicine residents and fellows in internal medicine sub-specialty programs.

The cases cover 7 general areas:

1. Patient-Physician Relationship
2. Informed Consent
3. Privacy and Confidentiality
4. Medical Student Participation In Patient Care
5. End-of-Life Care
6. Conflicts of Interest
7. Access to Care

The cases pose challenges common to residents and fellows. In each case, the reader is presented with several alternative courses. Selecting an option will link the reader to an explanation of whether that option is **preferred**, **acceptable**, or to be **avoided**. These determinations are grounded in the AMA's *Code of Medical Ethics*, a starting point for physician understanding of appropriate professional conduct.

The AMA was founded, in large part, to develop a code of ethical conduct for the profession. Today, this core responsibility lies with the AMA's Council on Ethical and Judicial Affairs.

The educational modules in this month's *Virtual Mentor* were developed by Ethics staff members Abraham P. Schwab, MA, Jeanne Sokolec, EdD, MSW, Karine Morin, LLM, Faith Lagay, PhD, and Jennifer Reenan, MD.

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Module 1

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Case 1.1: Potential Patients—A Call from the Emergency Department

Case Presentation

Dr. Kale has decided to retire and has begun to tell his patients that Dr. Stevens, a partner in the practice, will assume care for his patients. Harry Jones, one of Dr. Kale's patients, tells Dr. Kale he would like to switch since he has heard that Dr. Stevens is good with diabetic patients. Dr. Kale says he will talk with Dr. Stevens. When Dr. Stevens learns that Mr. Jones wants to become his patient, he reads Mr. Jones's file and discovers that he is HIV positive, on medication, and has high T scores. In addition to being seen in the internal medicine practice, Mr. Jones is being treated at an HIV clinic.

Mr. Jones, who is middle aged, was diagnosed with borderline Type II diabetes 6 months prior. The treatment plan was that he would monitor his diet, begin an exercise routine and be checked every 3 months. Medication was not initially necessary. However, subsequent blood tests have shown that Mr. Jones's glucose level is rising to the point where metaformin by mouth is indicated. Dr. Kale has talked with him regularly about the potential consequences of not sticking to his diet and exercise plan.

One afternoon Mr. Jones suddenly feels very light-headed and begins sweating profusely. He starts to slur his words and becomes frightened that perhaps he is having a stroke. He calls Dr. Stevens' office and is told via the options menu that if it is a medical emergency, he should call 911. Mr. Jones does so. The paramedics arrive and determine that he is in an acute hyperglycemic state. They stabilize Mr. Jones and tell him he needs to be taken to the emergency department for further assessment and treatment. Mr. Jones agrees. The nearest ER is in the hospital where his doctors are on staff so, when asked if he has an internist, Mr. Jones gives the name of Dr. Stevens, his "new" doctor.

The emergency room physician pages Dr. Stevens. Dr. Stevens returns the emergency room's page and is told that a "Mr. Jones" has been brought in by ambulance and has stated that Dr. Stevens is his doctor. Although Dr. Stevens is new to the group practice and would like to build his patient base, he is not sure that he is knowledgeable enough about the treatment of HIV complicated by diabetes. Dr. Stevens hesitates before responding to the ER doctor.

What should Dr. Stevens tell the ER doctor? (select an option)

A. That he has never actually seen Harry Jones and cannot take responsibility for his care.
B. That Mr. Jones is going to be a new patient, so admit him to the hospital with Dr. Stevens as his physician.
C. That he will provide consultation during the emergency, but Mr. Jones will need to be referred to another doctor for follow-up care.
D. That since Mr. Jones is HIV positive, he will not take him as a patient.

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Module 1

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Case 1.1: Potential Patients—A Call from the Emergency Department

Option Assessment

A. Telling the emergency room physician that he has never seen Harry Jones and therefore cannot take responsibility for him is an **acceptable** action according to the *Code*. Regarding the acceptance of potential patients, Principle VI of the AMA Principles of Medical Ethics states: "A physician shall, in the provision of patient care, except in emergencies, be free to choose whom to serve…." This basic principle is reconfirmed in Opinions 10.05, "Potential Patients," 9.06, "Free Choice" and 8.11, "Neglect of Patients." The opinions state that physicians have the "prerogative to choose whether to enter into a patient-physician relationship."Because other physicians are meeting Mr. Jones's emergent needs, Dr. Stevens has no specified obligations to Mr. Jones.

B. Informing the emergency room that Harry Jones is in fact his patient is the **preferred** option because Dr. Stevens has already indicated that he will accept Dr. Kale's patients. This option is also supported by the *Code* in Opinion 8.11, "Neglect of Patient:" "Once having undertaken a case, the physician should not neglect the patient." Whether or not Dr. Stevens has undertaken the care of Mr. Jones can be disputed, but Mr. Jones is already operating under the presumption that Dr. Stevens is his doctor.

C. The emergency nature of the situation complicates the issue of what Dr. Stevens "should" do. Agreeing to consult during the emergency situation while not becoming Mr. Jones's primary care physician is **acceptable.** Opinion 10.05 (4), "Potential Patients" states that "greater medical necessity of a service engenders a stronger obligation to treat."Dr. Stevens' familiarity with Mr. Jones's medical history is such that Mr. Jones's medical treatment may be substantially improved by Dr. Stevens' involvement.

D. The prerogative of the physician to decline a patient is not absolute. HIV status is not a sufficient reason to decline a potential patient, thus this option should be **avoided**. Opinion 10.05 (2b) states "physicians cannot refuse to care for patients based on race, gender, sexual orientation or any other criteria that would constitute "invidious discrimination." Nor, according to Opinion 2.23, "HIV Testing," can a physician discriminate against patients with infectious diseases or HIV seropositivity: "It is unethical to deny treatment to HIV-infected individuals because they are HIV seropositive."

Compare these options

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Case 1.1: Potential Patients—A Call from the Emergency Department

Option Comparison

Option B—informing the emergency room that Mr. Jones is his patient—is the preferable choice because accepting Mr. Jones as a patient concretely fulfills the purpose of medicine, which is to "provide competent medical care, with compassion and respect for human dignity and rights" (Principles of Medical Ethics I.). Options A and C present "acceptable," though conflicting, options for the physician. Option A—telling the ER that Dr. Stevens cannot take on the care of Mr. Jones—is acceptable because up to this point Dr. Stevens has had no patient-physician relationship with Mr. Jones. Option C—providing care during an emergency without accepting him as a patient—is also acceptable because it acknowledges the acute nature of the situation and the assistance Dr. Stevens may be able to provide. Option D should be avoided because HIV status, by itself, does not justify refusing care.

Preferable: Option B

Acceptable: Options A and C

Avoid: Option D

Additional discussion and information

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Case 1.1: Potential Patients—A Call from the Emergency Department

Additional Information

Physicians are professionals who have obligations to use their skill and knowledge for the benefit of society. Although physicians retain a great degree of control over their practice, they often must subjugate their self-interest to the interests of patients. Physicians may not always have the prerogative of choosing whom to serve. Professional responsibilities to provide care, the need for patients to receive care, and the responsibility to act in the best interest of patients, all place limits on physicians' prerogative to select their patients.

Giving physicians some choice in "whom they serve" arises from the notion that the patient-physician relationship is generally one of "mutual consent." There are two bases for physicians' prerogative to choose whom to treat. The first is a general privilege held by all members of society that accords them a right to choose with whom to associate. Physicians do not give up their freedom of association merely by becoming professionals. But they do assume certain obligations that place limits on their choices in the context of serving patients.

The second aspect of the physicians' prerogative stems from the notion of professionalism. Physicians are granted considerable autonomy within the context of the patient-physician relationship, and this autonomy includes the freedom to choose whether to undertake the treatment of a particular patient. However, this autonomy is not designed to further physicians' self-interests and is not without qualifications. The *Code* balances individual choice with the greater concern of providing access to care, greater responsibility in emergency situations, and continuity of care. In Opinion 10.05, "Potential Patients," the *Code* provides clear guidance about when it is unethical to refuse a patient, as well as when such refusals are justifiable. It states:

Opinion 10.05, "Potential Patients"

> (2) The following instances identify the limits on physicians' prerogative [to refuse patients]:
>
> > a) Physicians should respond to the best of their ability in cases of medical emergency...
> > b) Physicians cannot refuse to care for patients based on race, gender, sexual orientation, or any other criteria that would constitute invidious discrimination...
> > c) Physicians may not refuse to care for patients when operating under a contractual arrangement that requires them to treat...
>
> (3) In situations not covered above, it may be ethically permissible for physicians to decline a potential patient when:
>
> > a) The treatment request is beyond the physician's current competence.
> > b) The treatment request is known to be scientifically invalid...

c) A specific treatment sought by an individual is incompatible with the physician's personal, religious or moral beliefs."

Generally physicians have greater latitude in refusing potential patients when the refusal occurs prior to the establishment, or the appearance of an establishment, of a patient-physician relationship. Once a professional relationship has been initiated, it is clearly unacceptable to neglect the care of a patient.

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Module 1

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Case 1.2: Fundamentals of the Patient-Physician Relationship—Mr. Jones Keeps Calling

Case Presentation

Dr. Stevens opts to accept Mr. Jones as his patient, meeting him for the first time in the emergency room. During the first appointment after his hospitalization, Mr. Jones expresses shock about the emergency and is concerned that his medical condition is deteriorating. He tells Dr. Stevens that he hopes he will never need to give himself insulin shots. Dr. Stevens talks with Mr. Jones about his concerns, reiterating the need for him to watch his diet, exercise, and, now, take his oral medication correctly and regularly.

Mr. Jones leaves the office feeling like he has less to worry about. However, every time he mentions going to the emergency room, people tell him about their diabetes and relate horror stories about relatives or acquaintances who have had limbs amputated or gone blind. Mr. Jones again becomes concerned and anxious about his condition. He calls Dr. Stevens' office several times during the next month asking to talk with the nurse or, preferably, Dr. Stevens.

As Dr. Stevens' practice grows he has less time to consult with patients over the telephone, especially with the same patient asking the same questions over and over. In addition, Dr. Stevens gets the sense that Mr. Jones is not doing all that he should to monitor and manage his illness. Mr. Jones's anxiety keeps rising, and Dr. Stevens becomes frustrated.

What should Dr. Stevens do about Mr. Jones? (select an option)

A. Tell Mr. Jones to schedule an appointment within the next two weeks and ask him to make a written list of his questions.
B. Tell Mr. Jones to "Come and see me when you're sticking to your diet and doing what I told you to do."
C. Tell the office assistant to explain to Mr. Jones that they will discuss his concerns during their next scheduled meeting time in three months.
D. Tell Mr. Jones that it would be helpful for him to see a diabetes educator at the hospital who could talk with him about appropriate diet and exercise.

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Module 1

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Case 1.2: Fundamentals of the Patient-Physician Relationship—Mr. Jones Keeps Calling

Option Assessment

A. Scheduling a follow-up appointment within two weeks to answer the patient's questions is the **preferable** option and is supported by Opinion 10.01 "Fundamental Elements of the Patient-Physician Relationship" that describes the relationship as a "collaborative" one in which the physician provides "information and guidance…with courtesy, respect, responsiveness and timely attention….

B. Dr. Stevens should **avoid** making adherence to treatment a condition for Mr. Jones's access to his physician. Opinion 10.01, "Fundamental Elements of the Patient-Physician Relationship" (2) states that the patient "has the right to make decisions regarding the health care that is recommended by his or her physician." To refuse Mr. Jones access implies that his right to health care depends on his adherence to Dr. Stevens' advice.

C. Asking Mr. Jones to wait three months to address his concerns should be **avoided.** Mr. Jones's telephone calls fall within the accepted behavior of one who is in the role of patient, eg, bringing medical concerns to the doctor who assesses the concerns, provides information to the patient and, if necessary, determines a medically appropriate treatment plan in collaboration with the patient. Opinion 10.01, "Fundamentals of the Patient-Physician Relationship," (1) speaks to the patient's right "to receive information… and guidance…as to the optimal course of action." In addition, failing to respond ignores the patient's "right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs."

D. Referring Mr. Jones to a diabetes educator is **acceptable** under Opinions 3.03, "Allied Health Professionals" and 3.04, "Referral of Patients," which affirm that physicians often work "in concert with allied health professionals." The principles that govern this collaboration assert that the referral must be made for the good of the patient and must be to an allied professional with appropriate training and licensing for his or her specific practice. The primary care physician has the obligation to cooperate with other providers in order to maintain the patient's "right to continuity of health care."

Compare these options

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Case 1.2: Fundamentals of the Patient-Physician Relationship—Mr. Jones Keeps Calling

Option Comparison

Option A is preferable because scheduling a follow-up appointment within two weeks demonstrates compassion for the patient's suffering and acknowledges the patient's right to bring concerns and questions to the physician. Option B — refusing to see the patient until he demonstrates compliance with the treatment plan—should be avoided because it fails to respect Mr. Jones's freedom to make decisions, and it may undermine the collaborative relationship. Option C —asking the patient to wait three months to address his concerns—should be avoided also, because it fails to provide a timely response to the patient's legitimate concerns. Option D—referring the patient to an allied health professional—is acceptable and is very often an adjunct element of the treatment plan.

Preferable: Option A

Acceptable: Option D

Avoid: Options B and C

Additional discussion and information

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Case 1.2: Fundamentals of the Patient-Physician Relationship—Mr. Jones Keeps Calling

Additional Information

Collaboration, the hallmark of contemporary patient-physician interactions, is only possible in a trusting relationship. Patients need to trust that their well-being will be the primary consideration, and physicians need to trust patients to provide accurate information and appropriate feedback. New patients, particularly those first seen during emergencies, may not immediately trust their physicians, and, even when patients and physicians have worked together over time, a new medical event may alter the nature of the relationship. Physicians can sometimes view repetitive phone calls from their patients—especially those who seem to ignore the medical advice they receive—as impositions on their time. But these telephone calls are signs that the patient considers him- or herself to be in a relationship with a physician and that he or she trusts the physician.

Providing follow-up appointments allows the physician to assess the patient's on-going medical status and provides an opportunity to clarify the patient's understanding of what has been said to him or her during previous appointments. Moreover, such discussions engage the patient in the shared responsibility for maintaining or restoring his or her health. The physician's demonstrated commitment to patient care fosters or improves the patient-physician relationship.

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Module 1

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Case 1.3: Physicians' Political Communications with Patients and Their Families—Who Should I Vote For?

Case Presentation

Dr. Allworthy has been a physician for nearly 35 years. He has many long-time patients with whom he often engages in non-medical conversations about vacations, new restaurants, good movies, etc. When asked about changes in health care, he usually sighs and says, "Being a doctor isn't what it used to be!" Given the upcoming election and the candidates', as well as media's, attention to health care-related issues such as rising malpractice insurance, costs for medication, and changes in Medicare, Dr. Allworthy's patients are beginning to press him for his opinions on these subjects and to ask for whom he is voting. Since elected officials at local, state, and federal levels will be tackling many of these issues through policy decisions and specific statutes, Dr. Allworthy is thinking that he should inform his patients about what he believes is in their best interests and who he believes is the best candidate.

What should Dr. Allworthy do about involving patients in political advocacy? (select an option)

A. In the 30 days preceding the national election, tell patients who inquire which candidates they should vote for.
B. Hand out flyers with instructions on how patients can inform their elected representatives of their positions on proposed legislation.
C. When patients ask his opinion, provide them with an overview of the issues and what particular options will mean for health care in general.
D. Explain that it is not appropriate for him to discuss political issues with patients –even health-related issues.

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Module 1

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Case 1.3: Physicians' Political Communications with Patients and Their Families—Who Should I Vote For?

Option Assessment

A. Telling patients for whom they should vote should be **avoided**.
According to Opinion 9.012, "Physicians' Political Communication with Patients and Their Families," "Conversations about political matters are not appropriate at times when patients or families are emotionally pressured by significant medical circumstances. Physicians are best to judge both the intrusiveness of the discussion and the patient's level of comfort."

B. Providing patients flyers and instructions on how to notify their elected representatives is an **acceptable** activity under Opinion 9.012, "Physicians' Political Communications" as long as patients do not feel pressured to take the flyers. This opinion clearly states that physicians should not allow their positions on political matters to interfere with the delivery of high-quality professional care.

C. Providing patients with information and opinions related to health care issues is the **preferred** course of action. Opinion 9.012, "Physicians' Political Communications" states that, in "fulfilling their responsibility to work for the reform of, and to press for the proper administration of, laws that are related to health care, physicians should keep themselves well-informed as to current political questions….In addition, "it is natural that in fulfilling these political responsibilities, physicians will express their views to patients or their families."

D. Explaining to patients that it is not appropriate to discuss political issues is an **acceptable** course of action. While Opinion 9.012, "Physicians' Political Communications" acknowledges the right of physicians to express their views when appropriate, it mandates that they do so with due consideration. The responsibility for judging whether the discussion is within the patient's level of comfort lies with the physician.

Compare these options

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Module 1

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Case 1.3: Physicians' Political Communications with Patients and Their Families—Who Should I Vote For?

Option Comparison

The manner in which physicians advocate for political candidates and issues can have serious consequences for the patient-physician relationship. Patients can easily become concerned that they will disappoint or anger the physician if they disagree with the physician's opinion and that the disagreement might affect the health care they receive. Other variables, such as the length of a particular patient-physician relationship or degree of formality in the relationship, can affect how patients feel about complying or disagreeing with the physician's political opinions.

When physicians indiscriminately exercise their right to advocate for political causes, as in option A, they are exhibiting a lack of concern for the effect on the individual patient and thus should avoid doing so as a general practice. Asking patients to take flyers with instructions on how to notify their elected representatives, as in option B, is an acceptable form of political advocacy. Option C is the preferred course of action because it provides the patient or family with relevant information but allows them to make the final choice for whom they vote. Option D—explaining that talking politics with patients is taboo—is acceptable in maintaining clear professional boundaries between physician and patient.

Preferable: Option C

Acceptable: Options B and D

Avoid: Option A

Additional discussion and information

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Module 1

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Case 1.3: Physicians' Political Communications with Patients and Their Families—Who Should I Vote For?

Additional Information

Physicians enjoy the rights and privileges of free speech shared by all Americans. In addition to these ordinary political rights, physicians have a particular and enhanced duty to work for the reform of, and to press for the proper administration of, laws that affect health care issues. When patients turn to them for advice about health care matters, physicians are in a position to offer them well-informed, thoughtful opinions. Thus, it is natural for physicians to express their views to patients or their families, and doing so may also solicit the support of patients or their families for particular positions, parties, or candidates. However, these rights and privileges must be exercised with sensitivity to the context of the patient-physician relationship in general and to the particular encounter.

Political conversations should not exploit the medical authority of the physician. To avoid the over-reliance of patients on physicians' non-medical opinions, the ideal discussion should be an interactive one in which the patient receives information from the physician but feels free to exercise his or her own judgment. Communication about political matters must be undertaken with sensitivity to the threats such communication can pose to the patient-physician relationship, especially when the patient is vulnerable and dependent on the physician's help. Physicians should exercise due care in discussing specific issues or opinions on matters that are directly related to the patient's health condition. Finally, physicians should cease political conversations if it becomes apparent that the patient or family is at all uncomfortable, even if the patient or family member initiated the conversation.

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Module 1

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Case 1.4: Terminating the Patient-Physician Relationship—Saying Goodbye to Mr. Jones

Case Presentation

Almost a year has passed since Mr. Jones became Dr. Stevens' patient. During that time Mr. Jones has not adhered to the treatment plan for his diabetes. Although Mr. Jones maintains that he watches his diet, he has gained ten pounds and admits that he does not exercise as he should. His insurance provides prescription coverage, but he does not always refill his diabetes medications in time to assure continuous dosages. Mr. Jones's health is slipping to the point where he might need to switch to insulin by injection.

Reasoning with Mr. Jones about the consequences of non-adherence to his chronic illness management regimen has not worked. Since Mr. Jones appears competent, Dr. Stevens doesn't understand his failure to follow through on the agreed-upon treatment plan and is considering terminating his relationship with Mr. Jones. Dr. Stevens' practice is rapidly growing, with a waiting list of prospective patients.

What should Dr. Stevens do about Mr. Jones? (select an option)

A. Write Mr. Jones a letter stating that he has not been adhering to his treatment plan and that he should look for a new doctor immediately.
B. Inform the appointment desk that if Mr. Jones calls for an appointment, he is not to be given one and should be told that Dr. Stevens is no longer his doctor.
C. Write Mr. Jones a letter stating that they seem to be having difficulty agreeing on an appropriate treatment plan and suggest that it might be in Mr. Jones's best interests to see another physician.
D. Write Mr. Jones a letter requesting that they meet in the next two weeks and review his treatment plan.

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Module 1

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Case 1.4: Terminating the Patient-Physician Relationship—Saying Goodbye to Mr. Jones

Option Assessment

A. Telling Mr. Jones that Dr. Stevens' services are terminated "effective immediately" should be **avoided**. Opinion 8.115, "Termination of the Physician-Patient Relationship" obligates the physician to give "… notice… sufficiently long in advance of withdrawal to permit another medical attendant to be secured."

B. Ignoring Mr. Jones's request for an appointment should be **avoided.** While patient-physician relationships can be terminated by either party, Opinion 8.115, "Termination of the Patient-Physician Relationship" obligates the physician to give "notice…sufficiently long in advance of withdrawal to permit another medical attendant to be secured." Moreover, refusing to see a patient without sufficient notice and without noting the patient's medical condition may constitute neglect; Opinion 8.11, "Neglect of Patient" states: "Once having undertaken a case, the physician should not neglect the patient."

C. Writing Mr. Jones a letter expressing what Dr. Stevens sees as the difficulty in their particular patient-physician relationship is an **acceptable** option. Expressing concern and recommending another physician does not violate Opinion 8.115, "Termination of the Patient-Physician Relationship." Dr. Stevens is providing "notice sufficiently long in advance of withdrawal to permit another medical attendant to be secured." Given the potential harm Mr. Jones could incur if he continues to ignore his treatment plan, Dr. Stevens is correct in addressing the issue.

D. Talking with Mr. Jones directly about what Dr. Stevens sees as a difficulty in their relationship is the **preferred** option. This conversation will give Dr. Stevens adequate time to explain his reason for withdrawing from the relationship with Mr. Jones and give him the opportunity to express his hope that Mr. Jones's relationship with another doctor might be more effective. Moreover, Dr. Stevens will not violate Opinion 8.115, "Termination of the Patient-Physician Relationship," which obligates the physician to give "notice…sufficiently long in advance of withdrawal to permit another medical attendant to be secured."

Compare these options

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Module 1

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Case 1.4: Terminating the Patient-Physician Relationship—Saying Goodbye to Mr. Jones

Option Comparison

Options C and D—writing the patient a letter stating that there appears to be a difficulty in their relationship or discussing this difficulty directly with Mr. Jones—are both acceptable. D is the preferred option because it gives Dr. Stevens and Mr. Jones the chance to discuss the nature of the difficulty, leaving open the possibility for a resolution and a continuation of the relationship. Options A and B—immediate termination of the patient-physician relationship or rejecting the request for an appointment—should be avoided because immediate termination either through implication or direct notification violates the *Code of Medical Ethics.*

Preferable: Option D

Acceptable: Option C

Avoided: Options A and B

Additional discussion and information

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Module 1

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Case 1.4: Terminating the Patient-Physician Relationship—Saying Goodbye to Mr. Jones

Additional Information

At times the relationship between patient and physician can be perceived as "difficult" by either the patient or the physician. Physicians might label a patient as difficult when they perceive him or her to be demanding or refusing to follow the agreed-upon treatment plan. Studies conducted in this area suggest that a difficult patient-physician relationship emerges from the conflicting expectations and misunderstood behaviors on the part of both patient and physician.

Putting concerns to patients in writing is not unusual when talking with the patient does not seem to be effective or when documentation is prudent. The written communication must be clear about what will occur next. Requesting that the patient come in for an appointment to discuss what seems to be a problem situation demonstrates courtesy and respect. Illness can make people feel vulnerable and unsure of the future. Rather than accelerating the difficulty, the physician can facilitate a discussion in which the problem is acknowledged, both patient and physician's perspectives are identified, the physician tries to understand his or her own reactions to the patient's behavior, and there is an attempt to negotiate grounds for continuing the relationship.

Nonetheless, knowing if and when to refer a patient is also important. When a physician terminates the relationship and patients do not fully understand why, they may feel that they are being punished or abandoned by their doctor. These feelings may create hesitancy for the patient to seek additional medical care.

Physicians who terminate a relationship with a patient, must give the patient sufficient time to find another physician. Patients, especially those with diagnosed conditions, have the right to expect "continuity of care." Without sufficient notice the patient's health can be put into severe jeopardy necessitating emergency treatment.

Although some state laws require 30 days notice, in other states "sufficiency of notice" is an open time frame that will vary from patient to patient and situation to situation. With patients for whom a transfer can be made relatively easily, "sufficient" may be the time it takes to transfer of records to the physician in the next office. In other situations, 30 days may be necessary. Prudence suggests giving the patient a reasonable period of time to accept the termination emotionally and secure a new physician. In those situations where the patient does not wish to accept alternative sources of health care, it is in the best interests of the patient and physician to have a clear date by which the physician will no longer accept responsibility for the patient.

Module 1 Feedback Questionnaire

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Module 1: Patient-Physician Relationship

Feedback Questionnaire

In Module 1 on the patient-physician relationship, how would you rate the relevance of clinical cases?
- Excellent
- Very good
- Good
- Fair
- Poor

How would you rate the explanation of courses of action?
- Excellent
- Very good
- Good
- Fair
- Poor

How would you rate the overall coverage of the topic?
- Excellent
- Very good
- Good
- Fair
- Poor

Submit

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Module 2

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Case 2.1: Respect for Patient Decision Making—Mr. Douglas's Choice of Treatment

Case Presentation

Ian Douglas, a 53-year-old businessman, worked long hours and enjoyed a successful and lucrative career. He had smoked on and off for 25 years. Recently, Mr. Douglas had been feeling tired and having trouble breathing when he climbed stairs. Every so often he had chest pains. When Mr. Douglas and his wife, Lynn, sat down to talk to their teenage son about failing 2 of his classes. Mr. Douglas lost his temper and the chest pains started. This time they crept up the side of his neck, so he stopped and went to lie down. That's when he decided he was going to see a doctor.

In Dr. Kim's office, Mr. Douglas explained that he was having chest pains that lasted no longer than 5 minutes and were always relieved by rest. He said he'd been having the symptoms for a while, but they didn't seem to be getting any better or worse. Dr. Kim got an EKG in the office, which was normal, and had him undergo a stress test. Mr. Douglas had to stop the test because he started feeling fatigued and having mild chest pains. Dr. Kim explained that the tests showed some ischemia and marked ST changes on his EKG, indicating that Mr. Douglas needed an angiogram in the next day or 2 to better evaluate his coronary arteries.

When Mr. Douglas returned to the doctor for the results of the angiogram, Dr. Kim told him that his three main coronary arteries were all severely blocked. "The good news," Dr. Kim said, " is that we caught this before you had a major heart attack. The bad news is that you should have triple bypass surgery as soon as possible."

Mr. Douglas gasped. "Don't you think that's jumping the gun, I just have a little heart problem, right? I know I've got to do something about this. I'll quit smoking, and I'll go to the gym, but I'm not having open heart surgery for these little chest pains."

Dr. Kim shook his head, "Mr. Douglas, I understand that you believe your symptoms don't warrant major surgery, but your heart is working overtime right now. It is just a matter of time before it gives out. You should start eating better and you must stop smoking, but there is no question that the surgery is necessary, and I would like it to happen as soon as possible. You'll have to take a few weeks off work to recover from the procedure, but you should be able to return to work in a month or two."

"Listen, doc, I have a major deal that has to go through within the next month," Mr. Douglas insisted. "How about I start taking care of myself, and you let me get this deal signed, and then we'll talk about the surgery, okay?"

What should Dr. Kim do? (select an option)

A. Ask Mr. Douglas to restate his understanding of his medical condition and explain that lifestyle changes will not reverse the current condition.
B. Tell Mr. Douglas that he will die without surgery.
C. Ask Mr. Douglas to inform his wife of his condition so they can discuss his alternatives.
D. Recommend that Mr. Douglas get a second opinion.

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Module 2

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Case 2.1: Respect for Patient Decision Making—Mr. Douglas's Choice of Treatment

Option Assessment

A. Asking Mr. Douglas to restate the nature of his medical condition and explaining the role of lifestyle changes is **preferable**; it is supported by the first sentence of Opinion 8.08, "Informed Consent": "The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice." By asking Mr. Douglas to restate the nature of his medical condition, the physician can discover whether he has the appropriate information. Moreover, explaining in detail the effectiveness of lifestyle choices (eg, quitting smoking and regular exercise) for prevention of his condition versus treatment of his condition is supported by the same sentence of Opinion 8.08, "Informed Consent": "The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice." By explaining (or re-explaining) these differences in effectiveness, the physician ensures that Mr. Douglas has enough information to make an informed decision.

B. Telling Mr. Douglas that he will die without surgery should be **avoided** because it is not supported by the *Code* and may violate Opinion 8.08, "Informed Consent": "The physician's obligation is to present the medical facts accurately to the patient...and to make recommendations for management in accordance with good medical practice." While it is likely that Mr. Douglas will have a heart attack if he doesn't have surgery, it is not certain that he will die. Telling the patient he will die is an attempt to coerce him into accepting the physician's recommended treatment; this constitutes undesirable paternalistic behavior on the physician's part.

C. Suggesting that Mr. Douglas inform his wife of his condition so they can discuss his alternatives is an **acceptable** option not clearly addressed by the *Code*. This course of action may fall under Opinion 8.08, "Informed Consent", which states that the "physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice." By encouraging Mr. Douglas to involve his spouse in the decision-making process, the physician acknowledges the value of (usually helpful) input from family and other social relationships in important decisions.

D. Suggesting that Mr. Douglas obtain a second opinion is an **acceptable** alternative not clearly addressed by the *Code*. This course of action may fall under Opinion 8.08, "Informed Consent," which states that the "physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice." A second opinion will likely emphasize to Mr. Douglas the seriousness of his condition and may help him make a reasoned decision.

Compare these options

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Case 2.1: Respect for Patient Decision Making—Mr. Douglas's Choice of Treatment

Option Comparison

To assure that Mr. Douglas is aware of the likely outcomes of his choice, option A is preferable and is expressly supported by the *Code* because it addresses the potential shortcoming of Mr. Douglas's decision-making capacity, specifically, his understanding of the likely consequence of no treatment. In requiring Mr. Douglas to restate his medical condition, option A gives Dr. Kim the chance to explain the limits of lifestyle options on treating existing conditions and to correct any of Mr. Douglas's misconceptions.

Option C, asking Mr. Douglas to bring his wife into the conversation, gives him an opportunity to carefully consider how his decision will affect the people and life he values. Option D (getting a second opinion) is also an acceptable alternative that gives Mr. Douglas another opportunity to have the severity of his condition explained. Although this may not help him clarify his values, it may emphasize to him the severity of his condition.

Options B, telling Mr. Douglas he will die, should be avoided. This options ignores the uncertainty inherent in any medical prognosis. No physician can know that a patient in Mr. Douglas's situation will die without treatment in the next month, and stating so attempts to coerce Mr. Douglas.

Preferable: Option A

Acceptable: Option C and D

Avoid: Option B

Additional discussion and information

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Case 2.1: Respect for Patient Decision Making—Mr. Douglas's Choice of Treatment

Additional Information

The right of patients to make informed decisions about their medical treatment is a cornerstone of contemporary ethical medical practice. The current *Code* reflects this right in a number of Opinions including Opinion 10.01, "Fundamental Elements of the Patient-Physician Relationship": "The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives...[and] patients may accept or refuse any recommended medical treatment"; and Opinion 8.12, "Patient Information": "Patients have a right to know their past and present medical status and to be free of any mistaken beliefs concerning their conditions."

Generally, patients are not privy to the specialized knowledge of medicine, and, without help, they are likely to misunderstand their diagnoses and treatment options. Accordingly, physicians and other medical professionals are obliged to use their expertise to help patients make informed decisions about their medical care. As the *Code* emphasizes again and again, autonomous decision making is a fundamental tenet of good medical care. This point is expressed most directly in Opinion 8.08, "Informed Consent":

Opinion 8.08, "Informed Consent"

> The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice...The physician's obligation is to present the medical facts accurately...[and] to help the patient make choices from among the therapeutic alternatives consistent with good medical practice...Social policy does not accept the paternalistic view that the physician may remain silent because divulgence might prompt the patient to forego needed therapy. Rational, informed patients should not be expected to act uniformly, even under similar circumstances, in agreeing to or refusing treatment.

For patients to exercise informed consent (to be autonomous) they must be competent and have decision-making capacity. Determination of a patient's decision-making capacity is an informal judgment by physicians and other health care practitioners about the patient's ability to give informed consent for *this* decision.

The following generally accepted elements of informed consent can help determine whether Mr. Douglas can give informed consent in this case: (1) the patient must be able to understand the information that he or she receives about his or her medical condition and the likely outcomes associated with all treatment options, including no treatment. (2) The patient must be informed of diagnosis and treatment alternatives with associated risks and benefits (including the risks and benefits of no treatment). (3) The patient must be able to make an uncoerced judgment about the information in light of his or her personal values and goals. Here it is recognized that an individual's "voluntariness," that is, his or her ability to make uncoerced decisions, can be compromised by physical, emotional, or psychological states and by the influence of drugs or alcohol. (4) The patient must be able to communicate his or her wishes with consistency over time.

Mr. Douglas would undoubtedly be judged legally competent, but Dr. Kim has a legitimate concern about whether Mr. Douglas understands the likely consequences of his decision. He seems to know that the surgery will severely limit his activity for some time, but he may not be clear on the likely outcome of refusing surgery.

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Module 2

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Case 2.2: Disclosure and Patient Information—Mr. Douglas's Angiogram Gets a Second Look

Case Presentation

For the first presentation of his cardiology elective, Scott was to select an angiogram and discuss his observations with the other students, residents, and faculty. He selected Mr. Douglas's angiogram taken during his visit with Dr. Kim.

Scott decided the angiogram showed 3, possibly 4, significantly to severely blocked arteries. The next time he saw the attending cardiologist, Dr. Carlson, Scott asked him to look at the film to see if he concurred. Dr. Carlson pinpointed 4 areas of interest on the angiogram, and asked Scott, "What are those?" "They look like 1 significant and 3 severe atherosclerotic stenoses," Scott answered, and Dr. Carlson agreed.

Scott noticed that the short narrative accompanying the angiogram mentioned only the 3 severe blockages. Assuming Dr. Kim would want to know about this information, Scott tracked him down and asked whether he wanted to inform Mr. Douglas of the new diagnosis.

Dr. Kim responded, "I told Mr. Douglas about the severity of his condition, but he was adamant that he was not interested in surgery because he has a misguided belief that lifestyle changes will resolve his condition. I don't think news of one more significant blockage is going to change his mind."

Scott wasn't satisfied. Believing that Mr. Douglas was in danger of an acute myocardial infarction, he thought Mr. Douglas should know about the greater severity of his condition. But Scott couldn't take it upon himself to track down Mr. Douglas and call him. The guy would think he was nuts, not to mention that he'd be undermining the relationship between Dr. Kim and Mr. Douglas.

Scott mentioned the case to his wife that night, mostly to let her know about his diagnostic "catch." But Becky's response was all about Mr. Douglas. "It's okay for you to practice on those patients," Becky said, "for the good of medical education and the benefit of society. Now here comes a case where somebody might benefit from the fact that a student carefully looked at his angiogram. That could only happen in a teaching hospital. You have to do something, Scott."

The next day Scott approached Dr. Carlson to tell him about his exchange with Dr. Kim. Upon informing Dr. Carlson of the exchange, Scott didn't know what to expect. Dr. Carlson shook his head. "Don't worry about it Scott, I'll take care of it."

What should Dr. Carlson do? (select an option)

A. Follow Dr. Kim's instructions that no further action is needed.
B. Contact Mr. Douglas directly.
C. Tell Dr. Kim that if he does not inform Mr. Douglas, then Dr. Carlson will feel obligated to do so.

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Case 2.2: Disclosure and Patient Information—Mr. Douglas's Angiogram Gets a Second Look

Option Assessment

A. Following Dr. Kim's advice that no further action is needed should be **avoided** because it would violate Opinion 8.12, "Patient Information," which states: "[A physician's] ethical responsibility includes informing patients of changes in their diagnoses resulting from retrospective review of test results...This obligation holds even though the patient's medical treatment or therapeutic options may not be altered."

B. Contacting Mr. Douglas directly is **acceptable** and is supported by the *Code* in Opinion 8.12, "Patient Information," which states : "[A physician's] ethical responsibility includes informing patients of changes in their diagnoses resulting from retrospective review of test results...This obligation holds even though the patient's medical treatment or therapeutic options may not be altered." This obligation, however, must be balanced with Dr. Carslon's intrusion into Dr. Kim's and Mr. Douglas's relationship.

C. Informing Dr. Kim that if he does not inform Mr. Douglas, then Dr. Carlson will feel obligated to do so is **preferable**. This will respect Dr. Kim's relationship with Mr. Douglas but also make it clear that, one way or another, Dr. Carlson will fulfill his "ethical responsibility [that] includes informing patients of changes in their diagnoses resulting from retrospective review of test results...even though the patient's medical treatment or therapeutic options may not be altered" (from Opinion 8.12, "Patient Information").

Compare these options

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Case 2.2: Disclosure and Patient Information—Mr. Douglas's Angiogram Gets a Second Look

Option Comparison

Given the clear obligation to provide patients with accurate information about their medical condition, option A (choosing not to inform Mr. Douglas) should be avoided because it violates the demands of the *Code* in Opinion 8.12, "Patient Information." Even though Dr. Carlson does not have an existing relationship with Mr. Douglas, he has an obligation (as does Scott) to make sure Mr. Douglas is apprised of his medical condition.

Option B (contacting Mr. Douglas) is an acceptable alternative because it fulfills Dr. Carlson's obligation to Mr. Douglas, but it may undermine the trust between Dr. Kim and Mr. Douglas. To help preserve the trust in their relationship, option C is the preferable alternative. It allows Dr. Kim the opportunity to inform Mr. Douglas of the new diagnosis himself, but makes clear that the ethical obligation to inform Mr. Douglas of the diagnostic error will be fulfilled regardless.

Preferable: Option C

Acceptable: Option B

Avoid: Option A

Additional discussion and information

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Case 2.2: Disclosure and Patient Information—Mr. Douglas's Angiogram Gets a Second Look

Additional Information

Opinion 8.12, "Patient Information" notes that, "Patients have a right to know their past and present medical status and to be free of any mistaken beliefs concerning their conditions." It is often difficult for physicians to satisfy the ethical duty to inform patients when a medical intervention has produced unexpected outcomes as a result of poor judgment, human error, or unknown causes. Disclosure can also be difficult when physicians or other medical practitioners have misinterpreted or misreported diagnostic test results. As Opinion 8.12, "Patient Information," makes clear, failure to disclose any such problems undermines the ethical responsibility to respect patient autonomy.

Opinion 8.12, "Patient Information"

> ...Patients have a right to know their past and present medical status and to be free of any mistaken beliefs concerning their condition. Situations occasionally occur in which a patient suffers significant medical complications that may have resulted from the physician's mistake or judgment. In these situations, the physician is ethically required to inform the patient of all the facts necessary to ensure understanding of what has occurred. Only through full disclosure is a patient able to make informed decisions regarding future medical care.
>
> [The physician's] ethical responsibility includes informing patients of changes in their diagnoses resulting from retrospective review of test results or any other information. This obligation holds even though the patient's medical treatment or therapeutic options may not be altered by the new information.
>
> Concern regarding legal liability which might result following truthful disclosure should not affect the physician's honesty with a patient.

The obligation to uncover and disclose information regarding an unexpected harm or an inaccurate diagnosis arises from physicians' responsibility to act as patient advocates and to promote the patient's best interests, regardless of competing personal interests.

Some contend that the doctrine of "therapeutic privilege" permits a physician to withhold information that, if disclosed, could cause psychological distress or could undermine trust and lead the patient to rash decisions that would result in even greater negative effects. In the rare instances where this may be a concern, the physician should involve appropriate members of the patient's family, or other advocates, and consult a disinterested party, such as a trusted colleague or member of the ethics committee. Therapeutic privilege should not be invoked (or more accurately, hidden behind) merely as a means to avoid disclosing a diagnostic or medical error or an unexpected harm.

Communication about diagnostic or medical errors or unexpected harms should be made with tact, including an expression of concern and regret. Opinion 8.121, "Ethical Responsibility to Study and Prevent Error and Harm," explains how physicians might express their concern over unexpected harms to patients; "An expression of concern need not be an admission of responsibility. When patient harm has been caused by an error, physicians should offer a general explanation regarding the nature of the error and the measures being taken to prevent similar occurrences in the future." Many times, this explanation will preserve trust and will allow continuity of care with the same health care team. Such communication is most important when decisions need to be made promptly in response to the harm that has occurred. However, if the disclosure injures the patient's trust in the physician so severely that the patient prefers to obtain subsequent care elsewhere, the physician has a responsibility to assist the patient in obtaining continuing care.

If a physician who is responsible for an error or harm is unwilling or unable to acknowledge his or her responsibility to the patient, a neutral party should communicate the information to the patient. Alternately, a health care professional may discover an error or harm that a patient experienced under someone else's care. It is clear that even if a physician is not responsible for the harm, that physician still has the ethical obligation to be honest and forthcoming with information pertaining to the patient.

Related topic: Preventing errors

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Case 2.2: Disclosure and Patient Information—Mr. Douglas's Angiogram Gets a Second Look

Related topic: Preventing errors

Because of their central role in the provision of medical care and the unique ethical obligations that flow from caring for vulnerable patients, physicians also have a responsibility to enhance patient safety through identification and correction of the causes of diagnostic or medical errors and patient harm. Uncovering the exact causes of an error—including systemic causes such as mislabeling of medications and failure to transmit information—and correcting them when possible should be high priorities. The error in the case at hand seems to be simply a mistake of human judgment, but, as Opinion 8.121 explains, an investigation should be undertaken nonetheless.

Opinion 8.121, "Ethical Responsibility to Study and Prevent Error and Harm"

> In the context of health care, an error is an unintended act or omission, or a flawed system or plan, that harms or has the potential to harm a patient. Patient safety can be enhanced by studying the circumstances surrounding health care errors.
>
> > 1) Because they are uniquely positioned to have a comprehensive view of the care patients receive, physicians must strive to ensure patient safety and should play a central role in identifying, reducing, and preventing health care errors. This responsibility exists even in the absence of a patient-physician relationship.
> > 2) Physicians should participate in the development of reporting mechanisms that emphasize education and systems change, thereby providing a substantive opportunity for all members of the health care team to learn.

Physicians concerned with the rise in professional liability claims and awards may think that the reporting and disclosing of errors and harms will only add to their problems. But some data suggest that the major determinant of the initiation of professional liability claims may be faulty communication and patient dissatisfaction [1, 2], rather than the quality of care [3]. On the basis that transparency—as opposed to secrecy—promotes trust, commentators have argued that open disclosure of errors may mitigate patient discontent and maintain patient confidence and, therefore, may be an important tool to reduce the risk of professional liability [4]. Such advice appears consistent with a recent study, which found that 98 percent of individuals who were presented with various scenarios expected or wished for the physician's active acknowledgement of an error [5]. Some patients may file lawsuits specifically to uncover information they otherwise have not been able to obtain. Also, for many patients, an offer of money is less likely to make them terminate a legal action against a physician than an explanation, an apology, and an assurance that corrective measures would be undertaken to prevent future similar errors [6].

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Case 2.3 Surrogate Decision Making—Mrs. Douglas's Choice of Treatment for Her Husband

Case Presentation

Even after he was informed of his new diagnosis, Mr. Douglas was steadfast in his refusal of bypass surgery. A few weeks later, Dr. Kim was only half surprised to get a phone call from Mrs. Douglas informing him she was taking her husband to the ER. Dr. Kim arrived as Mrs. Douglas was describing what happened to the ER physician.

"I found Allan lying on the kitchen floor. He said his chest hurt and the pain wasn't going away like it usually did. I decided to take him to the hospital. I grabbed the aspirin and the nitroglycerine you gave him. He was wheezing and having trouble breathing. He actually threw up in the car. Then he swallowed the nitroglycerin and I don't think he threw up again. He passed out on the way here and only woke up when they helped him from the car."

Dr. Kim checked Mr. Douglas's pulse, which was weak, and noticed his sweat-soaked clothes. His systolic pressure was 65. Dr. Kim paged Dr. Carlson.

When Dr. Carlson arrived he received a synopsis of what had happened and then asked Mrs. Douglas a few questions.

He asked for BP measurements in both arms to check for aortic aneurysm. Ruling that out, he ordered tests on cardiac enzymes, CBC, and electrolytes and a coagulation profile. He also ordered an ECG, to get a current picture of the location and severity of the blockages.

"He's in cardiogenic shock," Dr. Carlson soon announced. "Get a cardiac surgeon down here."

Dr. Imenez arrived and was informed of the situation. After examining the previous angiogram and ECG, he and Dr. Carlson explained to Mrs. Douglas that, because of the location of the blockages and the number of them, Mr. Douglas's best chance for long-term survival was bypass surgery.

Mrs. Douglas gave Dr. Kim a concerned look. "I know he told you that he didn't want bypass surgery, and I guess if there's another option I want to pursue it."

Dr. Kim took a moment to respond, "Mrs. Douglas, I tried to convince Allan he needed bypass surgery, but he was really concerned about some business deal. He's not going to be able to do any business deals if he doesn't have this surgery."

Dr. Carlson added, "If any other treatment, like coronary angioplasty, had a reasonable chance at success, we might try it, but, given the location and severity of the blockages, his long-term survival is substantially diminished with any treatment other than surgery."

"If he didn't want the surgery, I don't think you should do it," Mrs. Douglas responded.

What should Drs Kim, Carlson, and Imenez do? (select an option)

A. Get a court-appointed guardian other than Mrs. Douglas.
B. Continue recommending bypass surgery to Mrs. Douglas.
C. Prep Mr. Douglas for bypass surgery.
D. Treat Mr. Douglas without surgery (ie, catheterization or pharmacological treatment).

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Case 2.3 Surrogate Decision Making—Mrs. Douglas's Choice of Treatment for Her Husband

Option Assessment

A. Getting a court appointed guardian is **acceptable** and may be supported by the *Code* in this case, but it is too early to tell. Given that his life is now threatened, Mr. Douglas would most likely agree to the surgery if he were conscious. Opinion 8.081, "Surrogate Decision-Making" states that "When a physician believes that a decision is clearly not what the patient would have decided or could not be reasonably judged to be within the patient's best interests, the dispute should be referred to an ethics committee before resorting to the courts." Because of the urgency of this situation, however, it may be difficult to call an ethics consultation in time, so the physicians might move for an emergency court appointment of another guardian for Mr. Douglas.

B. Continuing to recommend bypass surgery to Mrs. Douglas is **preferable**; it is supported by the *Code* in Opinion 8.081, "Surrogate Decision-Making": "Physicians should provide [the surrogate with] advice, guidance and support; explain that decisions should be based on substituted judgment when possible and otherwise on the best interests principle; and offer relevant medical information as well as medical opinions in a timely manner." Mrs. Douglas does not appear to know why Mr. Douglas did not want the by-pass surgery and the only reason he gave Dr. Kim was the business deal. Accordingly, both substituted judgment and best interest standards would likely call for the surgery, but further conversation with Mrs. Douglas may confirm or refute this.

C. Prepping Mr. Douglas for by-pass surgery should be **avoided** because it violates the *Code* in Opinion 8.081, "Surrogate Decision-Making": "Physicians should recognize the proxy or surrogate as an extension of the patient, entitled to the same respect as the competent patient." Without further discussion between Mrs. Douglas and Drs Kim, Carlson, and Iminez, prepping Mr. Douglas for surgery would deny her the respect due a legitimate surrogate decision maker.

D. Treating Mr. Douglas without surgery (i.e., catheterization and/or pharmacological treatment) should be **avoided** because it is not supported by the *Code* and may violate the physician's responsibility to ensure decisions are made "on the basis of sound substituted judgment reasoning or the best interest standard" (from Opinion 8.081, "Surrogate Decision-Making").

Compare these options

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Module 2

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Case 2.3 Surrogate Decision Making—Mrs. Douglas's Choice of Treatment for Her Husband

Option Comparison

Mrs. Douglas has refused to consent to surgery for her husband. This decision is not based on the best interests standard, since it is in the interest of Mr. Douglas's survival to have cardiac surgery. Mrs. Douglas claims to be using the "substituted judgment" standard, offering the decision her husband reached earlier in the course of his illness when he did not believe he would have a heart attack and didn't want to take time out from his work for the surgery. This may not be the decision Mr. Douglas would make now because he cannot continue with his business unless he has surgery. Accordingly, the preferable course of action is option B—continuing to recommend surgery to Mrs. Douglas. Pursuing this option will likely uncover any other reasons Mrs. Douglas may have for making this decision.

If Mrs. Douglas continues to reject surgery because Mr. Douglas had previously refused and she does not provide further explanation, option A (getting a court-appointed guardian) is an acceptable option. Although involving the courts should be avoided if possible, if Mrs. Douglas makes her decisions without sound basis in substituted judgment or the best interests standard, the physicians have an obligation to try to find another surrogate.

Options C (prepping Mr. Douglas for surgery) and D (treating Mr. Douglas without surgery) should be avoided. So long as Mrs. Douglas refuses and the courts do not appoint an additional guardian, prepping Mr. Douglas for surgery fails to respect Mrs. Douglas as the legitimate surrogate decision maker. The poor prognosis of option D indicates that it too should be avoided. If Mrs. Douglas remains the legal decision maker and she requests a treatment, however, this treatment may offer Mr. Douglas some chance of survival.

Preferable: Option B

Acceptable: Option A

Avoid: Options C and D

Additional discussion and information

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Module 2

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Case 2.3 Surrogate Decision Making—Mrs. Douglas's Choice of Treatment for Her Husband

Additional Information

Patients who cannot make their own medical decisions lack competence and/or decision-making capacity. Incompetent and incapacitated patients create distinct obstacles to respect for patient autonomy because it's not intuitively obvious how to respect the autonomy of an individual who is not capable of making a decision. Surrogate decision making is used to overcome or, at least, resolve this obstacle.

Opinion 8.081, "Surrogate Decision-Making" (Amended, December 2004)

> If a patient lacks the capacity to make a health care decision, a reasonable effort should be made to identify a prior written expression of values such as a pertinent living will, or a health care proxy. When reasonable efforts have failed to uncover relevant documentation physicians should consult state law. Physicians should be aware that under special circumstances (for example, reproductive decisions for individuals who are incompetent), state laws may specify court intervention. In the absence of [applicable] state law...the patient's family, domestic partner, or close friend should become the surrogate decision maker.
>
> When there is evidence of the patient's preferences and values, decisions concerning the patient's care should be made by substituted judgment. This entails considering the patient's advance directive (if any), the patient's views about life and how it should be lived, how the patient has constructed his or her identity or life story, and the patient's attitudes towards sickness, suffering, and certain medical procedures...
>
> If there is no reasonable basis on which to interpret how a patient would have decided, the decision should be based on the best interests of the patient, or the outcome that would best promote the patient's well-being...

To protect the well-being and autonomy of the incompetent or incapacitated patient, three standards have been established in ethics and law to guide surrogate decisions: 1) the documented advance directive, 2) substituted judgment, and 3) the best interest standard.

An advance directive is a document that enables competent persons to exercise their rights to direct medical treatments in the event that they lose their decision-making capacity. There are two general categories of advance directives: 1) a living will, which indicates the types of treatment an individual wishes to receive or forgo under specified circumstances, and 2) a durable power of attorney for health care (or health care proxy appointment), which designates another person to make health care decisions on behalf of the patient.

When an incompetent or incapacitated patient does not have documented treatment preferences or goals and has not appointed a proxy, health care decisions should be determined by substituted judgment when possible, that is, attempting to decide as the patient would, if he or she had decision-making capacity.

Lacking a reasonable basis for interpreting how the patient would have decided, the "best interest" standard should be used. Making a decision based on another's best interests is less an act of respecting the patient's autonomy than it is an expression of beneficence. In the more difficult cases, the best interest standard for decision making is essentially a judgment about quality of life. One rough way to establish the patient's best interests is to ask if the decision is one that most reasonable persons would choose for themselves.

Surrogate decision makers are entitled to the same respect and professional obligations as the decisionally capable patient. Obviously, this will include the features of informed consent (i.e., disclosure and recommendations), and it will also include confidentiality.

If surrogates are in doubt about using either decision-making standard—substituted judgment or best interest—if there is disagreement between surrogates, or if a surrogate appears to be making a self-interested rather than patient-interest decision, an ethics consultation may help. This action is supported by the *Code* in Opinion 8.081, "Surrogate Decision-Making": "When a physician believes that a decision is clearly not what the patient would have decided or could not be reasonably judged to be within the patient's best interests, the dispute should be referred to an ethics committee before resorting to the courts." The urgency in the present case, however, precludes this possibility.

Related topic: Advance directives

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Module 2

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Case 2.3 Surrogate Decision Making—Mrs. Douglas's Choice of Treatment for Her Husband

Related topic: Advance directives

Opinion 8.081, "Surrogate Decision-Making" also recommends that:

> Physicians should encourage their patients to document their treatment preferences or to appoint a health care proxy with whom they can discuss their values regarding health care and treatment. Because documented advanced directives are often not available in emergency situations, physicians should emphasize to patients the importance of discussing treatment preferences with individuals who are likely to act as their surrogates.

Dr. Kim should have recommended either an advance directive or that Mr. Douglas discuss his preferences with Mrs. Douglas. He might also have raised the possibility of a DNR, should Mr. Douglas be incapacitated. This obligation is especially poignant in this case because Mr. Douglas had a substantial risk of presenting in an emergency situation in which he was incapacitated. Had Dr. Kim discussed the possibility of this kind of situation with Mr. Douglas during their first discussion, Mr. Douglas may have given clear indication about his preferences for treatment.

Module 2 Feedback Questionnaire

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Module 2: Informed Consent

Feedback Questionnaire

In Module 2 on informed consent, how would you rate the relevance of the cases?
- Excellent
- Very good
- Good
- Fair
- Poor

How would you rate the explanation of courses of action?
- Excellent
- Very good
- Good
- Fair
- Poor

How would you rate the overall coverage of the topic?
- Excellent
- Very good
- Good
- Fair
- Poor

Submit

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Module 3

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Case 3.1: Respecting Privacy—No Students Please

Case Presentation

"Mr. Jonsen is in Exam 2" Ms Wilson, the ER nurse, tells Dr. Macklin as he and Ahmed Daar, a medical student, come out of Exam 3.

Dr. Macklin grabs the chart and looks it over before stepping into the room. He notices that Mr. Jonsen is complaining of a rash, sore throat, headache, and fever.

As they enter the room, Dr. Macklin says, "Hi Mr. Jonsen, I'm Dr. Macklin and this is Mr. Daar, a medical student. What seems to be the problem today?"

Mr. Jonsen glances at Ahmed and asks, "Does he have to be in here? Because if he doesn't, I'd like him to not be."

Without looking at Ahmed, Dr. Macklin says, "This is a teaching hospital, Mr. Jonsen, and medical students are expected to observe. If they aren't allowed to observe, they can't be trained to be the doctors of tomorrow. Mr. Daar, here, has the same obligations of confidentiality that I do. Anything you say to us will remain confidential."

"I still don't think I want him in here," Mr. Jonsen explains, "and so unless he has to be, I'd appreciate it if he'd leave."

What should Dr. Macklin do? (select an option)

A. Inform Mr. Jonsen that Ahmed will be present during his care at this hospital.
B. Refer Mr. Jonsen to another ER.
C. Instruct Ahmed to leave the room.
D. Try to convince Mr. Jonsen to allow Ahmed to stay.

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Module 3

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Case 3.1: Respecting Privacy—No Students Please

Option Assessment

A. Informing Mr. Jonsen that Ahmed will be present despite his objection should be **avoided** and is not supported by the *Code*. Opinion 5.059, "Privacy in the Context of Health Care" states "physicians must be mindful of patient privacy, which encompasses information that is concealed from others outside of the patient-physician relationship." Ahmed is not Mr. Jonsen's physician, and Mr. Jonsen's care is not dependent on Ahmed's presence.

B. Referring Mr. Jonsen to another (non-teaching hospital) ER should be **avoided;** it is not supported by the *Code* and is not a reasonable option. At this point, Mr. Jonsen's medical state has not been established, and his demand for privacy is supported by Opinion 5.059, "Privacy in the Context of Health Care," which states that "physicians must seek to protect patient privacy in all of its forms, including (1) physical...(2) informational...(3) decisional...and (4) associational."

C. Instructing Ahmed to leave the room is **preferable**; it is supported by the *Code* and may be the best course of action in this situation. Opinion 5.059, "Privacy in the Context of Health Care" states that "physicians should be aware of and respect the special concerns of their patients regarding privacy." Also, Mr. Jonsen's vehement refusals indicate a steadfast commitment to maintaining his privacy.

D. Continuing to try convince Mr. Jonsen to allow Ahmed in the room is **acceptable—**up to a point—and is supported by the *Code*. Opinion 5.059, "Privacy in the Context of Health Care" states that "privacy is not absolute, and must be balanced with the need for the efficient provision of medical care and the availability of resources." Because every medical student's education depends on observing clinical practice, some patient privacy will be compromised. Attempts at persuasion should not be carried to the point that they harm Dr. Macklin's relationship with Mr. Jonsen.

Compare these options

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Case 3.1: Respecting Privacy—No Students Please

Option Comparison

Mr. Jonsen has been steadfast in his demands that Ahmed leave the room during his interaction with Dr. Macklin and his quick observation that Ahmed probably did not need to be in the room for his care indicates that his decision is resolute. Accordingly, option C (instructing Ahmed to leave the room) is the preferable option at this point. If Mr. Jonsen had been less persistent in his pursuit of maintaining privacy, option D (convincing Mr. Jonsen to allow Ahmed to remain) would have been preferable. Given Mr. Jonsen's opposition, option D is only an acceptable alternative in this case.

Because Mr. Jonsen has a right to privacy and rebuking his attempts to exercise it is unnecessarily confrontational, option A (insisting on Ahmed's presence) should be avoided. Simply sending Mr. Jonsen to another ER (option B) and thereby refusing care because of his attempt to protect his privacy implicitly denies his right to privacy. Furthermore, sending him away without verifying that his condition is not emergent could also constitute neglect (see Opinion 8.11, "Neglect of Patients") and violate EMTALA. Accordingly, option B should also be avoided.

Preferable: Option C

Acceptable: Option D

Avoid: Options A and B

Additional discussion and information

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Case 3.1: Respecting Privacy—No Students Please

Additional Information

Privacy and confidentiality are companion concepts in the patient-physician interaction. They differ in the following respect: privacy means that you don't have to share personal information or access to your person with others. Confidentiality—in the context of the patient-physician relationship—serves the purpose of persuading patients to relinquish their privacy on the condition that what they say and what the physician discovers in examining them will be kept confidential.

Patient privacy, however, must be balanced with the informational needs of others involved in the patient's care and also with the need for medical students to participate in patient care, as noted in Opinion 8.087, "Medical Student Involvement in Patient Care."

Opinion 5.059, "Privacy in the Context of Health Care"

> ...Physicians must seek to protect patient privacy in all of its forms, including (1) physical, which focuses on individuals and their personal spaces, (2) informational, which involves specific personal data, (3) decisional, which focuses on personal choices, and (4) associational, which refers to family or other intimate relations. Such respect for patient privacy is a fundamental expression of patient autonomy and is a prerequisite to building the trust that is at the core of the patient-physician relationship.
>
> Privacy is not absolute, and must be balanced with the need for the efficient provision of medical care and the availability of resources. Physicians should be aware of and respect the special concerns of their patients regarding privacy. Patients should be informed of any significant infringement on their privacy of which they may otherwise be unaware.

Neither privacy nor confidentiality is absolute. The provision of affordable and efficient care often requires patients to come to health care facilities, rather than receive care in their homes. In such settings, patients must share many common areas, and many professionals participate in the care of each patient. Privacy cannot always be protected in such circumstances. In certain other circumstances, "overriding social considerations" as set out in Opinion 5.05, "Confidentiality," (see Case 2 Confidentiality) may warrant not only breaches of confidentiality but also an invasion of patient privacy. For instance, on the rare occasion when a person is suspected of physically abusing someone under his or her care (often a child, but possibly the elderly or physically or mentally impaired), superseding the obligations of privacy must be considered. It may be appropriate to implement covert video surveillance to monitor for the occurrence of such abuse. In all other filming scenarios, it is always desirable to obtain the patient's consent prior to filming or, at a minimum, to disclose to the patient that filming will occur (See also Opinion 5.045, "Filming Patients in Health Care Settings," and Opinion 5.046, "Filming Patients for the Education of Health Professionals").

In the case of Mr. Jonsen's refusal to divulge information in Ahmed's presence, Opinion 7.025, "Records of Physicians: Access by Non-Treating Medical Staff" and Opinion 9.123, "Disrespect and Derogatory Conduct in the Patient-Physician Relationship" should also be considered.

Opinion 7.025 states: "Only physician or other health professionals who are involved in managing the patient, including providing consultative, therapeutic, or diagnostic services, may access the patient's confidential medical information. All others must obtain explicit consent to access the information." This indicates that it would be a violation of Mr. Jonsen's confidentiality for Dr. Macklin to divulge what he learns from Mr. Jonsen.

If, however, it becomes clear to Dr. Macklin that Mr. Jonsen's refusal to allow Ahmed's observation is a bigoted refusal, he may decide to transfer Mr. Jonsen so long as emergent care is not needed. Opinion 9.123 states: "[When p]atients...act in a prejudicial manner toward physicians, other health care professionals, or others in the health care setting...[it] may constitute sufficient justification for the physician to arrange for the transfer of care."

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Module 3

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Case 3.2: Duty to Report—An HIV Diagnosis

Case Presentation

After Mr. Daar left Exam 2, Dr. Macklin began a physical examination. Upon discovering localized symmetric mucocutaneous lesions, generalized nontender lymphadenopathy and red papular lesions 4-5 mm in diameter, Dr. Macklin confirmed Mr. Jonsen's complaints of sore throat, fever, and headache.

"Have you had any unprotected sex or used any intravenous drugs in the last year?"

"No drugs, but I've had unprotected sex, why?"

"Well, I'd like to run a few tests because I'd guess that you have secondary syphilis, but I want to confirm that diagnosis before we go any further."

"Is syphilis treatable?"

"Yes, but first I need to confirm the diagnosis. Just in case, I'd also like to test you for other common STDs, including HIV, that may be latent in your system."

After a pause, Mr. Jonsen mutters, "Alright, go ahead."

Mr. Jonsen does test positive for syphilis, and he also tests positive for HIV. Dr. Macklin returns to Exam 2 to deliver the news.

"As we expected, you've got secondary syphilis. The good news is that penicillin is a highly effective treatment and so we should be able to clear this up pretty quickly. Unfortunately, Mr. Jonsen, you've also tested positive for HIV." Dr. Macklin hands Mr. Jonsen a couple of slips of paper. "Here's the name of a nearby HIV clinic and a prescription for penicillin." Dr. Macklin pauses for a moment while Mr. Jonsen stares at the floor. "Obviously you shouldn't have unprotected sex because you put any partner at risk for infection as well."

Mr. Jonsen looks up, "I think I'm entitled to make my own decisions, but thanks for the input." As he starts putting his clothes back on he says, "I expect you to keep this information confidential."

"I'm afraid I can't do that Mr. Jonsen. State law requires me to report all cases of sexually transmitted diseases. I also need your assurance that you won't have unprotected sex."

"I guess you don't always get what you need." Mr. Jonsen retorts as he gathers his things.

What should Dr. Macklin do? (select an option)

A. Inform the appropriate authorities about the STDs and that Mr. Jonsen is likely to put others at risk for infection.
B. Ask Mr. Jonsen to stay so they can plan therapy, counseling, and referral for Mr. Jonsen's follow-up care.
C. Record the diagnosis in Mr. Jonsen's medical chart and take no other action.

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Case 3.2: Duty to Report—An HIV Diagnosis

Option Assessment

A. Informing the appropriate authorities of Mr. Jonsen's STDs and of the possibility that he may put others at risk is **acceptable**; state law requires the former. Regarding the latter, endangerment to third parties, reporting Mr. Jonsen may be supported by the *Code* if Dr. Macklin is convinced that Mr. Jonsen plans to continue endangering others. According to Opinion 2.23, "HIV Testing," if the physician is unable to persuade the patient to discontinue putting others at risk, the physician should notify authorities of the endangerment. If Dr. Macklin does not know for certain that Mr. Jonsen is endangering others, or if he is successful in persuading his patient not to continue to do so, Dr. Macklin need not notify the authorities that Mr. Jonsen is a danger to others.

B. Asking Mr. Jonsen to stay so they can plan therapy, counseling, and referral for follow-up care is the **preferred** action**.** Requesting that Mr. Jonsen stay will provide some time for him to reflect on his medical condition and will give Dr. Macklin an opportunity to talk about necessary treatment and counseling services. It will also give Dr. Macklin more time to persuade Mr. Jonsen against endangering others by his conduct.

C. Making a note in Mr. Jonsen's chart and doing nothing else should be **avoided** because it violates the *Code* in Opinion 2.23, "HIV Testing": "the physician should, within the constraints of the law: (1) attempt to persuade the infected patient to cease endangering the third party; and (2) if persuasion fails, notify authorities..." Moreover, in the state where Dr. Macklin is practicing, state law requires a report on all sexual transmitted diseases.

Compare these options

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Case 3.2: Duty to Report—An HIV Diagnosis

Option Comparison

Extending the ER visit so that Dr. Macklin can discuss follow-up care and convince Mr. Jonsen to avoid unprotected sex and other at-risk activities (option B) is the preferable option. Mr. Jonsen's disease must be reported, regardless, to the appropriate authorities and, if Dr. Macklin fails to convince Mr. Jonsen that he should avoid putting others at risk, it may also be necessary to inform public health authorities that Mr. Jonsen's behavior is endangering others (option A).

Option C—noting the diagnosis and taking no other action—should be avoided for the 2 reasons mentioned above: physicians must report certain types of diseases and diagnoses to the health authorities, and HIV seropositive status is one such diagnosis; the risk of harm that Mr. Jonsen places others in by continued unprotected sex argues that Dr. Macklin cannot just record the diagnosis in Mr. Jonsen's chart and take no further action.

Preferable: B

Acceptable: A

Avoid: C

Additional discussion and information

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Case 3.2: Duty to Report—An HIV Diagnosis

Additional Information

The obligation to maintain patient confidentiality dates back to the Hippocratic Oath and remains essential to the practice of medicine. Maintaining confidentiality produces the conditions necessary for optimal medical practice. Specifically, patients who trust their physician to maintain confidentiality will be more likely to share important personal information (eg, whether or not they use drugs) that can help attain a more accurate diagnosis and effective treatment plans.

Opinion 5.05, "Confidentiality"

> The information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services...
>
> The obligation to safeguard patient confidences is subject to certain exceptions which are ethically and legally justified because of overriding social considerations...

When patients pose threats of harm to specific third-parties or to the public health, physicians may have a duty to breach confidentiality. These threats can take a variety of forms, including intended violent acts as well as irresponsible or malicious actions arising from the patient's medical condition. Specifically, patients who are HIV positive may put third parties at risk through a variety of behaviors including needle sharing and unprotected sexual intercourse.

Opinion 2.23, "HIV Testing"

> The confidentiality of the results of HIV testing must be maintained as much as possible and the limits of a patient's confidentiality should be known to the patient before consent is given.
>
> Exceptions to confidentiality are appropriate when necessary to protect the public health or when necessary to protect individuals, including health care workers, who are endangered by persons infected with HIV. If a physician knows that a seropositive individual is endangering a third party, the physician should, within the constraints of the law: (1) attempt to persuade the infected patient to cease endangering the third party; (2) if persuasion fails, notify authorities; and (3) if the authorities take no action, notify the endangered third party...

A patient's HIV status should remain confidential, except under the clearly defined circumstances where disclosure is necessary for safeguarding public health or identifiable third parties. The reporting requirements differ from state to state, and physicians should be aware (and should make patients aware) of what information will be reported.

Opinion 2.23, "HIV Testing" clearly states that "the limits of a patient's confidentiality should be known before consent [to testing] is given." Dr. Macklin failed to inform Mr. Jonsen of the limits of the obligation of confidentiality in this kind of case. It is not clear whether doing so would have made a difference in Mr. Jonsen's decisions or reaction, but Dr. Macklin slipped up on this obligation just the same.

The physician's duty to report is not limited to communicable diseases (like STDs). When physicians have reason to believe that individuals may be a threat to the welfare of others or have been the victims of violence, they should inform appropriate authorities. Physicians have this duty to report because of their responsibility to the public good. The following Opinions articulate the features of this responsibility.

Opinion 2.02, "Abuse of Spouses, Children, Elderly Persons and Others at Risk"

> The physician should comply with the laws requiring reporting of suspected cases of abuse of spouses, children, elderly persons, and others....Absent such legal requirement, for mentally competent, adult victims of abuse, physicians should not report to state authorities without the consent of the patient.

Opinion 2.24, "Impaired Drivers and Their Physicians"

> Physicians should assess patients' physical or mental impairments that might adversely affect driving abilities...The physician must be able to identify and document physical or mental impairments that clearly relate to the ability to drive; [and] the driver must pose a clear risk to public safety...[However], the determination of the inability to drive safely should be made by the state's Department of Motor Vehicles...Physicians should disclose and explain to their patients this responsibility to report...Physicians should protect patient confidentiality by ensuring that only the minimal amount of information is reported and that reasonable security measures are used in handling that information.

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Module 3

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Case 3.3: Confidential Care for Minors and Protecting Genetic Information

Case Presentation

Ms Johnson brought her daughter, Mandy, to see Dr. Jones for her first gynecological visit when Mandy was 14 years old. Dr. Jones performed a regular physical, but not a vaginal exam, and talked to Mandy about the changes that were leading her to sexual maturity.

Dr. Jones did not see Mandy again until she was 16 when she made an appointment and showed up on her own worried that she was pregnant. She had used a home pregnancy test, which supported her suspicion. Still, she wanted Dr. Jones to confirm her pregnancy. After getting a history of her sexual activity, Dr. Jones diagnosed the pregnancy using a hormonal assay. Upon completing the test, he informed Mandy that she was in fact pregnant. Based on her history, he estimated that she was around 10 weeks pregnant. Upon general examination, she was in good health.

Mandy and Dr. Jones were now in a difficult situation. Dr. Jones, who treats her immediate family and some extended family members, was well aware that Mandy's paternal grandmother had been diagnosed with Huntington's. Her father (in his early 40s) did not exhibit any symptoms at this point, but he had chosen not to be tested. Mandy appeared to be well informed about her family's medical history and informed Dr. Jones that she wanted to be tested for Huntington's.

"If I have Huntington's, my baby might have Huntington's, and I couldn't put my baby through that."

What should Dr. Jones do? (select an option)

A. Contact Mandy's parents to inform them of her intention to get tested for Huntington's.
B. Begin the process of testing Mandy for Huntington's disease.
C. Refer Mandy to a genetic counselor and/or adolescent psychologist.

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Case 3.3: Confidential Care for Minors and Protecting Genetic Information

Option Assessment

A. Contacting Mandy's parents to inform them of her intention to get tested for Huntington's should be **avoided**; it likely violates the *Code* in Opinion 5.055, "Confidential Care for Minors": "Where the law does not require otherwise, physicians should permit a competent minor to consent to medical care and should not notify parents without the patient's consent...For minors who are mature enough to be unaccompanied by their parents for their examination, confidentiality of information disclosed...should be maintained."

B. Beginning the process of testing Mandy for Huntington's disease is premature and should be **avoided**; it is not supported by the *Code* and may violate Opinion 2.12, "Genetic Counseling": "Counseling should include reasons for and against testing as well as discussion of inappropriate uses of genetic testing." Simply beginning the process of Mandy's genetic testing, without any counseling on the implications and significance of a test, does not provide Mandy with the necessary basis for informed decision making about the implications for her or her pregnancy.

C. Referring Mandy to a genetic counselor and/or adolescent psychologist is **preferable** and supported by the *Code*. Opinion 5.055, "Confidential Care for Minors" states: "Physicians should permit a competent minor to consent to medical care and should not notify parents without the patient's consent. Depending on the seriousness of the decision, competence may be evaluated by physicians for most minors. When necessary, experts in adolescent medicine or child psychological development should be consulted."

Compare these options

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Case 3.3: Confidential Care for Minors and Protecting Genetic Information

Option Comparison

Mandy's readiness to be tested conceals how she feels about learning her genetic status. Hence, referring her to a genetic counselor or adolescent psychologist (option C) is preferable, and beginning the process of genetic testing (option B) should be delayed. An opportunity to discuss her thoughts and feelings about her genetic status is important because it's unknown whether she has explored the topic with her parents, or anyone else.

Although discussion with an adolescent psychologist may indicate the need to inform Mandy's parents of her desire for a genetic test, there is no clear evidence that this is necessary. Accordingly, option A (informing Mandy's parents) should also be avoided.

Preferable: Option C

Avoid: Options A and B

Additional discussion and information

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Case 3.3: Confidential Care for Minors and Protecting Genetic Information

Additional Information

Adolescent patients create a particularly troublesome set of concerns about confidentiality. Minors are not legally empowered to make health care decisions independent of a parent or legal guardian. And yet, minor patients are regularly encouraged to make, or at least help make, their health care decisions, and minors are tried as adults in a court of law with increasing regularity.

Opinion 5.055, "Confidential Care for Minors"

> When minors request confidential services, physicians should encourage them to involve their parents...Physicians should permit a competent minor to consent to medical care and should not notify parents without the patient's consent...Use of the courts for competence determinations should be made only as a last resort.
>
> When an immature minor requests contraceptive services, pregnancy-related care..., or treatment for sexually transmitted disease, drug and alcohol abuse, or mental illness, physicians must recognize that requiring parental involvement may be counterproductive to the health of the patient...When the physician does breach confidentiality to the parents, he or she must discuss the reasons for the breach with the minor prior to the disclosure.
>
> ...Confidentiality may be justifiably breached in situations for which confidentiality for adults may be breached, according to Opinion 5.05, "Confidentiality."

Parents generally are responsible for making health care decisions for their children, but, as children mature and approach adolescence, this patient-physician-parent relationship changes. While it is true that young minors lack the capacity to make autonomous health care decisions, many older minors are mature enough to do so. In general, adolescents 14 and above should be evaluated carefully to determine whether they are mature enough to make decisions about their medical care.

Minors who are determined to be capable due to their maturity are entitled to the same degree of autonomy and confidentiality as an adult patient. Parental involvement should always be encouraged, but parental consent should not be required for the treatment of mature minors, and information disclosed in the patient-physician interaction must not be disclosed to the parents or third parties without patient consent.

Because Mandy is in a position where she may request an abortion if she has the Huntington's allele, it is also important to consider whether or not her parents should be informed if she requests an abortion.

Opinion 2.015, "Mandatory Parental Consent to Abortion"

> Physicians should ascertain the law in their state on parental involvement to ensure that their procedures are consistent with their legal obligations.
>
> Physicians should strongly encourage minors to discuss their pregnancy with their parents...
>
> Physicians should not feel or be compelled to require minors to involve their parents before deciding whether to undergo an abortion....Physicians should explain under what circumstances (eg, life-threatening emergency) the minor's confidentiality will need to be abrogated.
>
> Physicians should try to ensure that minor patients have made an informed decision after giving careful consideration to the issues involved...Minors should be urged to seek the advice and counsel of those adults in whom they have confidence, including professional counselors, relatives, friends, teachers, or the clergy.

Where law does not require it, parental consent need not be obtained before providing contraceptive services, treatment of sexually transmitted diseases, pregnancy-related care (including pregnancy testing, prenatal/postnatal care, delivery services, and abortion), drug and alcohol abuse treatment and mental illness treatment to minors who request these services. The absence of confidentiality may keep adolescents from seeking health care that is necessary to prevent serious harm.

An important consideration to be weighed when deciding whether to breach a minor's confidentiality is the possibility that disclosing sensitive information such as sexual behavior, pregnancy, or drug use to the parents might place the minor in danger.

Related topic: Genetic information

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Module 3

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Case 3.3: Confidential Care for Minors and Protecting Genetic Information

Related topic: Genetic information

Many people believe that, because of its sensitive nature, some medical information warrants higher standards of confidentiality than other medical information. For instance, psychiatric records and HIV status often are protected more rigorously because of social stigmas and the potential for discrimination based on such information. The following Opinions address physician responsibilities regarding genetic information:

Opinion 2.131, "Disclosure of Familial Risk in Genetic Testing"

> 1) Physicians have a professional duty to protect the confidentiality of their patients' information, including genetic information. (2) Pre- and post-test counseling must include implications of genetic information for patients' biological relatives... [P]hysicians should make themselves available to assist patients in communicating with relatives to discuss opportunities for counseling and testing, as appropriate. (3) Physicians who order genetic tests should have adequate knowledge to interpret information for patients.

Opinion 2.138, "Genetic Testing of Children"

> ...Before testing of children can be performed, there must be some potential benefit from the testing that can reasonably be viewed as outweighing the disadvantages of testing, particularly the harm from abrogating the children's future choice in knowing their genetic status...
>
> When a child's genetic status is determined incidentally...[t]his information should not be disclosed to third parties. Genetic information should be maintained in a separate portion of the medical record to prevent mistaken disclosure. When a child is being considered for adoption, the guidelines for genetic testing should be the same as for other children.

Opinion 2.137, "Ethical Issues in Carrier Screening of Genetic Disorders"

> All carrier testing must be voluntary, and informed consent from screened individuals

is required. Confidentiality of results is to be maintained. Results of testing should not be disclosed to third parties without the explicit informed consent of the screened individual.

There are other situations where genetic information may be sought by third parties. Specifically, insurance companies may attempt to procure a patient's genetic information. Opinion 2.135, "Insurance Companies and Genetic Information" states that "Physicians should not participate in genetic testing by health insurance companies to predict a persons' predisposition for disease. As a corollary, it may be necessary for physicians to maintain separate files for genetic testing results." Physicians should also make it clear to insurance companies that they will not provide genetic information for any of their patients.

Module 3 Feedback Questionnaire

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Module 3

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Module 3: Privacy and Confidentialty

Feedback Questionnaire

In Module 3 on privacy and confidentiality, how would you rate the relevance of the cases?
- Excellent
- Very good
- Good
- Fair
- Poor

How would you rate the explanation of courses of action?
- Excellent
- Very good
- Good
- Fair
- Poor

How would you rate the overall coverage of the topic?
- Excellent
- Very good
- Good
- Fair
- Poor

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Module 4

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Case 4.1: Balancing Patient Care and Student Education—Mr. Harvey's Central Line

Case Presentation

Mr. Harvey was admitted to the general medical service of a teaching hospital. It was his third admission in 8 months. One prior admission was, like this one, due to exacerbation of long-standing chronic obstructive pulmonary disease (COPD). The other admission was prompted by dizziness and fainting brought on by his poorly controlled diabetes. Mr. Harvey is 57 years old and is African American. Management of his health is complicated by obesity and (as he confessed to Tina Moseley, the third-year medical student who interviewed him when he arrived on the unit) his continued smoking. A chest X-ray ordered in the emergency department before Mr. Harvey's admission showed results consistent with pneumonia, though blood culture results were not back. Antibiotic treatment administered intravenously was indicated, but Mr. Harvey's peripheral circulation was poor, and several attempts to place the IV in his arms failed. Becoming somewhat irritable with the attempts, Mr. Harvey complained that, "No one in this place can ever find my veins."

Dr. Amanda Gage, the senior resident, decided that a subclavian central line should be placed to gain intravenous access. Dr. Gage is supervising 2 third-year medical students. The students—Kenny Krasnow and the previously mentioned Tina Moseley—are in week 6 of their 8-week internal medicine rotation. Kenny has successfully placed central lines on several occasions during his rotation. Tina has been unsuccessful on 2 attempts with different patients; in each case Dr. Gage stepped in and completed the placement. For a couple of reasons, Mr. Harvey is a good patient for Tina's next attempt. His condition is not emergent; he is accustomed to the teaching hospital routine, and has taken Tina into his confidence. He considers her to be "on his side." On the other hand, his obesity makes the procedure more difficult than usual. Because of his multiple health problems, should Tina puncture his lung, the complications would be life-threatening. Additionally, he is already irritable about the inability of the staff at this hospital to "find his veins."

Tina knows that she should succeed at placing a central line before completing her internal medicine rotation, and time is running out. Dr. Gage asks Tina to attempt to place the line. She is on her way to inform Mr. Harvey about the procedure and its risks and to obtain his consent. She identified herself as a student when she first introduced herself and interviewed him. They seem to communicate well, but Mr. Harvey continually refers to her as "doctor." As she walks, she wonders how much she should tell Mr. Harvey about her past attempts and whether she needs to remind him that she is a student. When she enters Mr. Harvey's room, he is chatting with his grown daughter who has just arrived.

What should Tina tell Mr. Harvey? (select an option)

A. She should remind him of her status as a student and inform him that she will be performing the procedure under supervision.
B. She should inform him that she will be performing the procedure.
C. She should describe the procedure and inform him that the health care team, including Dr. Gage, will be performing it.

D. She should remind him of her status as a student and inform him that she will be performing the procedure under supervision. She should also mention her previous failures to place a central line.

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Case 4.1: Balancing Patient Care and Student Education—Mr. Harvey's Central Line

Option Assessment

A. Reminding Mr. Harvey of her status as student and notifying him that she will be placing his central line with Dr. Gage's supervision is **preferable** and supported by *Code* Opinion 8.087, "Medical Student Involvement in Patient Care": "Patients should be informed of the identity and training status of individuals involved in their care and all health care professionals share the responsibility for properly identifying themselves."

B. Informing Mr. Harvey that she will be performing the procedure without reminding him of her status is **acceptable** but is not the preferred option. Opinion 8.087, "Medical Student Involvement in Patient Care" states that "Students and their supervisors should refrain from using terms that may be confusing when describing the training status of students." This course of action does not violate this standard, inasmuch as Tina has identified herself as a student, at least once. However, it would be better to remind Mr. Harvey that she is a medical student and then explain that she will place the central line under Dr. Gage's supervision.

C. Describing the medical procedure to Mr. Harvey without informing him that Tina will be performing the procedure should be **avoided**. It violates *Code* Opinion 8.087, "Medical Student Involvement in Patient Care": "Patients are free to choose from whom they receive treatment." It is important for the roles and activities of each member of the health care team to be clearly explained to the patient. This must be done in advance for patients who will be unconscious during the procedure.

D. Informing Mr. Harvey of her past difficulties is **acceptable**, but it is not required by the *Code*. Opinion 8.087, "Medical Student Involvement in Patient Care" states that patients "should be informed of the identity and training status of individuals involved in their care." Informing Mr. Harvey that Tina is a medical student fulfills the requirement. Further, Mr. Harvey's safety does not depend on Tina's individual expertise but on the structural expertise arising from the supervision of medical students by residents and attending physicians.

Compare these options

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Case 4.1: Balancing Patient Care and Student Education—Mr. Harvey's Central Line

Option Comparison

Medical students (and their supervising residents) have a responsibility to inform patients of their training status. Because Mr. Harvey may not have understood that Tina is a medical student, reminding him (option A) is preferable. Because Tina has already informed Mr. Harvey that she is a medical student, option B, informing him that she will do the procedure but not reminding him that she is a student, is acceptable. Option D is also acceptable: Tina does not violate the *Code* by informing Mr. Harvey of her past failures.

Option C—the vague statement that "the team" will perform the procedure—should be avoided. Because this statement may imply that someone else will be performing the procedure, and because she knows she will be, Ms Moseley should inform Mr. Harvey.

Preferable: Option A

Acceptable: Options B and D

Avoid: Option C

Additional discussion and information

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Case 4.1: Balancing Patient Care and Student Education—Mr. Harvey's Central Line

Additional Information

Perhaps the most valuable feature of medical education is the practical experience provided by supervised participation in clinical encounters. Medical students gain experience by performing basic procedures and observing clinical interactions. Patient care may also be enhanced by the involvement of medical students: medical students provide patients an additional opportunity both to discuss problems and to receive information because students have more time to spend with patients (eg, when taking a medical history). As Opinion 8.087, "Medical Student Involvement in Patient Care" makes clear, patients should be apprised of planned medical student involvement because some patients may prefer that students not be involved in their care:

Opinion 8.087, "Medical Student Involvement in Patient Care"

> Patients and the public benefit from the integrated care that is provided by health care teams that include medical students. Patients should be informed of the identity and training status of individuals involved in their care and all health care professionals share the responsibility for properly identifying themselves. . . Patients are free to choose from whom they receive treatment. When medical students are involved in the care of patients, health care professionals should relate the benefits of medical student participation to patients and should ensure that they are willing to permit such participation. Generally, attending physicians are best suited to fulfill this responsibility. . . in instances where a patient may not have the capacity to make decisions, student involvement should be discussed with the surrogate decision-maker involved in the care of the patient whenever possible.

Medical students may be able to gain more experiences sooner if patients are left unaware of their training status or planned involvement. Avoiding disclosure, however, implies that the primary mission of the teaching hospital is medical training and ignores a patient's right to choose whether to participate in student education. It is inappropriate to assume that a patient is implicitly willing to participate in the training of medical students or other health professionals merely by being admitted to an academic medical center. When they introduce themselves as students and verify that patients agree to student participation in their care, medical students engage in a simple form of truth-telling that constitutes a first step in establishing and reinforcing trust in the patient-physician relationship.

In those cases when patient consent is unattainable (eg, emergency care), the participation of medical students should be evaluated judiciously and employed cautiously.

Related topic: Medical students as "patients"

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Case 4.1: Balancing Patient Care and Student Education—Mr. Harvey's Central Line

Related topic: Medical students as "patients"

Just as it is important to get permission for students to perform procedures on patients, trainees should also be aware of the ethical concerns surrounding the use of their peers as "patients" for training purposes.

Opinion 3.09, "Medical Students Performing Procedures on Fellow Students"

> (1) In the context of learning basic clinical skills, medical students must be asked specifically to consent to procedures being performed by fellow students. The stringency of standards for ensuring the explicit and non-coerced informed consent increases as the invasiveness and intimacy of the procedure increase.
>
> (2) Instructors should explain to students how the procedures will be performed, making certain that students are not placed in situations that violate their privacy or sense of propriety. The confidentiality, consequences, and appropriate management of a diagnostic finding should also be discussed.
>
> (3) Students should be given the choice of whether to participate prior to entering the classroom and there should be no requirement that the students provide a reason for their unwillingness to participate.
>
> (4) Student should not be penalized for refusal to participate. Thus instructors must refrain from evaluating students' overall performance in terms of their willingness to volunteer as "patients."

Medical students pretending to be patients are not in a patient-physician relationship with each other. Consequently, the information disclosed to students should differ from that disclosed in a clinical context. Students should also consider the potential effect of the exam and the possible (unexpected) findings on their relationships with fellow students. As the invasiveness or intimacy of the procedure increases, greater care must be taken to ensure that students' informed consent is explicit and uncoerced.

Voluntariness and the forces that may undermine it deserve special scrutiny in this context. It should be recognized that coercive influences may stem from individuals or from situational factors, eg, the mere fact that students are in an educational setting and are being evaluated. Some students may have conditions that they do not wish to reveal but that might be detected upon physical examination. Unless they are presented with an explicit choice to volunteer, students may feel compelled to submit to the procedures, especially if they believe that their participation impacts the evaluation they receive from instructors. Instructors should refrain from including students' willingness or

unwillingness to participate as a contributing factor in their evaluations. Some students may give reasons for not participating as "patients," but reasons should not be required, and the decision not to offer reasons must be respected.

In short, students should be given the choice to volunteer in a non-coercive setting prior to entering the classroom and there should be no requirement that the students provide a reason for their refusal to participate.

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Module 4

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Case 4.2: Practicing a Procedure on the Newly Deceased—Mrs. Milos's Pericardiocentesis

Case Presentation

Maia Desai is a third-year emergency medicine resident in a large urban teaching hospital. Dr. Desai has 2 fourth-year medical students under her supervision. Lydia Santos and Carl Meyers have a few days remaining in their month-long rotation. Dr. Desai, a conscientious clinician and teacher, is pleased with Lydia's and Carl's performances during their rotation. Each has gained a good knowledge base and is acquiring skills in suturing lacerations, wound debridement, and assisting in advanced CPR codes.

On the students' last day in the ER rotation, Mrs. Milos, a 76-year-old woman with a history of two previous MIs, is brought in by ambulance from a local skilled nursing facility. Mrs. Milos was already intubated when the EMTs wheeled her into the ER. She suffered cardiac arrest en route, and the ambulance crew administered shock and pharmacologic treatment while continuing chest compressions. Mrs. Milos's son arrived by car soon after Mrs. Milos was wheeled into a treatment room. He was kept away from the resuscitation attempts and awaits news.

Despite all attempts to resuscitate Mrs. Milos, Dr. Desai calls off the code approximately 20 minutes after her arrival in the ER. After calling off the code, Dr. Desai realizes there's a chance that some pericardial blood has collected. This is an opportunity for Lydia or Carl to do a pericardiocentesis. Lydia and Carl recently practiced the techniques of pericardiocentsis on anatomical mannequins. Now they can take the next step in the learning process.

What should Dr. Desai do? (select an option)

A. Tell Lydia or Carl to attempt a pericardiocentesis.
B. Inform Mrs. Milos' son of her death and ask for consent to have a medical student attempt a pericardiocentesis.
C. Inform Mrs. Milos' son of her death and choose not to pursue this training opportunity.
D. Tell Lydia or Carl to inform Mrs. Milos' son of her death and ask for consent to attempt a pericardiocentesis.

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Case 4.2: Practicing a Procedure on the Newly Deceased—Mrs. Milos's Pericardiocentesis

Option Assessment

A. Telling Lydia or Carl to attempt pericardiocentesis should be **avoided**. It violates *Code* Opinion 8.181, "Performing Procedures on the Newly Deceased for Training Purposes": "physicians should obtain permission from the family before performing such procedures."

B. Informing Mrs. Milos's son of her death and asking for consent to have a medical student attempt a pericardiocentesis is **preferable**. By obtaining permission from Mrs. Milos's son, Dr. Desai would satisfy the requirements expressed by the *Code* in Opinion 8.181, "Performing Procedures on the Newly Deceased for Training Purposes": "physicians should obtain permission from the family before performing such procedures."

C. Simply informing Mrs. Milos's son of her death is **acceptable** in that it does not violate the *Code*, but it is not the best alternative because it does not help the students progress in their professional training. Because this situation provides an opportunity for a medical student to practice a valuable procedure, it should be pursued, so long as the teaching of this skill is, as Opinion 8.181, "Performing Procedures on the Newly Deceased for Training Purposes" stipulates: "the culmination of a structured training sequence" and not a random opportunity for which the trainees are unprepared.

D. Telling Lydia or Carl to inform Mrs. Milos's son about her death and ask for consent to attempt a pericardiocentesis should be **avoided** because it violates the *Code* in Opinion 8.18, "Informing Families of a Patient's Death": "It would not be appropriate for the attending physician or resident to request that a medical student notify family members of a patient's death."

Compare these options

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Case 4.2: Practicing a Procedure on the Newly Deceased—Mrs. Milos's Pericardiocentesis

Option Comparison

The difficulty of performing pericardiocentesis suggests that the opportunity for Lydia or Carl to learn by attempting the procedure on the recently deceased should be pursued. Accordingly, option B (in which the resident seeks Mrs. Milos's son's permission for the procedure) is the preferable option. Nonetheless, it is not a mandate of the *Code* for students to practice procedures on the recently deceased, so option C is an acceptable alternative.

Option A—performing pericardiocentesis without permission—should be avoided because it may violate the wishes of both Mrs. Milos and her son regarding the treatment of her body after death. Respect for patient and family preferences, even for procedures on the newly deceased, requires that permission be obtained. Option D should also be avoided because medical students should not be assigned the task of informing a patient's family members of his or her death.

Preferable: Option B

Acceptable: Option C

Avoid: Options A and D

Additional Discussion and Information

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Case 4.2: Practicing a Procedure on the Newly Deceased—Mrs. Milos's Pericardiocentesis

Additional Information

Performing procedures on the newly deceased for training purposes without gaining permission from the family violates the norm of respect for deceased patients and their families. It also threatens to undermine the trust in the medical profession that is so pivotal to its relationship with the community. Because the patient receives no benefit, the traditional concept of presumed consent does not apply here, and there can be no waiver of informed consent.

Opinion 8.181, "Performing Procedures on the Newly Deceased for Training Purposes"

> Physicians should work to develop institutional policies that address the practice of performing procedures on the newly deceased for purposes of training...[that] ensure that the interests of all parties involved are respected under established and clear ethical guidelines...The following considerations should be addressed before medical trainees perform procedures on the newly deceased:
>
> (1) The teaching of life-saving skills should be the culmination of a structured training sequence, rather than relying on random opportunities. Training should be performed under close supervision, in a manner and environment that takes into account the wishes and values of all involved parties.
>
> (2) Physicians should inquire whether the deceased individual had expressed preferences regarding handling of the body or procedures performed after death. In the absence of previously expressed preferences, physicians should obtain permission from the family...When reasonable efforts to discover [such] preferences...or to find someone with authority to grant permission...have failed, physicians must not perform procedures for training purposes on the newly deceased patient.

This opinion challenges the claims put forward by both the President's Commission [1] and the American Heart Association [2] regarding intubation—both have argued that this non-invasive procedure can be performed without consent. This will remain a contentious issue, but the primacy of respect for patient and family preferences suggests that even these non-invasive procedures require permission. Similar to the views on organ donation in the United States, there should be a presumption of refusal which can only be overcome by previously expressed preferences or family permission.

Regardless of Dr. Desai's decision about attempting a pericardiocentesis, in Opinion 8.18, "Informing Families of a Patient's Death," the *Code* is clear that Lydia and Carl should not be asked to inform Mrs. Milos's son of her death. If Dr. Desai has some prior experience informing families of a patient's death as the treating physician in the ER, she may be in the best position to inform the patient's family. Outside of the ER, it is much more likely that the resident on the case would not be primarily responsible. Instead, as Opinion 8.18 explains: "Physicians in residency training may be asked to participate in the communication of information about a patient's death if that request is commensurate

with the physician's prior training or experience and previous close personal relationship with the family."

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Module 4 Feedback Questionnaire

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Module 4: Medical Student Participation in Patient Care

Feedback Questionnaire

In Module 4 on student involvement in patient care, how would you rate the relevance of the cases?
- Excellent
- Very good
- Good
- Fair
- Poor

How would you rate the explanation of courses of action?
- Excellent
- Very good
- Good
- Fair
- Poor

How would you rate the overall coverage of the topic?
- Excellent
- Very good
- Good
- Fair
- Poor

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Module 5

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Case 5.1: Futile Care—An Inoperable Cancer

Case Presentation

Mrs. Scott, a trim, recently retired teacher who has enjoyed relatively good health, visited Dr. Lee, her general internist, for her annual check-up. She had several complaints including back pain, intermittent nausea, loss of appetite, and fatigue for the last several months. She said her back pain usually followed a meal, and her chart disclosed that she had lost 10 pounds since her last check-up. On physical examination, Dr. Lee was unable to draw any firm conclusions as to the cause of these symptoms. He ordered standard diagnostic blood work which showed mild normochromic anemia and low albumin. Because this is a common finding in several chronic diseases, Dr. Lee told Mrs. Scott they would have to set up an appointment at the hospital for more diagnostic tests. Dr. Lee knew that Mrs. Scott's father had died of pancreatic cancer, and, because she was also a regular smoker, she was at increased risk. Since her symptoms were suggestive of pancreatic cancer, he scheduled her for an abdominal CT scan at the local hospital.

The CT scan confirmed that Mrs. Scott did, in fact, have pancreatic cancer. Dr. Lee waited until Mrs. Scott had dressed. When she asked what the test showed, he told her about the diagnosis of pancreatic cancer. Immediately she said, "I want you to get it removed."

"I've already called for a surgery consult to evaluate the possibility of a surgical resection."

Upon consultation, the surgical oncologist, Dr. Parihar, suggested a biopsy to confirm the diagnosis of pancreatic cancer. After evaluating the CT and the biopsy, he informed Dr. Lee who informed Mrs. Scott that the pancreatic cancer was inoperable. Indeed, the spiral CT indicated that the cancer was locally situated in the body and tail of the pancreas, that it had spread substantially—not only were the local lymph nodes involved, but there were distant metastes. Finally, the CT showed local invasion into the vascular structures—specifically, the superior mesenteric and celiac arteries. In Dr. Lee's judgment, Mrs. Scott had no more than 4-6 months to live.

Even after she was informed by Dr. Lee of the uselessness of surgery for her condition, Mrs. Scott continued to demand surgery to remove the tumor.

What should Dr. Lee do? (select an option)

A. Allow Dr. Parihar to assume complete care for Mrs. Scott.
B. Urge Dr. Parihar to acquiesce to Mrs. Scott's request for surgery.
C. Reiterate the reasons that surgery is not indicated.
D. Ask Mrs. Scott to discuss why she wants the surgery.
E. Suggest to Mrs. Scott that she should seek a second opinion or transfer to another hospital.

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Module 5

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Case 5.1: Futile Care—An Inoperable Cancer

Option Assessment

A. Allowing Dr. Pandihar to assume complete care for Mrs. Scott is to be **avoided.** Dr. Lee's withdrawal from Mrs. Scott's care at this time may violate several of the *Code's* guidelines and cause her to feel abandoned and helpless. Opinion 8.11 "Neglect of Patient" prohibits neglecting patients once they have come under one's care. Opinions 2.21 "Euthanasia" and 2.211 "Physician-Assisted Suicide" caution physicians not to abandon patients once it has been determined that cure is impossible. Patients with terminal illnesses need multidisciplinary support; their primary physicians should not withdraw from participating in their care at this time.

B. Urging Dr. Parihar to acquiesce to Mrs. Scott's requests should be **avoided;** it is not supported by the *Code*. Opinion 2.037, "Medical Futility in End-of-Life Care" states: "Attempts should be made to negotiate disagreements if they arise, and to reach resolution within all parties' acceptable limits, with the assistance of consultants as appropriate." Moreover, Opinion 2.19 "Unnecessary Medical Services" states that "Physicians should not provide, prescribe, or seek compensation for services that they know are unnecessary."

C. Reiterating the reasons that surgery is not indicated is **preferable**. *Code* Opinion 2.037, "Medical Futility in End-of-Life Care" states: "Joint decision-making should occur between patient or proxy and physician to the maximum extent possible...Attempts should be made to negotiate disagreements if they arise, and to reach resolution within all parties' acceptable limits, with the assistance of consultants as appropriate." Attempts to reach agreement may well start by further explaining to Mrs. Scott the reasons why surgery will not achieve the medical goal she desires.

D. Asking Mrs. Scott to discuss why she wants surgery is **acceptable** and is supported by the *Code* in Opinion 2.037, "Medical Futility in End-of-Life Care," which states: "Joint decision-making should occur between patient or proxy and physician to the maximum extent possible...Attempts should be made to negotiate disagreements if they arise, and to reach resolution within all parties' acceptable limits, with the assistance of consultants as appropriate." Giving Mrs. Scott the opportunity to express the motivations for her wishes is one step in the process in joint decision-making and should provide an opportunity to negotiate the existing disagreement.

E. Suggesting to Mrs. Scott that she should seek transfer to another hospital may be supported by the *Code*, but, at this point, should be **avoided**. Opinion 2.037, "Medical Futility in End-of-Life Care" states that "If the process [of negotiating disagreements about futile care] supports the physician's position and the patient/proxy remains unpersuaded, transfer to another institution may be sought and, if done, should be supported by the transferring and receiving institution." It is still too early, however, in the process of discussing her request for an apparently futile surgery to warrant transfer to another institution.

Compare these options

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Case 5.1: Futile Care—An Inoperable Cancer

Option Comparison

Mrs. Scott may have expectations about the surgery that are unknown to Dr. Lee and Dr. Parihar. Accordingly, option D (having Mrs. Scott discuss her reasons for wanting the surgery) is an acceptable first step. Option C (further explaining why surgery will not achieve Mrs. Scott's medical goals) is the preferred action.

Option B, performing the surgery, should be avoided for a number of reasons including the failure to foster joint decision-making. More importantly, physicians are not ethically obligated to deliver care that they do not think will benefit the patient. Option A—referring Mrs. Scott to Dr. Parihar—may cause her to think she is being abandoned by her physician and provoke feelings of helplessness. Option E should also be avoided at this point in the case. Although it may be necessary later, a more thorough attempt should be made to discuss the issues involved before Mrs. Scott's care is transferred to another physician or hospital.

Preferable: Option C

Acceptable: Option D

Avoid: Options A, B, and E

Additional discussion and information

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Case 5.1: Futile Care—An Inoperable Cancer

Additional Information

In the course of clinical care of a critically ill patient, it may become clear that the patient's condition is terminal and that further intervention will do no more than prolong the dying process. At this point, further intervention is often described as "futile," a term whose meaning depends on a subjective judgment. This judgment arises from considerations about quality of life, which Opinion 2.17, "Quality of Life," clearly leaves to patients: "quality of life, as defined by the patient's interests and values, is a factor to be considered in determining what is best for the individual." Nevertheless, patient decisions about futile or non-futile care do not compel physicians to comply with requests that, in the physician's judgment, meet no treatment or care goals.

For non-terminal situations, Opinion 2.035 defines the limits of physician obligations when patients request an unindicated treatment.

Opinion 2.035, "Futile Care"

> Physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patients. Patients should not be given treatments simply because they demand them. Denial of treatment should be justified by reliance on openly stated ethical principles and acceptable standards of care...

For patients with a terminal prognosis, the AMA recommends defining futility on a case-by-case basis, taking full account of the context and individuals involved. The *Code*, in Opinion 2.037, "Medical Futility in End-of-Life Care," outlines a due process approach to achieving this case-by-case determination:

Opinion 2.037, "Medical Futility in End-of-Life Care"
To assist in fair and satisfactory decision-making about what constitutes futile intervention:

> (1) All health care institutions, whether large or small, should adopt a policy on medical futility; and
> (2) Policies on medical futility should follow a due process approach. The following seven steps should be included in such a due process approach to declaring futility in specific cases.
>
> > (a) Earnest attempts should be made in advance to deliberate over and negotiate prior understandings between patient, proxy, and physician on what constitutes futile care for the patient, and what falls within acceptable limits for the physician, family, and possibly also the institution

(b) Joint decision-making should occur between patient or proxy and physician to the maximum extent possible.
(c) Attempts should be made to negotiate disagreements if they arise, and to reach resolution within all parties' acceptable limits, with the assistance of consultants as appropriate.
(d) Involvement of an institutional committee such as the ethics committee should be requested if disagreements are irresolvable.
(e) If the institutional review supports the patient's position and the physician remains unpersuaded, transfer of care to another physician within the institution may be arranged.
(f) If the process supports the physician's position and the patient/proxy remains unpersuaded, transfer to another institution may be sought and, if done, should be supported by the transferring and receiving institution.
(g) If transfer is not possible, the intervention need not be offered.

This procedural approach (or "due process" as it is referred to above) is preferable because in cases of patient-physician disagreement, it can incorporate institutional and community standards for patient benefit. It also allows a hearing for patient or proxy assessments of worthwhile outcomes, and for physicians' or other professionals' intention in treating the patient. Finally, it has the advantage of providing a system for addressing the ethical dilemmas around end-of-life care without immediate recourse to the court system.

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Module 5

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Case 5.2: Physician Assisted Suicide and Euthanasia—Mrs. Scott's Plan for the Future

Case Presentation

After following the appropriate procedural steps, including consultation with the hospital's ethics committee, the physician's judgment is confirmed: Mrs. Scott is requesting futile care. Dr. Lee recommends that she see a medical oncologist (not a surgeon) for a full assessment and treatment alternatives, and he offers her information about hospice care. Not surprisingly, Mrs. Scott requests a referral to a different surgical oncologist, hoping she will find one who disagrees with Dr. Pandihar's judgment. Dr. Lee provides her with this referral, also.

Several weeks later, Dr. Lee notices that Mrs. Scott has an appointment that afternoon. Dr. Lee doubts she found a surgeon willing to perform the surgery, and he guesses she's back for another referral. He gets Mrs. Scott's chart and heads to exam room 2.

As he enters, he gives his usual greeting, "Hello, Mrs. Scott, and how are you doing today?"

"Not too well."

"The nurse said you didn't explain exactly why you're here today."

"I didn't want to get her involved. You see, Dr. Lee, no one will do the surgery. They all tell me that I only have 6 months to live. I'm sorry I blew up at you and Dr. Parihar, but I..." she trails off.

Dr. Lee speaks comfortingly, "As much as I would have preferred it didn't happen, it's an understandable reaction to such grave news. Did you meet with the medical oncologist, and were you able to get in touch with the hospice care facilities I recommended?"

"I met with the medical oncologist and he confirmed that I have a few months to live. He also gave me some information about some hospice places." She pauses. "Dr. Lee, I want you to give me a prescription for barbiturates. I don't want to spend the last few months of my life in agonizing pain. I watched my father die a painful, slow death, and I don't want any part of that. I want some control over how I die. I know this could put you in a compromising position, so I should also tell you that I've had some pain that regular strength pain killers do not alleviate. Please, Dr. Lee, just give me the prescription."

What should Dr. Lee do? (select an option)

A. Prescribe the barbiturates and inform Mrs. Scott of the proper dosing levels for pain treatment and the amount that would result in an "overdose."
B. Inform Mrs. Scott that he will not prescribe barbiturates for the reasons she has suggested, but that he will prescribe appropriate pain control.
C. Inform Mrs. Scott that she will have to ask another physician for assistance in ending her life and give her contact

information for several other physicians.

D. Recommend Mrs. Scott see a counselor, either pastoral or otherwise, or undergo a psychological evaluation.

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Case 5.2: Physician Assisted Suicide and Euthanasia—Mrs. Scott's Plan for the Future

Option Assessment

A. Prescribing the barbiturates and informing Mrs. Scott of the appropriate dosing levels potentially makes Dr. Lee an accessory to Mrs. Scott's suicide and, so, should be **avoided**; it also violates the *Code* in Opinion 2.211, "Physician-Assisted Suicide": "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer."

B. Informing Mrs. Scott that he will not prescribe barbiturates for the reasons she has suggested—he will not take part in physician-assisted suicide—is supported by the *Code* in Opinion 2.211, "Physician-Assisted Suicide": "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks." Further, offering to prescribe analgesics or opioids to alleviate her pain and suffering is **preferable** and is also supported in Opinion 2.211, "Physician-Assisted Suicide": "physicians must aggressively respond to the needs of patients at the end of life...Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication."

C. Informing Mrs. Scott that she will have to ask another physician for assistance in ending her life and referring her to other physicians should be **avoided** and is not supported by the *Code*. Opinion 2.211, "Physician-Assisted Suicide" states: "physicians must aggressively respond to the needs of patients at the end of life...Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication."

D. Recommending Mrs. Scott see a counselor, either pastoral or otherwise, or undergo a psychological evaluation is **acceptable** and is supported by the *Code* in Opinion 2.211, "Physician-Assisted Suicide": "Multidisciplinary interventions should be sought, including specialty consultation, hospice care, pastoral support, family counseling, and other modalities." This course of action, however, may not be warranted at this point.

Compare these options

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Case 5.2: Physician Assisted Suicide and Euthanasia—Mrs. Scott's Plan for the Future

Option Comparison

Because physician-assisted suicide is not supported by the AMA's *Code of Medical Ethics*, prescribing barbiturates for Mrs. Scott as in option A should be avoided. Nonetheless, Mrs. Scott is suffering and in need of medical care, so, in the absence of independent reasons, referring her to another physician, option C, should also be avoided.

There is still a great deal that medicine can do for Mrs. Scott. Hence, Dr. Lee should not abandon this patient and should attempt to treat her pain effectively, as stated in option B. Option D—recommending that Mrs. Scott see a counselor—is acceptable, but the need for this action will be clearer after her pain is under better control and Dr. Lee learns more about her illness and state of mind.

Preferable: Option B

Acceptable: Option D

Avoid: Options A and C

Additional discussion and information

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Case 5.2: Physician Assisted Suicide and Euthanasia—Mrs. Scott's Plan for the Future

Additional Information

The physician's role is healing disease, preserving life, and relieving suffering. In end-of-life care, the duties to relieve suffering and preserve life can come into conflict. Although as much as possible should be done to relieve suffering, the physician's duty to preserve life is overriding. Even though physician-assisted suicide is now legal in Oregon, it remains the position of the AMA that physician-assisted suicide violates the traditional prohibition against using the tools of medicine to cause a patient's death. Physician-assisted suicide also carries societal risks, including the potential for coercive pressures on patients to choose suicide.

Opinion 2.211, "Physician-Assisted Suicide"

> Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (eg, the physician provides sleeping pills and information about the lethal dose...
>
> It is understandable, though tragic, that some patients in extreme duress— such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.
>
> Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible...

While in some difficult cases physician-assisted suicide may seem appropriate, the medical profession does not condone the practice due to the likelihood of grave harm. Physicians instead must strive to identify the concerns behind patients' requests for assisted suicide, and make concerted efforts at finding ways to address these concerns short of assisting suicide, including providing more aggressive comfort care. At the present, many physicians are not adequately informed about the modalities of pain control for patients with severe chronic pain. The success of the hospice movement illustrates the extent to which aggressive pain control and close attention to patient comfort and dignity can ease the transition to death.

Related topic: Euthanasia

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Case 5.2: Physician Assisted Suicide and Euthanasia—Mrs. Scott's Plan for the Future

Related topic: Euthanasia

Euthanasia, a cousin to physician-assisted suicide, is also prohibited by the *Code*.

Opinion 2.21, "Euthanasia"

> Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering. It is understandable, though tragic, that some patients in extreme duress— such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.
>
> ...The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life...Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.

There may be cases where a patient's pain and suffering are not reduced to tolerable levels and the patient requests a physician's help to die. If a physician cannot ease the pain and suffering of a patient by means short of death, using medical expertise to aid an "easy" death may seem to be the humane and appropriate treatment for the patient. But the prohibition against medically killing patients is a strong and lasting tradition in medical ethics that is based upon a professional commitment to healing.

Weakening the prohibition against euthanasia, even in the most compelling situations, has troubling implications. Though the magnitude of such risks are impossible to predict accurately, the medical profession and society as a whole must not consider these risks lightly. Condoning euthanasia by physicians might undermine public trust in medicine's dedication to preserving the life and health of patients. Moreover, in a society that condones euthanasia, some patients may fear the prospect of involuntary or nonvoluntary euthanasia if they think their lives are no longer deemed valuable by others.

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Case 5.3: Withdrawing or Withholding Treatment—Respecting Patients' End-of-Life Decisions

Case Presentation

Dr. Lee prescribed Mrs. Scott a low-dose opiod patch and anti-nausea medication. He also recommended that Mrs. Scott undergo a psychological evaluation for depression and maintain an ongoing relationship with the medical oncologist. A few weeks later, Dr. Lee received a call that Mrs. Scott was en route to the hospital. She had passed out while her sister was visiting and had knocked her head against a coffee table. Upon arriving at the hospital, Dr. Lee discovered that Mrs. Scott had lost even more weight and was dehydrated. Her heart rate was a little low and her blood pressure was weak but steady. The most significant concern at that point was the possibility of an internal cranial hemorrhage. Mrs. Scott was not conscious, and her sister agreed to have her undergo a head CT to determine if there was internal bleeding.

As they waited for the head CT, Mr. Scott arrived and informed Dr. Lee that his wife had not been eating regularly, though she had been keeping close contact with her family and friends. Everyone, it seems, had been encouraging her to seek hospice services, a course of action she resisted.

The neurosurgeon informed Mr. Scott and Dr. Lee that the CT showed several small acute subdural hematomas, but no edema. She recommended observation with daily re-evaluation. She suggested that, at least for a few days, Mrs. Scott might not be consistently lucid. Over the next several days, as expected, Mrs. Scott cycled through periods of lucidity and confusion. Although she was not worsening, she also was not eating—her albumin was very low and she was losing even more weight. The medical oncologist, Dr. Walker, recommended the placement of a PEG tube—if Mrs. Scott was to reverse her cachectic state and improve her quality of life, she would need better nutrition. Because of Mrs. Scott's compromised condition, Mr. Scott was asked to consent, which he did.

Over the next several days, Mrs. Scott's periods of confusion were diminishing and the subdural hemotoma was resolving with no lasting effects or edema. Her albumin levels had increased and she even gained a little weight. As she became more and more consistently lucid, she requested that the PEG tube be removed. Finally, she asked Dr. Lee to remove the PEG tube. After a short conversation, he recommended that they meet the next day with her family and the medical oncologist.

To begin the meeting, Dr. Lee and Dr. Walker describe Mrs. Scott's diagnosis and prognosis and identify her possible courses of treatment, including aggressive therapy, palliative care, and no treatment. They describe in some detail the risks and benefits of each course and recommend palliative care including the PEG. Mrs. Scott seems to accept their recommendation. She explains that she has suffered long enough and asks Dr. Lee to recommend a hospice facility. Before he has chance to respond, she adds, "But first, as I asked you yesterday, I'd like you to remove the PEG tube."

What should Dr. Lee do? (select an option)

A. Order the removal of the PEG tube.
B. Ask Mr. Scott to persuade Mrs. Scott to keep the PEG tube in.

C. Call for a psychological evaluation of Mrs. Scott.

D. Inform Mrs. Scott that he will not remove the feeding tube.

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Case 5.3: Withdrawing or Withholding Treatment—Respecting Patients' End-of-Life Decisions

Option Assessment

A. Because Mrs. Scott apparently has decision-making capacity, ordering the removal of the PEG tube is **preferable** and supported by the *Code* in Opinion 2.20, "Withholding or Withdrawing Life-Sustaining Medical Treatment": "The principle of patient autonomy requires that physicians respect the decisions to forego life-sustaining treatment of a patient who possesses decision-making capacity."

B. Asking Mr. Scott to persuade Mrs. Scott to keep the PEG tube should be **avoided.** It is not supported by, and may violate the *Code* in Opinion 2.20, "Withholding or Withdrawing Life-Sustaining Medical Treatment": "The principle of patient autonomy requires that physicians respect the decisions to forego life-sustaining treatment of a patient who possesses decision-making capacity."

C. Calling for a psychological evaluation of Mrs. Scott should be **avoided** because it is not a sensible alternative unless Mrs. Scott has given some indication that she may lack decision-making capacity. If she has not, then this is merely an attempt to circumvent her autonomy which violates the *Code* in Opinion 2.20, "Withholding or Withdrawing Life-Sustaining Medical Treatment": "The principle of patient autonomy requires that physicians respect the decisions to forego life-sustaining treatment of a patient who possesses decision-making capacity."

D. Informing Mrs. Scott that he will not remove the PEG tube should be **avoided** because it violates the *Code* in Opinion 2.20, "Withholding or Withdrawing Life-Sustaining Medical Treatment": "The principle of patient autonomy requires that physicians respect the decisions to forego life-sustaining treatment of a patient who possesses decision-making capacity."

Compare these options

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Case 5.3: Withdrawing or Withholding Treatment—Respecting Patients' End-of-Life Decisions

Option Comparison

Without reason to suspect that her decision-making capacity is compromised, all courses of action that override or circumvent Mrs. Scott's decision (options B, C and D) should be avoided.

Because the autonomous choices of patients to refuse medical treatment should be respected, option A is preferable.

Preferable: Option A

Avoid: Options B, C, and D

Additional discussion and information

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Case 5.3: Withdrawing or Withholding Treatment—Respecting Patients' End-of-Life Decisions

Additional Information

The principle of patient autonomy requires that physicians respect a competent patient's decision to forgo any medical treatment. This principle is not altered when the likely result of withholding or withdrawing a treatment is hastening the patient's death.

Opinion 2.20, "Withholding or Withdrawing Life-Sustaining Medical Treatment"

> The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the preferences of the patient should prevail. The principle of patient autonomy requires that physicians respect the decision to forego life-sustaining treatment of a patient who possesses decision-making capacity...There is no ethical distinction between withdrawing and withholding life-sustaining treatment. A competent, adult patient may, in advance, formulate and provide a valid consent to the withholding or withdrawal of life-support systems in the event that injury or illness renders that individual incompetent to make such a decision. A patient may also appoint a surrogate decision maker in accordance with state law. If the patient receiving life-sustaining treatment is incompetent, a surrogate decision maker should be identified...Though the surrogate's decision for the incompetent patient should almost always be accepted by the physician, there are...situations that may require either institutional or judicial review and/or intervention in the decision-making process...When there are disputes among family members or between family and health care providers, the use of ethics committees specifically designed to facilitate sound decision making is recommended before resorting to the courts...Even if the patient is not terminally ill or permanently unconscious, it is not unethical to discontinue all means of life-sustaining medical treatment in accordance with a proper substituted judgment or best interests analysis.

Decisions to forgo life-sustaining treatment, which so profoundly affect a patient's well-being, cannot be made independent of a patient's subjective preferences and values. Many types of life-sustaining treatments are burdensome and invasive, so that the choice for the patient is not simply a choice between life and death. When a patient is dying of cancer, for example, a decision may have to be made whether to use a regimen of chemotherapy that might prolong life for several additional months but also would be painful and debilitating. Patients, however, are no longer required to choose between aggressive life-sustaining or life-prolonging treatment and no treatment; medical professionals are becoming increasingly aware of the value of palliative care.

There is no ethical distinction between withdrawing and withholding life-sustaining treatment. A patient's right to refuse treatment is independent of whether treatment has begun.

In summary, according to the principle of respect for patient autonomy, patients who possess decision-making capacity have the right to forgo any life-sustaining treatment. Physicians must respect these patient decisions, and they must

ensure that patients are well-informed about their prognoses and treatment options and understand that comfort and dignity will be top priorities whether or not they decide to forgo life support.

Related topic: DNR orders

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Case 5.3: Withdrawing or Withholding Treatment—Respecting Patients' End-of-Life Decisions

Related topic: DNR orders

Cessation of cardiac or respiratory function will be an inevitable part of Mrs. Scott's dying process; accordingly, CPR could be used prior to her death. Two sets of circumstances indicate that CPR should not be used in this and similar cases.

First, as previously discussed, patients have the right to refuse medical treatment, even when such a refusal is likely to result in serious injury or death. Mrs. Scott, therefore, may express in advance her preference that CPR be withheld in the event of cardiac arrest. Such a refusal serves as the basis for a do-not-resuscitate order. DNR orders, at least in theory, permit patients to express their preferences regarding the use of life-prolonging treatment while they still have decision-making capacity.

Second, CPR should not be used when an attempt to resuscitate the patient would be futile in the judgment of the health care team. A physician is not ethically obligated to make a specific diagnostic or therapeutic procedure available to a patient, even upon specific request, if the use of such a procedure would be futile (see also Case I of this module). Specifically, futility in this case and others like it would be the inability to restore pulmonary or respiratory function.

Opinion 2.20, "Do-Not-Resuscitate Orders"

> ...Patients at risk of cardiac or respiratory failure should be encouraged to express in advance their preferences regarding the use of CPR, and this should be documented in the patient's medical record. These discussions should include a description of the procedures encompassed by CPR and, when possible, should occur in an outpatient setting when general treatment preferences are discussed or as early as possible during hospitalization...Physicians should not permit their personal value judgments about quality of life to obstruct the implementation of a patient's preferences regarding the use of CPR...
>
> DNR orders only preclude resuscitative efforts in the event of cardiopulmonary arrest and should not influence other therapeutic interventions that may be appropriate for the patient.

In practice, physicians and patients alike may find it difficult to engage in discussions about the possibility of patient death, particularly in the early stages of hospitalization. However, as the need for such a discussion becomes urgent, the patient no longer may be capable of participating in the decision-making process. An absence of patient involvement may result in mistaken impressions about the medical procedures employed during resuscitation efforts

and the probable outcome of CPR, or may result in the implementation of decisions that are not in accord with the patient's values and preferences. There is a good deal of evidence that Mrs. Scott would not want to be resuscitated, but this conclusion would be presumptuous on the part of the medical staff without direct discussion of a DNR.

In some cases, the successful application of CPR has been gauged by criteria that relate to the length of patient survival. Such criteria include, for example, survival for at least 24 hours following initial resuscitation, survival until discharge from the hospital, and survival for some other timeframe. Using any of these definitions of successful treatment, CPR is judged to be futile if it is unlikely to prolong the life of the patient for the period of time set forth in the criteria. This interpretation of futility is inconsistent with the principle of patient autonomy, which requires that patients be permitted to choose from among available treatment alternatives that are appropriate for their condition, particularly when such choices are likely to be influenced by personal values and priorities.

Judgments of futility that involve value judgments are appropriate only if the patient is the one to determine what is or is not of benefit among reasonable treatment alternatives, in keeping with his or her personal values and priorities. Patients, therefore, should be encouraged to discuss the expected benefits and objectives of medical treatment with their physicians and to engage in an ongoing dialogue regarding the potential for achieving these goals.

Module 5 Feedback Questionnaire

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Module 5: End-of-Life Care

Feedback Questionnaire

In Module 5 on end-of-life care, how would you rate the relevance of the cases?
- Excellent
- Very good
- Good
- Fair
- Poor

How would you rate the explanation of courses of action?
- Excellent
- Very good
- Good
- Fair
- Poor

How would you rate the overall coverage of the topic?
- Excellent
- Very good
- Good
- Fair
- Poor

Submit

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Module 6

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Case 6.1: Gifts from Industry—The Cost of Lunch

Case Presentation

Dr. Mathews is chief resident of the internal medicine residency program at a large teaching hospital. The department chairman asked him to seek sources of funding for the weekly noontime conferences, adding, "With all those drug companies out there wanting time with physicians, you shouldn't have a problem finding someone to buy us sandwiches or pizza once a week."

Dr. Mathews asked, "That's okay with you and the department, allowing a drug company to buy lunch once a week?"

"I think so," the chairman said. "Everyone knows by now that each drug rep is going to tout his own wares. It's a wash, in the end. Most 6-year-olds know how to discriminate among fast-food ads on television; I think residents can make sound independent decisions, don't you?"

Dr. Mathews had, in fact, been talking with a rep from Melissima Inc who was trying to push Melissima's ACE inhibitor. If any product message could be neutralized by the sheer number of competing ads, an ACE inhibitor ad would be it. The rep okayed the plan. She would be there at the weekly conferences, but would only provide information if someone posed a question, she explained.

Dr. Mathews thought that, with a few words from himself to the residents before the Melissima sponsorship kicked off, everything would be okay. After a while, he'd switch companies and let a Melissima competitor buy lunch. Or if it turned out that the Melissima rep was being too chatty, having too much to say to the residents, he'd switch. These things needed to be judged on a case-by-case basis, Mathews thought. All company sponsorship cannot be condemned as bad. By rough calculation, though, Melissima would be spending about $650 to $700 on the food per week. He wasn 't sure that information would pass the "how would it look in the headlines" test.

What should Dr. Mathews do about funding for lunch at the noontime conferences? (select an option)

A. Refuse to allow Melissima or any other industry member to sponsor the lunches.
B. Allow Melissima to sponsor the lunches but rotate industry members regularly and set a cap on the amount spent per attendee.
C. Allow Melissima to sponsor the lunches without a spending limit but rotate industry member regularly.
D. Allow Melissima to sponsor the lunches indefinitely but set a cap on the amount spent per attendee.
E. Allow Melissima to sponsor the lunches indefinitely without a spending limit.

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Case 6.1: Gifts from Industry—The Cost of Lunch

Option Assessment

A. Refusing Melissima's sponsorship of the lunches is **acceptable**. Although refusing unequivocally avoids all concerns raised in Opinion 8.061, "Gifts to Physicians from Industry," there is no prohibition against industry subsidies.

B. Allowing Melissima to sponsor the lunches, rotating industry members regularly and setting a cap on the amount spent per attendee is **preferable**. Accepting gifts from competing industry members does not violate the *Code* and the spending limit is supported by the *Code*. Opinion 8.061, "Gifts to Physicians from Industry" states: "Gifts accepted...should primarily entail a benefit to patients and should not be of substantive value...[and] textbooks, modest meals, and other gifts are appropriate if they serve a genuine educational function."

C. Allowing Melissima to sponsor the lunches without a spending limit but rotating industry member regularly should be **avoided**. It may violate the *Code* in Opinion 8.061, "Gifts to Physicians from Industry": "Gifts accepted...should primarily entail a benefit to patients and should not be of substantive value...[and] textbooks, modest meals, and other gifts are appropriate if they serve a genuine educational function." Without a spending limit, there is a risk that Melissima or some other industry member would provide more than a modest meal.

D. Allowing Melissima to sponsor the lunches indefinitely but setting a cap on the amount spent per attendee is **acceptable**. It does not violate the *Code* and the spending limit is supported by the *Code* in Opinion 8.061, "Gifts to Physicians from Industry": "Gifts accepted...should primarily entail a benefit to patients and should not be of substantive value...[and] textbooks, modest meals, and other gifts are appropriate if they serve a genuine educational function."

E. Allowing Melissima to sponsor the lunches indefinitely without a spending limit should be **avoided** because it may violate the *Code* in Opinion 8.061, "Gifts to Physicians from Industry": "Gifts accepted...should primarily entail a benefit to patients and should not be of substantive value...[and] textbooks, modest meals, and other gifts are appropriate if they serve a genuine educational function." Without a spending limit, there is a risk that Melissima would provide more than a modest meal.

Compare these options

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Case 6.1: Gifts from Industry—The Cost of Lunch

Option Comparison

Because the weekly conferences serve a genuine educational function, the spending limit confines the sponsorship, and the rotation among industry members limits the exposure of any particular industry representative, option B is the preferable alternative.

Refusing industry sponsorship (option A) is always acceptable, and setting a limit on Melissima's spending for the meals it provides (option D) is also acceptable. There may be some reason to avoid option D, nonetheless. Because of the frequency of the conferences, the weekly modest meal will accumulate to become a substantial gift.

Without a spending limit, there is no way to ensure that the gifts from Melissima or any other industry representative will be modest, and so options C and E should be avoided.

Preferable: Option B

Acceptable: Options A and D

Avoid: Options C and E

Additional discussion and information

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Case 6.1: Gifts from Industry—The Cost of Lunch

Additional Information

Throughout this discussion, "industry" refers to all "proprietary health-related entities that might create a conflict of interest." While relationships between industry and the medical community have resulted in important benefits for patient care, there has been growing concern about the potential negative consequences of the relationship. In particular, commentators have increasingly questioned the appropriateness of some of the gifts and other subsidies that are given to physicians by companies in the pharmaceutical, device, and medical equipment industries. Some of these gifts and subsidies may have inappropriate effects and are therefore cause for concern. Accordingly, Opinion 8.061, "Gifts to Physicians from Industry" addresses the appropriateness of gifts given to physicians by health care industries.

Opinion 8.061, "Gifts to Physicians from Industry"

> ...To avoid the acceptance of inappropriate gifts, physicians should observe the following guidelines:
>
> (1) Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantial value. Accordingly, textbooks, modest meals, and other gifts are appropriate if they serve a genuine educational function. Cash payments should not be accepted...
>
> (2) Individual gifts of minimal value are permissible as long as the gifts are related to the physician's work (eg, pens and notepads).
>
> (3) The Council on Ethical and Judicial Affairs defines a legitimate "conference" or "meeting" as any activity, held at an appropriate location, where (a) the gathering is primarily dedicated, in both time and effort, to promoting objective scientific and educational activities and discourse (one or more educational presentation(s) should be the highlight of the gathering), and (b) the main incentive for bringing attendees together is to further their knowledge on the topic(s) being presented. An appropriate disclosure of financial support or conflict of interest should be made.
>
> (4) Subsidies to underwrite the costs of continuing medical education conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible...Payments to defray the costs of a conference should not be accepted directly from the company by the physicians attending the conference.
>
> (5) Subsidies from industry should not be accepted directly or indirectly to pay for the costs of travel, lodging, or other personal expenses of physicians attending conferences or meetings, nor should subsidies be accepted to compensate for the physicians' time...It is appropriate for faculty at conferences or meetings to accept reasonable

honoraria and to accept reimbursement for reasonable travel, lodging, and meal expenses...

(6) Scholarship or other special funds to permit medical students, residents, and fellows to attend carefully selected educational conferences may be permissible as long as the selection of students, residents, or fellows who will receive the funds is made by the academic or training institution...

(7) No gifts should be accepted if there are strings attached...

Some of the gift-giving practices by industry are ethical and beneficial to patients. Nonetheless, the practice of gift giving raises a number of ethical concerns. First, industry invests in promotional activities because promotions increase sales. There is no evidence that physicians knowingly or intentionally compromise their patients' care as a result of gifts from industry. Nevertheless, the practice of gift giving may subtly influence practice patterns such that they are based on considerations other than scientific knowledge and patient needs. Moreover, gifts may also affect a physician's continuing education because physicians only have time to attend a limited number of conferences, and industry can make their conferences more attractive by subsidizing the costs of attending.

Second, even if gifts from industry have no effect on a physician's practices, there may be a public impression of impropriety, especially if the gifts are of substantial value. Public trust in physicians may be undermined if it appears that the choice of a drug, device, or other product is influenced by the fact that the physician received a gift from the company that manufactures the product.

Finally, the costs of gifts from industry to physicians are ultimately passed on to the public. In effect, patients pay for a benefit that may be experienced primarily by their physicians.

For further discussion of this topic, see also the "Clarification of Opinion 8.061, Gifts to Physicians from Industry" in the *Code*, and see <www.ama-assn.org/go/ethicalgifts>, especially module 4.

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Module 6

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Case 6.2: Financial Incentives—The 50-Milligram Difference

Case Presentation

Dr. Dan Troy has been practicing internal medicine for more than 20 years in a multispecialty group practice and enjoys his work.

He was put in charge of monitoring the group's expenditures for prescription drugs. After some research, he discovered that in the case of many formularies, it was actually more cost-effective to prescribe a higher dose of the medication and have the patient split each pill rather than prescribing the actual dose the patient needed. For example, the cost of a single 50-mg tablet of Zoloft was $2.40 while the cost of a 100-mg tablet of Zoloft was $2.43.

Dr. Troy noted that his group has consistently exceeded the financial limit that many insurance companies place on expenditures for prescription medication. Adopting a policy to prescribe more cost-effective medication when possible would improve the group practice's insurance profile and, at the same time, reduce the insurer's overall spending on prescription drugs.

Two weeks later, one of Dr. Troy's well-established patients, Ajaz Ria, came in for a routine check-up and a refill on his medication. Mr. Ria is a middle-aged man who comes in regularly and usually gets a prescription for Zoloft for treatment of his depression. Dr. Troy prescribes 50-mg tablets, with instructions to take one tablet a day.

Dr. Troy examines Mr. Ria and is about to write out his prescription, when he realizes that if he writes the prescription for 100-mg tablets, it would represent a savings of more than $400 over the course of a year. Dr. Troy suggests this to Mr. Ria. He explains that it is more cost-effective to purchase the medication in that dosage and split the tablets than to fill twice as many prescriptions for the 50-mg pills. Mr. Ria thanks Dr. Troy for his concern but explains that he would rather have the prescription for the 50-mg pills because he is used to taking the whole pill each day and he's afraid he'd forget to split it in half. "Besides," he remarks, "I pay the same co-pay in either case, so why does it matter?"

What should Dr. Troy do about Mr. Ria's prescription? (select an option)

A. Inform Mr. Ria that he will write the prescription for 100-mg.
B. Respect Mr. Ria's preference by writing the prescription for 50-mg.
C. Inform Mr. Ria of Dr. Troy's incentive to write the larger prescription and ask if he would be willing to get the 100-mg prescription.

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Case 6.2: Financial Incentives—The 50-Milligram Difference

Option Assessment

A. Informing Mr. Ria that he will write the prescription for 100-mg should be **avoided**. It violates Opinion 8.054, "Financial Incentives and the Practice of Medicine," which states that physicians' "first duty must be to the individual patient. This obligation must override considerations of the reimbursement mechanism or specific financial incentives applied to a physician's clinical practice."

B. Writing the prescription for 50-mg is **acceptable**. It is supported by *Code* Opinion 8.054, "Financial Incentives and the Practice of Medicine": physicians "first duty must be to the individual patient. This obligation must override considerations of the reimbursement mechanism or specific financial incentives applied to a physician's clinical practice."

C. Informing Mr. Ria of Dr. Troy's financial incentive to write the larger prescription and asking if he would be willing to get the 100-mg prescription is **preferable**; it is the most reasonable option and is supported by the *Code* in Opinion 8.054, "Financial Incentives and the Practice of Medicine": "patients must be informed of financial incentives that could impact the level or type of care they receive."

Compare these options

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Case 6.2: Financial Incentives—The 50-Milligram Difference

Option Comparison

Because option C fulfills Dr. Troy's primary obligation to Mr. Ria and also informs him of the financial incentives in the background of their patient-physician relationship, it is preferable. Even though option B, continuing to write a prescription for 50-mg tablets, does not inform Mr. Ria of the financial incentive, one could argue that it is an acceptable alternative because it respects Mr. Ria's preference. Dr. Troy does not gain direct benefit from Mr. Ria's prescription at 50- or 100-mg doses; he only benefits if improving the practice's profile lowers costs down the road. It is preferable to inform Mr. Ria of the financial incentive. This will allow Dr. Troy to inform Mr. Ria that health care costs rise whether or not Mr. Ria pays for them out of his own pocket.

Because option A undermines Dr. Troy's obligations to Mr. Ria and fails to inform him of the financial incentive that motivates Dr. Troy's insistence, it should be avoided.

Preferable: Option C

Acceptable: Option B

Avoid: Option A

Additional discussion and information

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Case 6.2: Financial Incentives—The 50-Milligram Difference

Additional Information

The most fundamental goal of the medical profession is to provide for the health of patients. In the context of clinical care, this requires physicians to place the health interests of their individual patients before other concerns and to facilitate access to all necessary treatments.

Opinion 8.03, "Conflict of Interests: Guidelines"

> Under no circumstances may physicians place their own financial interests above the welfare of their patients. The primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration...If a conflict develops between the physician's financial interest and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit.

Accordingly, financial incentives as well as potential financial conflicts of interests should be judged according to their success or failure at fostering improvements in patient care. The following Opinion excerpts explain guidelines for these situations:

Opinion 8.051, "Conflicts of Interest under Capitation"

> ...(1) Physicians have an obligation to evaluate a health plan's capitation payments prior to contracting with that plan to ensure that the quality of patient care is not threatened by inadequate rates of capitation...Physicians should seek agreements with plans that provide sufficient financial resources for all necessary care and should refuse to sign agreements that fail in this regard.
>
> (2) Physicians must not assume inordinate levels of financial risk...
>
> (3) Stop-loss plans should be in effect to prevent the potential of catastrophic expenses from influencing physician behavior...
>
> (4) Physicians must be prepared to discuss with patients any financial arrangements which could impact patient care.

One potential benefit of financial incentives is a reduction of waste in the use of medical resources, including

payments by insurers for unnecessary services and prescriptions, thereby effectively increasing the pool of resources for care. Financial incentives, however, accomplish this social benefit by involving the personal financial interests of the physician in the therapeutic relationship.

As the above Opinions make clear, incentives should be judged according to the extent to which they allow physicians to maintain their role as advocates for the health of individual patients. Specifically, incentives should never discourage physicians from fulfilling their obligations to disclose all treatment options, to appeal denials of coverage for necessary care, to make referrals on the basis of individual patient needs, or to provide each patient with the treatments they believe will be of material benefit. (For normative standards on limitations to prescription coverage see Opinion 8.135, "Cost Containment Involving Prescription Drugs in Health Care Plans.")

The effect of financial incentives is felt most acutely when there is not a clear clinical course and the physician is called upon to render an objective analysis of several complex considerations. Because it is difficult to maintain true objectivity when a monetary reward or penalty is associated with one of the possible courses of action, placing limits on financial incentives helps protect clinical objectivity. There are several means of limiting the negative effects of these incentives including applying the incentives across groups of physicians and correlating incentives to large pools of patients over a substantial length of time.

The potential to affect the objectivity of physicians is not the only cause for concern about financial incentives. Inducements that are based on the use of resources across physicians' practices compound the conflict between the interests of the physician and those of the patient by introducing conflicts between patients. For instance, bonuses attached to patterns of reduced use encourage physicians to consider which patients need certain services most rather than what an individual patient needs.

Finally, patients have a right to be informed of all factors that could impact their care, including the payment system under which their physician practices. In this case, Mr. Ria should be told that his insurer's extra costs will likely come back as increases in coverage costs or decreases in covered care. A much more difficult question to answer than whether or not to disclose incentives is where the responsibility for providing such information lies. Disclosure prior to enrollment in a health plan is preferable, as the structure of financial inducements could influence the patient's decision to purchase a specific form of coverage. Some obligation, however, exists on the part of the physician to provide this information if it has not already been provided.

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Module 6

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Case 6.3: Office Sales—Supplemental Income

Case Presentation

Dr. Yueh, a member of Dr. Troy's group practice, approached Dr. Troy with a business proposition. He recently read some clinical studies of an herbal supplement he would like to begin selling from the office. He has procured an agreement from the manufacturer and all he needs now is the agreement of the members of the group. He offers to show Dr. Troy the clinical studies and has a sample display set up in his office. Dr. Troy asks Dr. Yueh to get him copies of the clinical studies and provide all the other relevant material—the cost of the supplements, the group's profit from the sales, etc.

The next morning Dr. Troy finds the published material about the clinical studies on his desk with a quick note from Dr. Yueh. The supplement's wholesale cost is $9/bottle and the recommended retail selling price is $15/bottle. Each bottle contains about a month's supply. Even though the clinical studies show marked improvement in research subjects' reported energy level and feelings of well-being, Dr. Troy is unsure of how reliable these subjective reports really are. Upon close investigation, he notes that the study was funded by the supplement's manufacturer. When he asks Dr. Yueh about other studies on the supplements, Dr. Yueh says that there are no other completed studies.

What should Dr. Troy tell Dr. Yueh? (select an option)

A. He cannot support the sale of this supplement in the office.
B. He will agree to sell it for a month according to the manufacturers recommendations, to see how things go.
C. He will agree to sell it from the office at wholesale cost.

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Case 6.3: Office Sales—Supplemental Income

Option Assessment

A. Telling Dr. Yueh that he cannot support the sale of the supplement is **preferable**. According to the *Code* in Opinion 8.063, "Sale of Health-Related Products from Physicians' Offices": "Physicians... should not sell any health-related products whose claims of benefit lack scientific validity...[and] should rely on peer-reviewed literature and other unbiased scientific sources." Whether or not the benefits of this supplement have scientifically valid support remains unclear. Further, there is reason to suspect that the one completed study is biased because it is funded exclusively by the manufacturer.

B. Telling Dr. Yueh that he will agree to sell the supplement for a month should be **avoided**. It violates *Code* Opinion 8.063, "Sale of Health-Related Products from Physicians' Offices": "Physicians...should not sell any health-related products whose claims of benefit lack scientific validity." Moreover, Opinion 8.063 goes on, "Physicians may distribute other health-related products to their patients free of charge or at cost...." Selling any product for substantial profit puts Dr. Troy in a position of financial conflict of interest that may compromise his independent medical judgment.

C. Telling Dr. Yueh that he will agree to sell the supplement from the office at wholesale cost should be **avoided**, even though there will be no financial conflict of interest. The clinical study does not meet the requirements of Opinion 8.063, "Sale of Health-Related Products from Physicians' Offices": "Physicians...should not sell any health-related products whose claims of benefit lack scientific validity...[and] should rely on peer-reviewed literature and other unbiased scientifice sources." There is reason to believe the available studies are biased, and there are no means for determining whether the claims of benefit are scientifically valid.

Compare these options

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Case 6.3: Office Sales—Supplemental Income

Option Comparison

Although selling these supplements wholesale would be less ethically questionable than selling them for a profit, options B and C both should be avoided because it is not clear that there is support for any claim of benefit for this product. Nor is it clear that this product serves a pateint need. Accordingly, option A—not selling the product from the office—is preferable.

Preferable: Option A

Avoid: Options B and C

Additional discussion and information

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Case 6.3: Office Sales—Supplemental Income

Additional Information

Selling any health-related or non-health-related products from the office risks demeaning the profession of medicine. Entrepreneurial financial endeavors are not unethical in and of themselves, but, when they are exercised within the patient-physician relationship, they can create a conflict between the physician's financial interest and the welfare of the patient. Under such circumstances there is serious concern that patients are being exploited. Physicians should take steps to minimize financial conflicts of this type. The following Opinions identify guidelines for the sale of both health-related and non-health-related products from the physician's office.

Opinion 8.063, "Sale of Health-Related Products from Physicians' Offices"

> "Health-related products" are any products that, according to the manufacturer or distributor, benefit health. "Selling" refers to the activity of dispensing items that are provided from the physician's office in exchange for money and also includes the activity of endorsing a product that the patient may order or purchase elsewhere that results in direct remuneration for the physician...
>
> In-office sale of health-related products by physicians presents a financial conflict of interest, risks placing undue pressure on the patient, and threatens to erode patient trust and undermine the primary obligation of physicians to serve the interests of their patients before their own.
>
> (1) Physicians who choose to sell health-related products from their offices should not sell any health-related products whose claims of benefit lack scientific validity...
>
> (2) Because of the risk of patient exploitation and the potential to demean the profession of medicine...the following guidelines apply:
>
> > (a) In general, physicians should limit sales to products that serve the immediate and pressing needs of their patients...
> >
> > (b) Physicians may distribute other health-related products to their patients free of charge or at cost, in order to make useful products readily available to their patients...
>
> (3) Physicians must disclose fully the nature of their financial arrangement with a manufacturer or supplier to sell health-related products...
>
> (4) Physicians should not participate in exclusive distributorships of health-related products which are available only through physicians' offices...

Opinion 8.062, "Sale of Non-Health-Related Goods from Physicians' Offices"

> ...Physicians should not sell non-health-related goods from their offices or other treatment settings, with the exception noted below.
>
> Physicians may sell low-cost non-health-related goods from their offices for the benefit of community organizations, provided that (1) the goods in question are low-cost; (2) the physician takes no share in profit from their sale; (3) such sales are not a regular part of the physician's business; (4) sales are conducted in a dignified manner; and (5) sales are conducted in such a way as to assure that patients are not pressured into making purchases.

It is important for physicians to limit in-office sales to those that serve the immediate and pressing needs of patients. As with prescription products, if a product is available at a local pharmacy, physicians should avoid selling it from their offices.

In-office sales of health-related products that are available only through physicians and offer a unique benefit to patient health raise particular concerns. Since patients are unable to purchase an equivalent product elsewhere, physicians have a monopoly on the market, and patients are captive consumers. Exclusive arrangements such as these are troublesome because they force patients either to purchase the product from their physician or to forgo the recommended treatment. If a physician strongly believes that a patient needs the product that is available only through physician-distributorship, then he or she should encourage the manufacturer to make the product accessible through alternative existing structures such as pharmacies.

Should it be deemed necessary to sell a health-related product from a physicians office, see also Opinion 8.03, "Conflicts of Interest Guidelines;" Opinion 8.032, "Conflict of Interest: Physician Ownership of Medical Facilities:" Opinion 3.01, "Nonscientific Practitioners;" Opinion 8.20, "Invalid Medical Treatments."

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Module 6

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Case 6.4: Treatment of Family Members and Significant Others—All in the Family

Case Presentation

Dr. Green is completing her internship year at a major teaching hospital. Her brother, Michael, who lives 100 miles away in a rural setting in the same state, has been seeing a psychiatrist for anxiety disorder and depression and has been taking medication for his illness. Without the medication, he suffers from severe panic attacks that force him to avoid most social situations, and he experiences episodic bouts of severe depression. Michael is almost at the end of his medication and has just learned that his psychiatrist is unreachable in the Canadian wilderness on vacation for the next two weeks. He telephones his sister and asks her to call in a prescription refill.

What should Dr. Green do about Michael's prescription? (select an option)

A. Tell Michael she can take over writing the prescription for him now that he knows what he should be taking.
B. Tell Michael she will write the prescription this time only because it is an emergency.
C. Ask a staff psychiatrist at the hospital to write the prescription.
D. Tell Michael to find another way to get the prescription filled.

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Case 6.4: Treatment of Family Members and Significant Others—All in the Family

Option Assessment

A. Telling Michael she can take over writing the prescription for him now that he knows what he should be taking should be **avoided**. *Code* Opinion 8.19 states that "Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for...immediate family members."

B. Telling Michael she will write the prescription this time only because it is an emergency may be an **acceptable** alternative that does not violate the *Code*. Opinion 8.19, "Self-Treatment or Treatment of Immediate Family Members" states: "Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for...immediate family members."

C. Asking a staff psychiatrist at the hospital to write the prescription is **preferable** because there is another physician available who will be in a better position to judge this request by Michael, and because this would remove Dr. Green from a potential conflict of interest. Indeed, the *Code* (in Opinion 8.19, "Self-Treatment or Treatment of Immediate Family Members") allows treatment of family only "In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available."

D. Telling Michael to find another way to get the prescription filled is an **acceptable** alternative that is supported by the Code in Opinion 8.19, "Self-Treatment or Treatment of Immediate Family Members" when it admonishes physicians to avoid the role of primary physician for family members because: "physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care."

Compare these options

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Module 6

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Case 6.4: Treatment of Family Members and Significant Others—All in the Family

Option Comparison

It is in the best interests of both patients and physicians to avoid having a family member act as the primary physician. Although this may be necessary at times, it should be avoided whenever possible. Accordingly, it is acceptable for Dr. Green to refuse to write the prescription for her brother (option D). Because this is short-term, however, and the failure to fill the prescription has significant risks, option B is also acceptable. Option C (consulting the staff psychiatrist) is preferable to both options B and D because it provides Michael with an alternative means of procuring the refill. Finally, option A, taking on the responsibility of writing Michael's prescription for the foreseeable future, should be avoided.

Preferable: Option C

Acceptable: Options B and D

Avoid: Option A

Additional discussion and information

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Module 6

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Case 6.4: Treatment of Family Members and Significant Others—All in the Family

Additional Information

Objectivity plays an important part in good clinical judgment. Previous sections of this chapter have identified how financial considerations can compromise physician objectivity; personal relationships may also undermine physician objectivity and, consequently, diminish the quality of patient care. Clinical relationships with family members and romantic and/or sexual relationships with patients are especially likely to jeopardize patient care. The *Code* addresses both of these:

Opinion 8.19, "Self-Treatment or Treatment of Immediate Family Members"

> ...Professional objectivity may be compromised when an immediate family member of the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment...Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member....Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care from their parents.
>
> ...In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available.
>
> Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

Opinion 8.14, "Sexual Misconduct in the Practice of Medicine"

> Sexual contact that occurs concurrent with the patient-physician relationship constitutes sexual misconduct. Sexual or romantic interactions between physicians and patients detract from the goals of the patient-physician relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and ultimately may be detrimental to the patient's well-being.
>
> ...At a minimum, a physician's ethical duties include terminating the physician-patient relationship before initiating a dating, romantic, or sexual relationship with a patient.

> ...Sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the previous professional relationship.

See also Opinion 8.145, "Sexual or Romantic Relations between Physicians and Key Third Parties."

Physician expertise and collaborative decision making are cornerstones of contemporary medical practice. Strong emotional connections to family members or significant others can alter physician judgment in ways the physician may be unable to recognize.

A second concern is that the power imbalance of the patient-physician relationship may be intensified in close personal relationships, inhibiting the family member or significant other from challenging, questioning, or disagreeing with the physician.

The ethical prohibition against romantic relationships or sexual contact with patients is not meant to be a bar to other kinds of non-sexual touching of patients by physicians. In addition to its role in physical examination, non-sexual touching may be therapeutic or comforting to patients. However, even non sexual contact with patients (beyond the appropriate touching of the physical examination) should be approached with caution.

It is of course possible for a physician and a patient to be genuinely attracted to or have genuine romantic affection for each other. However, any relationship in which a physician is (or risks) taking advantage of the patient's emotional or psychological vulnerability is unethical. Therefore, before initiating a dating, romantic, or sexual relationship with a patient, a physician's *minimum* duty is to terminate his or her professional relationship with the patient. These restrictions are more strict for psychiatrists, but all physicians should be aware of possible problems that can arise from these relationships.

Module 6 Feedback

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Module 6: Conflicts of Interest

Feedback Questionnaire

In Module 6 on conflict of interest, how would you rate the relevance of the cases?
- Excellent
- Very good
- Good
- Fair
- Poor

How would you rate the explanation of the courses of action?
- Excellent
- Very good
- Good
- Fair
- Poor

How would you rate the overall coverage of the topic?
- Excellent
- Very good
- Good
- Fair
- Poor

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Module 7

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Case 7.1: Indigent Care—Volunteering at the Clinic

Case Presentation

Dr. Mills has been volunteering one day a week at a free neighborhood health clinic that serves those with state medical cards as well as homeless individuals who walk in for acute care. On other days, Dr. Mills is part of an internal medicine practice group with five other physicians. Even though Dr. Mills receives less compensation because he is only in the office four days a week, his partners recently have been increasingly critical of his volunteer work on "practice time." One of their arguments is that some portion of office and patients' fees covers office expenses, and since he is only there four days a week, he is not paying his share. In his own defense, Dr. Mills has been arguing that the profession requires volunteer work and that his partners should commit some time to the free clinic.

What should Dr. Mills do about his volunteer work? (select an option)

A. Attempt to convince the others in his practice that physicians have a professional obligation to provide medical services to the poor.
B. Make arrangements to volunteer at the clinic at times that interfere less with his practice hours.
C. Seek employment at an institution that provides care to the uninsured and underserved.
D. Discontinue his volunteer work for the time being, and hope that other physicians will take his place.

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Module 7

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Case 7.1: Indigent Care—Volunteering at the Clinic

Option Assessment

A. Convincing his colleagues that providing voluntary medical services to needy populations is the **preferable** option according to Opinion 9.065, "Caring for the Poor" which states that "each physician has an obligation to share in providing care to the indigent"…and that "caring for the poor should be a regular part of the physician's practice schedule." So while Dr. Mills is correct about the physician's obligation, the *Code* does not specifically address how the obligation should be met.

B. Volunteering at a clinic without disrupting the care to his regular patients an **acceptable** option for Dr. Mills. The *Code* speaks to physicians' obligations to provide care to the poor, but it does not specifically mandate how this should be done. A few suggestions include: "Physicians can also volunteer their services at weekend clinics for the poor and at shelters for battered women or the homeless." The one caveat that is offered by the *Code* is that in fulfilling their obligation to the poor, physicians need not put their existing patients at risk. As Opinion 10.05, "Potential Patients" states: "…physicians have an obligation to share in providing charity care but not to the degree that would seriously compromise the care provided to existing patients."

C. Deciding to work solely in an institution that serves the uninsured and underserved is an **acceptable** action for physicians who believe strongly that these populations deserve equal access to health care. Principle VI of the Principles of Medical Ethics states: "A physician shall…except in emergencies, be free to choose whom to serve, …and the environment in which to provide medical care." Principle IX further states that: "A physician shall support access to medical care for all people." If Dr. Mills wishes to pursue this course, however, he must make sure that his current patients do not suffer because of his decision.

D. Discontinuing his volunteer work and placing the responsibility on others should be **avoided**. Principle IX of the *Code* and Opinion 9.065 view these activities as ongoing expectations of the profession, not time-limited obligations. In addition, if Dr. Mills discontinues his volunteer work, there could be a void in the continuity of services for some patients at the clinic, especially if other physicians took his place.

Compare these options

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Case 7.1: Indigent Care—Volunteering at the Clinic

Option Comparison

The volunteer medical care that Dr. Mills provides at the clinic is clearly fulfilling the expectations of the *Code*. However, the *Code* purposely does not mandate how medical care for the indigent should be provided. Instead, Opinion 9.065, "Caring for the Poor" recognizes that: "The measure of what constitutes an appropriate contribution may vary with circumstances such as community characteristics, geographic location, the nature of the physician's practice and specialty, and other conditions."

Option A—convincing other physicians to volunteer—is preferable because it could provide more resources (in terms of hours and expertise) for the medical care of the poor. Option B—finding alternative times to volunteer during non-practice hours—and option C—seeking employment at an institution serving the poor—are both acceptable. If Dr. Mills pursues option C, he must ensure that he does not put his current patients at risk. According to the *Code* it is not acceptable to leave care for the poor entirely up to others, as in option D. Accordingly, option D should be avoided.

Preferable: Option A

Acceptable: Options B and C

Avoid: Option D

Additional discussion and information

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Case 7.1: Indigent Care—Volunteering at the Clinic

Additional Information

The AMA has long recognized an ethical obligation of physicians to assume some individual responsibility for making health care available to the needy. Lack of access to health care, particularly primary and preventive care, has pronounced consequences both for the individuals who need care and for society in general. The objective of the medical profession is to care for the sick without concern for who they may be, what their diseases are, or whether they can afford to pay. This responsibility is based in ideals such as justice and beneficence—the ethical foundation of the medical profession.

Dedication to patients' welfare and acting as patients' advocates highlight the relationship between the medical profession and the public, including the disadvantaged. Without compassion and charity for all who are suffering, something essential goes out of medicine and the lives of its practitioners. The disappearance of these qualities of medical care would be an inestimable loss [1].

Reference

1. "Caring for the poor." Council on Ethical and Judicial Affairs, American Medical Association. *AMA.* 1993;269:2533-2537.
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Case 7.2: Physician Activism—Doctors Go on Strike

Case Presentation

Dr. Alex Nelson is an internist at a large private urban hospital. He is one of the more junior members of the practice, having finished his residency training only 2 years before.

Malpractice insurance premiums for Dr. Nelson and other physicians in the area have skyrocketed over the last couple of years. The situation has become so serious that his more senior colleagues ask him why he stayed in the area to practice after residency. Some of them say that they are considering retiring or finding other practice opportunities in another state. Not only can they not generate comfortable incomes after paying for malpractice premiums, they say, but they are also beginning to have trouble finding companies that will offer them any coverage at all.

Local physicians—including many of Dr. Nelson's colleagues—recently held a rally at the state capitol to draw attention to the situation in the hopes that legislators would take action to make malpractice insurance more affordable in the state. They have also lobbied their federal congressmen through professional associations. Despite their efforts, legislation to address the growing crisis remains stalled.

Frustrated by the lack of action on the part of policymakers, Dr. Nelson's colleagues decide that more drastic measures are needed. Specifically, they decide to plan a work stoppage. Based on physician work stoppages in other states, they decide to set aside one day on which only physicians who provide emergency care will work. They think this will draw more attention to the issue and force the legislators to move on the stalled bill. They plan the work stoppage for the following Monday and will hold another rally and a press conference on the same day.

Dr. Nelson is not quite sure how he feels about the issue. On one hand, he knows that the malpractice insurance crisis is real and appears to be worsening. He also knows that legislators might not realize how serious the situation has become. On the other hand, he isn't sure whether these tactics are ethical. How, he wonders, can physicians advocate for sustained access to care by denying care?

Still undecided about the planned work stoppage, Dr. Nelson is approached by his most senior colleague a few days before the planned stoppage. "So Alex, we'll see you down at the rally on Monday?"

What should Dr. Nelson do about the work stoppage? (select option)

A. Offer to be one of the physicians who provides emergency care on the day of the work stoppage.
B. Agree to participate in the rally as a way of showing solidarity with his colleagues though he thinks the action they are taking is unethical.
C. Refuse to attend the rally stating to his colleagues that he will maintain his regular schedule on the day of the work stoppage.
D. Attempt to convince his colleagues that the ethics of the profession will be compromised if they hold a work stoppage.

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Module 7

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Case 7.2: Physician Activism—Doctors Go on Strike

Option Assessment

A. Choosing to provide emergency care on a day when fewer doctors will be available is an **acceptable** option for Dr. Nelson. Emergency situations make demands on the profession that override individual physicians' rights and freedoms.

B. Agreeing to participate in the rally as a way of showing solidarity with his colleagues though he thinks the action they are taking is unethical should be **avoided**.

C. Maintaining his regular schedule in spite of the decision of his colleagues, even if it means handling the office himself, is the **preferred** course of action. Opinion 9.025, "Collective Action and Patient Advocacy" of the *Code* states, "Strikes and other collective action may reduce access to care, eliminate or delay necessary care, and interfere with continuity of care. Each of these consequences raises ethical concerns. Physicians should refrain from the use of the strike as a bargaining tactic. In rare circumstances, individual or grassroots actions, such as brief limitations of personal availability, may be appropriate as a means of calling attention to needed changes in patient care."

D. Further discussions with his partners about the possible gains and potential consequences of a work stoppage are **acceptable**. Opinion 9.025, "Collective Action and Patient Advocacy" recognizes that "physicians may participate in individual acts, grass roots activities, or legally permissible collective action to advocate for change, as provided for in the AMA's *Principles of Medical Ethics*." Opinion 9.025 goes on to admonish physicians that "whenever engaging in advocacy efforts, physicians must ensure that the health of patients is not jeopardized and that patient care is not compromised." In addition, it warns that "some actions may put them or their organizations at risk of violating antitrust laws. Consultation with legal counsel is advised."

Compare these options

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Case 7.2: Physician Activism—Doctors Go on Strike

Option Comparison

Option C—continuing to see patients—is the preferred option because the *Code* urges physicians not to use strikes as bargaining tactics. Option A—choosing to provide emergency care—is acceptable because it maintains the integrity of the physician who disagrees with the tactic. On the other hand, Dr. Nelson's disagreement with his colleagues' tactics does not necessarily imply disagreement with their cause. Maintaining on-going discussions about tactics and appropriate actions, as in option D, is always acceptable. Option B—being coerced to engage in these actions—especially by senior partners—should be avoided. Opinion 9.025, "Collective Action and Patient Advocacy" emphasizes that "physician participation should be voluntary and free from undue pressure by colleagues." Physicians are not only expected to respect patients, but are to offer the same respect to other physicians and health care providers.

Preferable: Option C

Acceptable: Options A and D

Avoided: Option B

Additional discussion and information

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Case 7.2: Physician Activism—Doctors Go on Strike

Additional Information

The ethical principle which requires "respect for the law and a responsibility to seek change when existing law may be contrary to the best interests of the patient" supports responsible advocacy on the part of physicians. Drawing the public's attention to complex health care issues involves decisions regarding what tactics will be the most effective means of communication. As frustrations rise from the lack of response to traditional actions—letter writing campaigns, telephone calls to legislators, use of lobbyists, etc.—calls for more radical approaches may become more prevalent.

In the area of health care, calls for work stoppages create conflicts of interest. One interest—"patient advocacy"—the presumed underlying reason for legislative changes—conflicts with another interest—continuity of patient care. Engaging in advocacy such that needed care is still provided may raise important issues in a constructive way without neglecting physician obligations. For example, elective or screening procedures may be briefly postponed without patient harm or abandonment. Due diligence in ensuring continuity of care and emergent care for patients must be carefully balanced with the aims of advocacy.

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Module 7

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Case 7.3: Retainer Practices—But I Can't Drive

Case Presentation

Dr. Sally Young, one of two primary care physicians in a small town, is tired of apologizing to her patients for the hours they spend in her waiting room and the constant rush to move on to the next patient. The 20-minute time slots Dr. Young's scheduler allots do not permit her to have a personal conversation with patients or allow them time to express all of their health concerns.

After some serious thinking and conversations with a colleague and an old friend of hers in Florida, Dr. Young has decided that she will transform her current practice into a retainer practice. She has worked out the finances and realized that she doesn't have to take a pay cut if she has fewer patients and charges them an annual fee in addition to the cost of the individual services she provides. She believes this arrangement will be more satisfying for the patients, and more fulfilling for her.

Dr. Young has sent each of her current patients a letter explaining that she will be changing her practice and that they will be charged a flat annual fee of about $3000 to continue to see her. The letter explains that, under the new practice set-up, Dr. Young will have fewer patients and will offer same-day appointments with more time for each. Dr. Young will also start making house calls and carrying a cell phone so her patients can reach her 24 hours a day. She tells her patients that she will continue to keep appointments as scheduled for the next 6 months but will not schedule any new non-urgent visits for patients who do not wish to participate in the new practice. The other primary care physician in town has told Dr. Young that her practice is full and cannot take a large influx of new patients. So each letter Dr. Young sends contains a list of other physicians in nearby towns, complete with the types of insurance each physician accepts.

Since the letters were sent out, Dr. Young's office has been flooded with phone calls from her patients. Mrs. Liles, a 73-year-old patient, has called 4 times since she received her letter. She insists to the staff that an exception be made for her. The closest primary care physician who is accepting new patients is a 30-minute drive away. Mrs. Liles lives down the street from Dr. Young's office and does not drive. There is no public transportation to the suggested physician's office, and Mrs. Liles cannot afford the roundtrip cab fare.

What should Dr. Young do about Mrs. Liles? (select an option)

A. Tell staff to reinforce the new arrangements of paying the retainer or transferring to another doctor.
B. Ask the other primary care physician in town to make an exception for Mrs. Liles since she is not able to travel to the physicians in nearby towns.
C. Tell Mrs. Liles that she will continue to see her as a patient but that Mrs. Liles will not receive the extra services that are covered by the retainer fee.

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Module 7

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Case 7.3: Retainer Practices—But I Can't Drive

Option Assessment

A. Strict enforcement of a pay or transfer policy without consideration for the needs of individual patients with regard to access and continuity of care should be **avoided.** Opinion 8.055, "Retainer Practices" (3) states that "if no other physicians are available to care for non-retainer patients in the local community, the physician may be ethically obligated to continue caring for such patients." In addition, 8.055 (5) states: "Physicians have a professional obligation to provide care to those in need, regardless of the ability to pay...." Physicians who engage in retainer practices should seek specific opportunities to fulfill this obligation.

B. If the other primary care physician will accept Mrs. Liles as a patient, transferring Mrs. Liles' care is the **preferred** action. Opinion 8.115, "Termination of the Physician-Patient Relationship" acknowledges that physicians may withdraw from a case but also cautions that "they cannot do so without giving sufficient notice to the patient…sufficiently long in advance of withdrawal to permit another attendant to be secured." Conditions for termination are further specified in Opinion 10.01, "Fundamental Elements of the Patient-Physician Relationship" (5) which adds the requirement of physicians to give the "patient reasonable assistance…."

C. Creating a practice in which there are retainer and non-retainer patients is **acceptable**.

Opinion 8.055, "Retainer Practices" (2)

> Physicians who engage in mixed practices, in which some patients have contracted for special services and amenities and some have not, must be particularly diligent to offer the same standard of diagnostic and therapeutic services to both categories of patients.

Compare these options

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Case 7.3: Retainer Practices—But I Can't Drive

Option Comparison

In order to insure Mrs. Liles' continued access to appropriate health care, option B is preferred. By arranging for the other physician in town to accept Mrs. Liles, this option provides her with continuity of care without special fees. The standard "sufficient opportunity to make alternative arrangements for care" is met in that Dr. Young will continue to see already scheduled patients for the next six months. While option C—allowing Mrs. Liles to be part of a retainer practice without paying the retainer or receiving special benefits—is acceptable, it may become confusing for the patient in terms of what she can and cannot expect from the doctor. Option A—enforcing the transfer policy without attention to Mrs. Liles; needs—should be avoided on the basis that it shows lack of "courtesy, respect, responsiveness, and timely attention" to Mrs. Liles' needs.

Preferable: Option B

Acceptable: Option C

Avoid: Option A

Additional discussion and information

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Case 7.3: Retainer Practices—But I Can't Drive

Additional Information

The *Principles of Medical Ethics* affirm the right of physicians to choose the environment in which to provide medical care and, except in emergencies, whom to serve. This right however, is not absolute. Loyalty to the interests of patients is essential and is a foundation on which the patient-physician relationship is based. This standard of putting patients' needs first imposes on physicians the "obligation not to abandon a patient who continues to require medical care."

Unlike large urban areas which have many medical care options, including transportation to and from medical offices and facilities, small towns and rural areas often have a limited array of choices. Retainer practices may be difficult to incorporate in small towns and rural areas because no other physicians are available or access to other physicians is compromised. Moreover, the creation of a retainer practice does not exempt a physician from the obligation to provide urgent care to those who cannot pay or to seek opportunities to provide non-urgent care to the needy.

Module 7 Feedback Questionnaire

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Module 7: Access to Care

Module 7 Feedback Questionnaire

In Module 7 on access to care, how would you rate the relevance of the cases?
- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

How would you rate the explanation of courses of action?
- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

How would you rate the overall coverage of the topic?
- ○ Excellent
- ○ Very good
- ○ Good
- ○ Fair
- ○ Poor

In answering the next 2 questions, consider all modules, 1-7.

The following changes would make this a more useful educational resource (check all that apply):
- ☐ More cases on each topic
- ☐ Fewer cases on each topic
- ☐ More alternative courses of action for each case
- ☐ Fuller discussion of alternatives and the Code of Medical Ethics
- ☐ Less discussion of alternatives and the Code of Medical Ethics
- ☐ Including more topics (e.g. research ethics)

How helpful would these case-based modules be if they were interactive so that learners could be scored and receive a certificate of satisfactory completion?
- ○ Very helpful
- ○ Somewhat helpful
- ○ Not helpful at all

If the AMA provided more ethics educational resources, would you be more likely To join the AMA?

- ○ Yes
- ○ No

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