

# EXAM QUESTIONS & ANSWERS

## LEGAL MEDICINE & MEDICAL ETHICS

### Source: Bioethics Topics

University of Washington School of Medicine

<http://depts.washington.edu/bioethx/topics/index.html>

The following multiple-choice Questions and Answers were developed in this format by the ABLM based on the Bioethics Case-based scenarios published by the University of Washington School of Medicine. There are discussions linked to each of the following topics. Links to additional readings and related websites are included at the end of each topic.

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## Advance Care Planning

1. An elderly woman told her daughters that if she ever ended up with dementia she wouldn't want to live like that. Years later she developed senile dementia and her daughters had her move into a nursing home. Although she did not recognize family or friends, she enjoyed the company of others and the nursing home's cat. When she stopped eating, her daughters were asked whether she should receive a feeding tube.<sup>1</sup>
  - a. The daughters may approve the insertion of a feeding tube with the proviso that future triggers could lead to its removal or nonuse.
  - b. The daughters should consider their mother's previously stated wishes as an advance directive and must not place a feeding tube.
  - c. The daughters cannot decide for their mother because of lack of both a power of attorney for health care and an advance directive.
  - d. Before placing a feeding tube, the daughters should obtain a court order.

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<sup>1</sup> **Answer: a**

The daughters should consider her previously stated wishes as well as her current best interests. The daughters don't know how to proceed because they did not have the advance care planning conversation that clarified what their mother meant when she said that she wouldn't want to live with dementia. Was it the cognitive problems, the problems with self care, living in an institution, or the sense that living with dementia would not bring any joy? Without knowing this, the daughters are unprepared to step into her mothers shoes.

Without really knowing their mother's wishes, the decision about a feeding tube is difficult. The daughters may choose to approve the insertion of a feeding tube with the proviso that future triggers could lead to its removal or nonuse. For example, if her current quality of life deteriorates to the point where she is no longer experiencing joy, or if she physically tries to remove the tube and keeping the tube in means restraining her, it may be appropriate to remove the feeding tube at that time.

<http://depts.washington.edu/bioethx/topics/adcaed1.html>

## Advance Care Planning

2. A patient who has coronary artery disease and congestive heart failure shows his physician his advance directive that states he wants to receive cardiopulmonary resuscitation and other forms of life-sustaining treatment has deeply held beliefs that suggest that not trying to live is tantamount to committing suicide.

What should the doctor do and say to the patient in response to this?<sup>2</sup>

- a. The doctor should educate the patient about the near futility of CPR under these circumstances.
- b. The doctor might want to ask the patient to explore this further with the chaplain.
- c. The patient's expression of a preference should be explored to understand its origins.
- d. All the above.

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<sup>2</sup> **Answer: d**

The patient's expression of a preference should be explored to understand its origins. It is possible that the patient believes, based on television shows, that CPR is usually effective. If this is the case, the doctor should educate the patient about the near futility of CPR under these circumstances. However, the physician may learn that the patient has deeply held beliefs that suggest that not trying to live is tantamount to committing suicide which he perceives as morally wrong. In this situation, the doctor might want to ask the patient to explore this further with the chaplain.

<http://depts.washington.edu/bioethx/topics/adcares2.html>

## Advance Care Planning

3. A patient tells his family that he would never want to be "kept alive like a vegetable". The term "vegetable" should be understood by the doctor to mean:<sup>3</sup>
- a. The patient does not want any heroics or extraordinary treatments.
  - b. Pull the plug if the patient is ever in terminal state on a respirator.
  - c. If the patient is in a comatose state, let him die.
  - d. The doctor should interpret the term as vague and not helpful in advance care planning discussions unless it is clarified.

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<sup>3</sup> **Answer: d**

The use of this expression is as vague as saying, "I don't want any heroics or extraordinary treatments" or, "Pull the plug if I'm ever in ...." If these types of comments in advance care planning discussions are not clarified, they are not helpful. For some patients being a "vegetable" means being in a coma, for others it means not being able to read.

<http://depts.washington.edu/bioethx/topics/adcares3.html>

## Advance Directives

4. An elderly man with end-stage emphysema presents to the emergency room awake and alert and complaining of shortness of breath. An evaluation reveals that he has pneumonia. His condition deteriorates in the emergency room and he has impending respiratory failure, though he remains awake and alert. A copy of a signed and witnessed living will is in his chart stipulates that he wants no "invasive" medical procedures that would "serve only to prolong my death." No surrogate decision maker is available.

Should mechanical ventilation be instituted?<sup>4</sup>

- a. The presence of a living will or other advance directive obviates the responsibility to involve a competent patient in medical decision making.
- b. If the patient has remained awake and alert, his living will is irrelevant to medical decision making.
- c. The potential risks and benefits of mechanical ventilation need not be presented to the patient because of the presence of a valid living will.
- d. Even if the patient refuses mechanical ventilation therapy, his wishes need not be honored because he is in the emergency room.

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<sup>4</sup> **Answer: b**

If the patient has remained awake and alert, his living will is irrelevant to medical decision making. The potential risks and benefits of mechanical ventilation need to be presented to the patient. If he refuses this therapy with an understanding of the consequences, his wishes should be honored. If he opts for mechanical ventilation, it should be instituted when it becomes medically necessary. The presence of a living will or other advance directive does not obviate the responsibility to involve a competent patient in medical decision making.

<http://depts.washington.edu/bioethx/topics/advdird1.html>

## Advance Directives

5. The same patient described in Question #4 presents confused and somnolent. A copy of a signed and witnessed living will is in his chart stipulates that he wants no "invasive" medical procedures that would "serve only to prolong my death." No surrogate decision maker is available.

Should mechanical ventilation be instituted?<sup>5</sup>

- a. Mechanical ventilation should NOT be instituted because it serve only to "prolong death" in this patient.
- b. Mechanical ventilation should be instituted because of the intent of the directive in the living will is evident.
- c. Mechanical ventilation should be instituted because the patient's pneumonia represents a potentially reversible condition from which the patient may recover fully.
- d. The living will is NOT a helpful guide to mechanical ventilation decision-making in this patient.

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<sup>5</sup> Answer: c

If the man has deteriorated to the point that he can no longer communicate, his living will may be a helpful guide to decisionmaking. The language of the directive, however, is difficult to interpret in this case. Pneumonia represents a potentially reversible condition from which the patient may recover fully. Mechanical ventilation does not serve only to "prolong death" but offers a significant chance to return to his previous level of functioning. Most patients with even end-stage emphysema can be successfully weaned from mechanical ventilation. The intent of the directive, whether to avoid intubation and ventilation at all costs or simply to withhold such therapies when they are clearly futile, is not evident. In the absence of other information to aid the decision, mechanical ventilation should be instituted, with the plan that it be discontinued if it becomes evident that the patient cannot be weaned.

<http://depts.washington.edu/bioethx/topics/advdird2.html>

## Breaking Bad News

6. Jose is a 62-year-old man who just had a needle biopsy of the pancreas showing adenocarcinoma. You run into his brother in the hall, and he begs you not to tell Jose because the knowledge would kill him even faster. A family conference to discuss the prognosis is already scheduled for later that afternoon.

What is the best way for the doctor to handle the situation?<sup>6</sup>

- a. The doctor should honor the request of the family member who is protecting his beloved brother from the bad news.
- b. The doctor should tell Jose's brother that withholding information is not permitted under any circumstance.
- c. Jose should withhold informing the patient about the pancreatic cancer because of the grave diagnosis.
- d. The doctor should ask Jose how he wants to handle the information in front of the rest of the family, and allow for some family discussion time for this matter.

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<sup>6</sup> **Answer: d**

It is common for family members to want to protect their loved ones from bad news, but this is not always what the patient himself would want. It would be reasonable to tell Jose's brother that withholding information can be very bad because it creates a climate of dishonesty between the patient and family and medical caregivers; also, that the only way for Jose to have a voice in the decision making is for him to understand the medical situation. Ask Jose how he wants to handle the information in front of the rest of the family, and allow for some family discussion time for this matter.

In some cultures it is considered dangerous to talk about prognoses and to name illnesses (e.g., the Navajo). If you suspect a cultural issue it is better to find someone who knows how to handle the issue in a culturally sensitive way than to assume that you should simply refrain from providing medical information. For many invasive medical interventions which require a patient to critically weigh burdens and benefits, a patient will need to have some direct knowledge of their disease in Western terms in order to consider treatment options.

<http://depts.washington.edu/bioethx/topics/badnwsd1.html>

## Breaking Bad News

7. A 25-year-old female medical student was doing a rotation in an HIV clinic. Sara is a 30-year-old woman who dropped out of college after she found that she contracted HIV from her husband, who has hemophilia. In talking to Sara, it turns out that the medical student and the patient shared a number of things--both are from the same part of Montana originally, also have young children, and like to cook. Sara now has advanced HIV. How should the medical student tell Sara about the advanced HIV and that she will need some blood tests without making her angry or upset?<sup>7</sup>
- The medical student should follow the protocol for breaking bad news because it covers everything.
  - The medical student should tell Sara about the advanced HIV and the need for blood tests and not be concerned about provoking a reaction.
  - The medical student should get another perspective perhaps from someone in clinic who has known Sara before breaking the bad news.
  - None of the above.

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<sup>7</sup> Answer: c

Although the protocol for breaking bad news is helpful, it doesn't cover everything. There are instances when you may provoke a reaction from a patient because you remind them of someone else--or, as in this case, themselves. In these instances it can be helpful to step back, get another perspective (perhaps from someone in clinic who has known Sara), and try not to take this reaction too personally--even though it is likely that Sara will know how to really bother you.

<http://depts.washington.edu/bioethx/topics/badnwsd2.html>

## Complementary Medicine

8. A young mother has just been informed that her 2-year-old son has leukemia. The mother refuses permission to begin chemotherapy and informs the oncology team that their family physician (a naturopath) will follow the child's illness.

What should you do as the team physician?<sup>8</sup>

- a. I should wait to hear from the family physician.
- b. I should honor the mother's request in this situation.
- c. I should arrange promptly a care conference with both the mother and the family's naturopathic physician to discuss the chemotherapy.
- d. If chemotherapy offers a clear and compelling survival benefit as the only hope this child has, and the mother refuses treatment, I am professionally obligated to seek a court order to appoint a guardian for the child.

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<sup>8</sup> **Answer: d**

Of utmost importance are the child's best interests, which include getting good medical care *and* maintaining a close connection with his mother. One way to achieve both is by requesting a care conference with both the mother and the family's naturopathic physician. If the mother refuses this meeting and you remain convinced that chemotherapy is the only hope this child has, you are professionally obligated to seek a court order to appoint a guardian for the child. If chemotherapy offers a clear and compelling survival benefit, the justification for seeking legal intervention increases.

<http://depts.washington.edu/bioethx/topics/compld1.html>

## Complementary Medicine

9. Your patient has been suffering from chronic low back pain for many years now. She voices her frustration with the various treatment modalities that you have been trying and says her friend had recommended a homeopath.

How do you respond?<sup>9</sup>

- a. Encourage your patient to consult with local experts or the library to find out more about what homeopathy can offer.
- b. Inform the patient that homeopathy is ineffective in treating her medical condition.
- c. Respond by saying that complementary medical therapy is reasonable for her condition and definitely not harmful.
- d. Encourage your patient to see a homeopath and discourage her from staying in contact with you.

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<sup>9</sup> **Answer: a**

In this case, there are few clearly effective treatments for the medical condition. Hence, complementary approaches may be a reasonable recommendation, assuming they are not harmful. While you may know little about homeopathy yourself, you may encourage your patient to consult with local experts or the library to find out more about what homeopathy can offer. It may be appropriate to seek alternative therapies, but they should be researched or recommended. Encourage your patient to stay in contact with you and explore opportunities.

<http://depts.washington.edu/bioethx/topics/compld2.html>

## Confidentiality

**10. Your 36-year-old patient has just tested positive for HIV. He asks that you not inform his wife of the results and claims he is not ready to tell her yet.**

**What would you say to your patient?<sup>10</sup>**

- a. Encourage the patient to share the information with his wife on his own, giving him a bit more time if necessary.**
- b. Tell the patient that his wife is at serious risk for being infected with HIV, and that you have a duty to ensure that she knows of the risk.**
- c. Tell the patient that public health law requires reporting both the patient and any known sexual partners to local health officers.**
- d. All the above.**

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<sup>10</sup> **Answer: d**

Because the patient's wife is at serious risk for being infected with HIV, you have a duty to ensure that she knows of the risk. While public health law requires reporting both your patient and any known sexual partners to local health officers, it is generally advisable to encourage the patient to share this information with his wife on his own, giving him a bit more time if necessary.

<http://depts.washington.edu/bioethx/topics/confidd1.html>

## Confidentiality

**11. A 75-year-old woman shows signs of abuse that appears to be inflicted by her husband. As he is her primary caregiver, she feels dependent on him and pleads with you not to say anything to him about it.**

**How would you handle this situation?<sup>11</sup>**

- a. This is a case of elder abuse and the doctor is required to always report incidents of abuse to the authorities.**
- b. The doctor is not permitted under HIPAA (Health Insurance Portability and Accountability Act) to report the abuse.**
- c. The laws supporting reporting elder abuse allow the doctor to break confidentiality and report suspected abuse.**
- d. The patient should not be reported. Instead, she should obtain support and access to other services in order to maintain her primary caregiver.**

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<sup>11</sup>**Answer: c**

In this case, the required reporting laws can be interpreted in a number of justifiable ways. The laws supporting reporting elder abuse (and child abuse) allow you to break confidentiality and report suspected abuse. However, if you think it is possible to give this woman support and access to other services without reporting the case immediately, those alternatives will help her more in the long run. Either way, you have an obligation to address her abusive situation.

<http://depts.washington.edu/bioethx/topics/confidd2.html>

## Confidentiality

**12. A 60-year-old man has a heart attack and is admitted to the medical floor with a very poor prognosis. He asks that you not share any of his medical information with his wife as he does not think she will be able to take it. His wife catches you in the hall and asks about her husband's prognosis.**

**What are you required to do legally?<sup>12</sup>**

- a. The doctor should inform the wife about her husband's poor prognosis.**
- b. The doctor is should not divulge the prognosis to the wife, but he should ask the nurse to let the wife know about her husband's condition.**
- c. The wife is certainly affected by her husband's health and prognosis and every effort should be made to encourage an open dialogue between them.**
- d. The doctor should not encourage the patient to talk to his wife about his condition.**

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<sup>12</sup> **Answer: c**

The duty to maintain confidentiality remains strong in this case as information about the patient's health does not directly concern others' health, welfare, or safety. There is no imminent danger to others here. However, the wife is certainly affected by her husband's health and prognosis and every effort should be made to encourage an open dialogue between them. It remains his responsibility to do so.

<http://depts.washington.edu/bioethx/topics/confidd3.html>

## Cross-cultural Issues & Diverse Beliefs -- Emphasis Pediatrics

**13. A mother brings her 18-month-old daughter to your office for a routine physical examination. The child has had no immunizations. Her mother says that they believe in naturopathic medicine and prefer not to immunize their children.**

**You would tell the mother in this situation that:<sup>13</sup>**

- a. You respect her (the mother's) wishes and say no more.**
- b. The risk faced by unimmunized individuals is relatively high.**
- c. The mother's refusal to immunize poses a significant likelihood of harm to her child.**
- d. The physician should be sure that the child's mother understands the risks of remaining unimmunized and attempt to correct any misconceptions about the degree of risk associated with getting immunized.**

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<sup>13</sup>**Answer: d**

The risk faced by unimmunized individuals is relatively low, and the mother's refusal to immunize does not pose a significant likelihood of harm to her child. The physician should be sure that the child's mother understands the risks of remaining unimmunized and attempt to correct any misconceptions about the degree of risk associated with getting immunized. If the mother persists in her request, the physician should respect her wishes.

<http://depts.washington.edu/bioethx/topics/crossd1.html>

## Cross-cultural Issues & Diverse Beliefs -- Emphasis Pediatrics

**14. A 23-year-old Navajo man has injured his leg after a fall. He presents to the emergency room of the reservation hospital where he is complaining of pain. His leg appears to be broken. The man requests that you call a medicine man before doing anything further.**

**What should the doctor do?<sup>14</sup>**

- a. Call the local medicine man before proceeding with treatment of the leg fracture.**
- b. The emergency room medical doctor is under no obligation to communicate with a medicine man about the patient's leg fracture.**
- c. Tell the patient that he will not call his medicine man.**
- d. Because the patient came to the emergency room, the doctor is allowed to begin treatment then call the medicine man.**

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<sup>14</sup> **Answer: a**

As a competent adult, this patient has the right to make decisions about his medical care. You must respect his wish not to be treated until he gives you permission to do so. Calling the local medicine man will show your respect for the patient and strengthen the patient's trust in you and your abilities.

<http://depts.washington.edu/bioethx/topics/crossd2.html>

## Cross-cultural Issues & Diverse Beliefs -- Emphasis Pediatrics

**15. A 3-year-old child is brought to your clinic with a fever and stiff neck. You are quite certain the child has meningitis. When you discuss the need for a spinal tap and antibiotic treatment, the parents refuse permission, saying, " We'd prefer to take him home and have our minister pray over him."**

**How should the physician handle this?<sup>15</sup>**

- a. The physician should do what the parents request to take the child home.**
- b. The physician should call the parent's religious leader and have him come to the hospital before providing standard medical therapy.**
- c. The physician has no duty to provide treatment to the child when the parents refuse treatment.**
- d. When efforts to obtain parental permission to treat the patient fail, the physician is justified in seeking legal help or may be legally authorized to proceed with the procedure and treatment of the child.**

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<sup>15</sup> **Answer: d**

The physician has a duty to provide treatment to a child when denying that treatment would pose a significant risk of substantial harm. Failure to diagnose and treat bacterial meningitis would seriously threaten the health and even life of this child. The physician should share his view with the family and seek to elicit their cooperation through respectful discussion. Inviting their religious leader to the hospital while also providing standard medical therapy may prove to be an acceptable compromise. Should these efforts not result in parental permission, the physician is justified in seeking legal help so as to proceed with the procedure and treatment of the child. In most states a physician is legally authorized to provide emergency treatment to a child without a court order when delay would likely result in harm.

<http://depts.washington.edu/bioethx/topics/crossd3.html>

## Do Not Resuscitate Orders

**16. Mr. H is a 24-year-old man who resides in a skilled nursing facility, where he is undergoing rehabilitation from a cervical spine injury. The injury left him quadriplegic. He has normal cognitive function and no problems with respiration. He is admitted to your service for treatment of pneumonia. The resident suggests antibiotics, chest physiotherapy, and hydration. One day while signing out Mr. H to the cross covering intern, the intern says "he should be a DNR, based on medical futility."**

**How would you respond to the intern?<sup>16</sup>**

- a. The patient should be a DNR because in this case CPR offers no chance of meaningful benefit to the patient and the probability of success is <1%.**
- b. The patient should NOT be a DNR based on medical futility.**
- c. The patient should be a DNR because even if the CPR is successful, his quality of life is below the minimum acceptable based on his quadriplegia and his pneumonia.**
- d. The patient should be a DNR because his quality of life is without value.**

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<sup>16</sup> **Answer: b**

Medical futility means that an intervention, in this case CPR, offers no chance of meaningful benefit to the patient. Interventions can be considered futile if the probability of success (discharged alive from the hospital) is <1%, and/or if the the CPR is successful, then the quality of life is below the minimum acceptable to the patient. In this case, Mr. H would have a somewhat lower than normal chance of survival from CPR, based on his quadriplegia (homebound lifestyle is a poor prognostic factor) and his mild pneumonia (in cases of severe pneumonia and respiratory failure survival is <1%). Furthermore, his quality of life, while not enviable, is not without value. Since he is fully awake and alert, you could talk with Mr. H about his view of the quality of his life. You could share with him the likely scenarios should he have an arrest and need CPR. After this discussion, Mr. H can tell you if he would like to have CPR in the event of an arrest or not. One cannot say on the basis of the current situation that CPR is futile. A decision about resuscitation should occur only after talking with the patient about his situation and reaching a joint decision.

<http://depts.washington.edu/bioethx/topics/dnrd1.html>

## Do Not Resuscitate Orders

**17. Mrs. W is an 81-year-old woman with recurrent colon cancer with liver metastases admitted to the hospital for chemotherapy. Because of her poor prognosis, you approach her about a DNR order, but she requests to be "a full code."**

**Can you write a DNR order anyway?<sup>17</sup>**

- a. No, because the patient requested "a full code."
- b. Yes, because Mrs. W is elderly, has a diagnosis of recurrent metastatic cancer, and the chance of a successful DNR is 0%.
- c. No, because the CPR for Mrs. W and in her condition could not be called "futile."
- d. Yes, because hospital policy allows doctors to write a DNR in this situation.

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<sup>17</sup> **Answer: b**

Mrs. W is elderly and has a diagnosis of metastatic cancer. In several prospective outcome studies of CPR in the hospital, patients like Mrs. W had 0% survival. Thus CPR for Mrs. W could be called "futile." Nevertheless, current policy at UWMC/Harborview and the VAMC state that one should not write a DNR order, even if CPR is judged to be futile, without patient or family concurrence. Rather, you should allow Mrs. W some time to come to grips with her diagnosis, while periodically re-addressing the CPR question with her. This is best done in the context of other medical decision that occur during her care. It is important to review other care goals with her, to allay possible fear that a DNR order may mean she will be abandoned or not cared for.

<http://depts.washington.edu/bioethx/topics/dnrd2.html>

## Do Not Resuscitate Orders

**18. Mrs. W is an 81-year-old woman with recurrent colon cancer with liver metastases admitted to the hospital for chemotherapy. Mrs. W still wants to be a "full code." Your intern suggests that you sign her out as a "slow code."**

**Should you do this?<sup>18</sup>**

- a. Yes, because slow codes are ethically justifiable.**
- b. Yes, because the "slow code" allows the appearance of respecting the patient's desire for CPR.**
- c. No, because the slow code is not actually complying with the request for a "full code" and is ethically unjustifiable.**
- d. No, because slow codes are illegal.**

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<sup>18</sup>**Answer: c**

A "slow code" allows the appearance of respecting the patient's desire for CPR while not actually complying with the respect. Slow codes are not ethically justifiable. Rather, you should continue efforts to discuss the DNR order with Mrs. W, perhaps with the help of her family or religious advisors.

<http://depts.washington.edu/bioethx/topics/dnrd3.html>

## Do Not Resuscitate Orders

**19. Mr. S is a 73-year-old man, with a history of severe coronary artery disease, peripheral vascular disease, and stroke. He suffers from right hemiplegia and mild expressive aphasia. He is awake and alert, and presents for right below the knee amputation (BKA) for vascular insufficiency. His chart carries a DNR order. In the holding area prior to surgery, the anesthesiologist discusses the DNR order with Mr. S, who appears depressed. Mr. S states unequivocally, that he does not wish CPR in the OR, regardless of its cause or positive prognosis. He tells his anesthesiologist that he is willing to go "so far, and no more." The patient agrees to subarachnoid anesthesia (spinal block) and sedation. He is not intubated. After about 20 minutes, the patient complains of weakness in his arms, and difficulty breathing. Within 3 minutes, his blood pressure and heart rate fall, and he abruptly arrests.**

**Should the patient be intubated and CPR commenced?<sup>19</sup>**

- a. Yes, because the probable cause of Mr. S's arrest is a cephalad migration of local anesthetic in the subarachnoid space, leading to a "high spinal block." With cardiopulmonary support, the prognosis for total recovery from this event is excellent.**
- b. No, because intubation, mechanical ventilation and CPR would be senseless due to medical futility in this case.**

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<sup>19</sup> **Answer: c**

The probable cause of Mr. S's arrest is a cephalad migration of local anesthetic in the subarachnoid space, leading to a "high spinal block." As a result of migration of the local anesthetic from the lumbar segments to high thoracic or even cervical segments, weakness or paralysis of respiratory muscles, including intercostal muscles and diaphragmatic muscles can result. The effect of local anesthetic on segments contributing to the cardiac accelerator fibers can cause bradycardia, and even cardiac arrest. With cardiopulmonary support, prognosis for total recovery from this event is excellent, with only rare cases of central nervous system damage or death reported. CPR would not be futile from a medical standpoint. Intubation and institution of mechanical ventilation will not alone restore Mr. S's circulation, and these measures alone will be useless. Medications to treat blood pressure and bradycardia will require at least temporary artificial circulation. From the standpoint of medical futility, intubation and mechanical ventilation would be senseless unless accompanied by full CPR, if even briefly.

It is hard to argue ethically for the institution of CPR in this patient, who while neurologically impaired, appeared to have full capacity to understand and make decisions regarding his own medical care. Despite preoperative discussion which included information about the good prognosis from CPR in the OR, the patient stated clearly his wishes to not be resuscitated if an arrest occurs.

Instituting CPR in this patient because the cause of arrest is anesthetic-related, would be like justifying transfusion in a Jehovah's Witness against their will because the surgery was the cause of life-threatening hemorrhage, yet adhering to their wishes if hemorrhage was due to non-surgical injuries.

<http://depts.washington.edu/bioethx/topics/dnraud1.html>

- c. No, because the patient stated clearly his wishes to not be resuscitated if an arrest occurs.**
- d. Yes, because the Anesthesiologist is under a duty to treat the apparent anesthesia complication.**

## Do Not Resuscitate Orders

**20. Mrs. P is a 74-year-old woman presenting for emergent treatment of a fracture-dislocation of her right hip, suffered in a fall at her nursing home. She appears frail, but is alert and oriented. She is accompanied by her daughter, and both state that they want her to receive full medical care. On admission two hours earlier, the emergency room physician heard a loud systolic murmur, and echocardiogram revealed critical aortic stenosis, with a valve area of 0.3 cm<sup>2</sup>. The surgeon suggests that the patient, because of her cardiac status and age, should have a DNR order in the chart.**

**Do you agree?<sup>20</sup>**

- a. No, because the patient has not consented to the DNR order.
- b. No, because the patient only suffered a fall at her nursing home.
- c. Yes, because cardiac arrest in the setting of critical aortic stenosis carries virtually zero chance of survival and CPR in this setting can be termed medically futile.
- d. Yes, because the hospital policy allows the doctor to write such an order.

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<sup>20</sup> **Answer: c**

Cardiac arrest in the setting of critical aortic stenosis carries virtually zero chance of survival, since the tight stenosis of the left ventricular outflow tract makes generation of systemic blood pressures compatible with life virtually impossible. CPR in this setting can easily be termed "[medically futile](#)." Current policy at UWMC/ Harborview and the VAMC require that patient or family agreement accompany DNR orders. A frank discussion with Mrs. P and her daughter about the issue of CPR should be initiated with the hope of establishing understanding with the patient and her family about the question of resuscitation.

<http://depts.washington.edu/bioethx/topics/dnraud2.html>

## End-of-Life Issues

**21. Skip is a 50-year-old man with metastatic non-small cell lung cancer. He decided to try palliative chemotherapy because "otherwise I might just as well roll over and give up." After the first cycle of carboplatin and taxol, he requires hospitalization for fever and neutropenia (a complication of the chemotherapy). You stop by for a visit, and he says he feels terrible, wonders "if the chemo is worth all this", but that he's too scared to stop.**

**How would you handle this situation?<sup>21</sup>**

- a. Encourage the patient to discontinue the palliative chemotherapy because it is an intervention providing, on average, a small benefit at considerable toxicity in metastatic non-small cell lung cancer.**
- b. Stop the palliative chemotherapy based of the side effects and medical futility.**

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<sup>21</sup> **Answer: c**

For metastatic nonsmall cell lung cancer, palliative chemotherapy is an intervention providing, on average, a small benefit at considerable toxicity. Yet for a patient who is well informed, understands the benefits and burdens, and wishes to proceed, a trial of palliative chemotherapy is justified. However, now Skip is voicing concern: the most important thing to do is hear him out. Find out what he is worried about, how he rates his quality of life, and what his goals are. This information will help you sort out what is going through his mind and help you guide him to a decision that will be the best for him.

As Skip thinks through his situation, ask him if he wants you to describe what would happen if he decides to have more chemotherapy, or stops his chemo and starts hospice care. Eventually you might ask him what a good death would be for him--he may not be able to answer immediately, but it might help him (and you) shape a care plan later. When you talk with Skip, keep in mind the goals of a decent death, which include:

1. Control of pain and other physical symptoms. The physical aspects of care are a prerequisite for everything that follows.
2. Involvement of people important to the patient. Death is not usually an individual experience; it occurs within a social context of family, significant others, friends, and caregivers.
3. A degree of acceptance by the patient. Acceptance doesn't mean that the patient likes what is going on, and it doesn't mean that a patient has no hopes--it just means that he can be realistic about the situation.
4. A medical understanding of the patient's disease. Most patients, families, and caregivers come to physicians in order to learn something about what is happening medically, and it is important to recognize their need for information.
5. A process of care that guides patient understanding and decision making. One great physician does not equal great care--it takes a coordinated system of providers.

<http://depts.washington.edu/bioethx/topics/eold1.html>

- c. Be certain that the patient is well informed, understands the benefits and burdens, and wishes to proceed with the trial of palliative chemotherapy, which is justified in this situation.**
- d. Stop chemotherapy and start hospice care.**

## End-of-Life Issues

**22. Angela is a 72-year-old woman with end stage congestive heart failure from coronary artery disease--she has had two myocardial infarctions. When her medical management is optimal, she is just able to take care of herself in her own apartment, but with any small decompensation, she ends up in the hospital. She comes in for a clinic visit, and her weight is up 2 kilograms and she is complaining of paroxysmal nocturnal dyspnea, even though she has been taking her meds as prescribed. Exasperated and discouraged, she asks, "Am I dying"? The cardiologist replies: "Well, no--this is all reversible."**

**What would you, as the medical-legal consultant/ethicist, say to Angela?<sup>22</sup>**

- a. Agree with the cardiologist that "--this is all reversible."**
- b. Tell the patient that her condition has deteriorated and that she is dying.**
- c. Inform the patient that the clinical course of congestive heart failure is unpredictable and includes periods of fairly good function alternating with decompensation right up until death, and that the terminal event is often sudden.**
- d. Tell the patient that she needs a hospice referral because her severe end-stage congestive heart failure is terminal.**

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<sup>22</sup> **Answer: c**

The SUPPORT study has shown us that the clinical course of dying from congestive heart failure is quite different from dying of lung cancer. Patients with lung cancer begin a visible, predictable decline several weeks before death that is usually evident to experienced clinicians. Patients with congestive heart failure, however, experience periods of fairly good function alternating with decompensation right up until death, and the terminal event for these patients is often sudden. This pattern of decline is not usually labeled by patients or physicians as "dying." The unpredictable course has resulted in very few hospice referrals for patients with end-stage congestive heart failure.

The best care plan in this situation would be based on a discussion with Angela about what kinds of contingency plans should be in place if she has a severe, possibly fatal decompensation. Some medical centers are developing Palliative Care or Comfort Care services to try to better match the needs of patients with less predictable end-stage illnesses.

<http://depts.washington.edu/bioethx/topics/eold2.html>

## Ethics Committees

23. Which of the following is NOT an underlying goal of ethics committees?<sup>23</sup>

- a. To promote the rights of patients;
- b. To promote shared decision making between patients (or their surrogates if decisionally incapacitated) and their clinicians;
- c. To promote fair policies and procedures that maximize the likelihood of achieving good, patient-centered outcomes; and
- d. To improve the public perception of health care professionals and health care institutions.

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**23 Answer: d**

What does an ethics committee do?

Ethics committees involve groups of individuals from diverse backgrounds who support health care institutions with three major functions: providing ethics consultation, developing and/or revising select policies pertaining to clinical ethics, and facilitating education about topical issues in clinical ethics.

The underlying goals of ethics committees are:

- to promote the rights of patients;
- to promote shared decision making between patients (or their surrogates if decisionally incapacitated) and their clinicians;
- to promote fair policies and procedures that maximize the likelihood of achieving good, patient-centered outcomes; and
- to enhance the ethical tenor of health care professionals and health care institutions.

Ethics committees or select members often help resolve ethical conflicts and answer ethical questions through the provision of consultations.

<http://depts.washington.edu/bioethx/topics/ethics.html>

## **Futility**

**24. A young accident victim has been in a persistent vegetative state for several months and family members have insisted that "everything possible" be done to keep the patient alive.**

**Should you honor the family's request?<sup>24</sup>**

- a. The request must be honored because the family members insisted to do "everything possible".**
- b. The request should be honored because of absence of a court order to withhold treatment.**
- c. The request should NOT be honored because it is unreasonable.**
- d. The request need NOT be honored if the doctor and the members of the health care team agree that the interventions in question requested by the family would be futile.**

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<sup>24</sup> **Answer: d**

This case illustrates the possible conflicts that can arise with patients or family members about withholding or withdrawing futile interventions. If you and other members of the health care team agree that the interventions in question would be futile, the goal should be to withdraw or withhold these interventions. Achieving this goal requires working in tandem with the patient and/or family, as well as drawing upon resources, such as social workers, hospital chaplains, and ethics committees. If there is no professional consensus about the futility of a particular intervention, then there is no ethical basis for overriding the requests of patients and/or family members for that intervention.

<http://depts.washington.edu/bioethx/topics/futild1.html>

## **Futility**

**25. An elderly patient with irreversible respiratory disease is in the intensive care unit where repeated efforts to wean him from ventilatory support have been unsuccessful. There is general agreement among the health care team that he could not survive outside of an intensive care setting. The patient has requested antibiotics should he develop an infection and CPR if he has a cardiac arrest.**

**Should a distinction be made between the interventions requested by the patient?<sup>25</sup>**

- a. The request by the patient for both the antibiotics and CPR must be honored.**
- b. The request by the patient for both the antibiotics and CPR should NOT be honored.**
- c. The doctor should obtain a court order before withholding CPR.**
- d. If there is a professional consensus about the futility of the CPR in this patient, then there is a basis for overriding the patient's request for CPR but not the antibiotics.**

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<sup>25</sup> **Answer: d**

This case also illustrates the possible conflicts that can arise with patients or family members about withholding or withdrawing futile interventions. If you and other members of the health care team agree that the interventions in question would be futile, the goal should be to withdraw or withhold these interventions. Achieving this goal requires working in tandem with the patient and/or family, as well as drawing upon resources, such as social workers, hospital chaplains, and ethics committees. If there is no professional consensus about the futility of a particular intervention, then there is no ethical basis for overriding the requests of patients and/or family members for that intervention.

<http://depts.washington.edu/bioethx/topics/futild2.html>

## Futility

**26. An elderly man who lives in a nursing home is admitted to the medical ward with pneumonia. He is awake but severely demented. He can only mumble, but interacts and acknowledges family members. The admitting resident says that treating his pneumonia with antibiotics would be "futile" and suggests approaching the family with this stance.**

**Do you agree?<sup>26</sup>**

- a. No I disagree because for this patient, treating pneumonia with antibiotics stands a reasonable chance of success.**
- b. Yes I agree that because the patient is severely demented, treating his pneumonia with antibiotics would be "futile".**
- c. Yes I agree that the treatment of pneumonia in this severely demented patient is futile because antibiotics may be ineffective, especially if the etiology is non-bacterial.**
- d. None of the above.**

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<sup>26</sup> **Answer: a**

In many cases, "futility" is used inaccurately to describe situations that appear undesirable. For this patient, treating pneumonia with antibiotics stands a reasonable chance of success. The patient's quality of life, though low, is not unacceptably so. Unless the patient (or if found incapacitated, his surrogate) was to say that he would find this quality of life unacceptably low, there is neither quantitative nor qualitative grounds for calling antibiotics futile in this case.

<http://depts.washington.edu/bioethx/topics/futild3.html>

## HIV and AIDS

**27. You are the ICU attending physician taking care of a 40-year-old gay man with AIDS who is intubated with his third bout of pneumocystis pneumonia. His condition is worsening steadily and he has not responded to appropriate antibiotic therapy. The patient's longtime partner, Richard, has a signed durable power of attorney (DPOA) and states that if the patient's condition becomes futile the patient would not want ongoing ventilation. As the ICU attending you decide that ongoing intubation is futile. You consult with Richard and decide to remove the patient from the ventilator to allow him to die in the morning. The patient's Roman Catholic parents arrive from Kansas and threaten a lawsuit if the ventilator is withdrawn.**

**Who is the legal decision maker here?<sup>27</sup>**

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### **<sup>27</sup> Answer: c**

Richard, the partner has a durable power of attorney and is the legal decision maker in this case. The document is a legally binding agreement that states Richard is the final arbiter of all medical decisions once the patient becomes incapacitated. This creates a legal foundation for Richard to keep his role as the final medical decision maker in conjunction with the attending physician while allowing room for discussion with the family on this difficult topic.

This is an unfortunate situation for everybody involved. The physician can help diffuse this situation by trying to understand the different perspectives that each of the involved individuals brings to the situation. The family arrives to see their dying son and may be confronted with multiple issues for the first time. First they may be finding out that their son is gay, that he has AIDS, and that he is immanently dying all at the same time. Any of these issues may be a shock to the family, so it is important to keep this perspective in mind when making difficult care decisions and to communicate clearly and honestly with them.

Communication regarding the patient's care should be consented to by the patient whenever possible. Alternatively, individuals in the gay communities in metropolitan areas that have been severely affected by AIDS have watched many of their friends die of their disease and are very well educated about end of life issues. It is likely that Richard as your patient's DPOA has spent significant time considering these issues with the patient before becoming the patient's surrogate. His role as the patient's significant other is not legally defined in many areas of the United States at this time. This relationship is often the equivalent of marriage in the gay community and should be respected by the hospital personnel in all points of medical care.

This is a case where several members may help with the decision. ICU nurses often have experience and perspective in dealing with grieving families of terminally ill patients as do staff social workers or grief counselors. Another invaluable resource in this case is a hospital chaplain or spiritual counselor who may be able to provide spiritual support and guidance to the family. It is important here to find out what resources are available in the hospital for Richard and the patient's family and after discussing the case with them, seek help from these other skilled professionals. If you as a physician have cultivated a relationship with these services it is often appropriate to invite them to a family meeting so that they can help you focus the discussion on the care of the patient, who is always your first priority as a physician.

Much has been written on the responsibility of the physician in taking care of the patient with AIDS. The AMA position is "A physician may not ethically refuse to treat a patient whose condition is within the physician's realm of competence.... neither those who have the disease or are infected by the virus should be subject to discrimination based on fear or prejudice, least of all from members of the health care community." From this quote it is safe to say that the physician has a fiduciary responsibility toward the

- a. The decision maker is the doctor; he decided that the patient's condition is futile.
- b. The parents are the legal decisions maker because the patient is single.
- c. The patient's partner, Richard, is the decision maker.
- d. Because of the conflict between the parents and the partner, a court order should be obtained to withdraw the ventilator.

## HIV and AIDS

**28. A 22-year-old woman is admitted to the hospital with a headache, stiff neck and photophobia but an intact mental status. Lab test reveal cryptococcal meningitis, an infection commonly associated with HIV infection. When given the diagnosis, she adamantly refuses to be tested for HIV.**

**How should the medical staff handle the situation?<sup>28</sup>**

- a. Test for HIV despite the patient's refusal.
- b. Do not test for HIV, because as for any other medical procedure, testing should be done only with the informed consent of the patient.
- c. Test the patient for HIV anonymously, without any identifying remarks.
- d. Report the patient's cryptococcal meningitis to the Public Health Department and ask the Department to test the patient for HIV.

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care of the HIV infected patient and there is no room within the profession for prejudice for people with AIDS. This stand on prejudice should cover not only gay men with AIDS, but also all other patients that a physician takes care of, even the next two cases.

<http://depts.washington.edu/bioethx/topics/aidsd1.html>

<sup>28</sup> **Answer: b**

Testing for HIV, as for any other medical procedure should be done only with the informed consent of the patient. Testing without consent is unethical in this setting. The physician's role in the care of this patient is ongoing support, education and guidance about her various options for care.

<http://depts.washington.edu/bioethx/topics/aidsd2.html>

## HIV and AIDS

**29. Your patient with cryptococcal meningitis eventually agrees to be tested for HIV and her test comes back positive. Due to her opportunistic infection she receives the diagnosis of AIDS.**

**Should she be reported to the department of public health?<sup>29</sup>**

- a. Yes the doctor must report her case to the department of public health in all 50 states.**
- b. Yes she should be reported, but only in the 30 states that require reporting AIDS.**
- c. She should be reported, but only if she consents to the reporting.**
- d. The doctor has a choice to either report her case to the department of public health or not.**

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<sup>29</sup> **Answer: a**

AIDS is a currently a reportable diagnosis in all 50 states of the union. Her diagnosis should be reported to the department of public health. Notably, HIV positivity without the diagnosis of AIDS is not reportable in all states. Currently, 30 of 50 states requires reporting of a positive test. It is important to find out the local states laws where you are practicing to know how to approach this problem.

<http://depts.washington.edu/bioethx/topics/aidsd3.html>

## HIV and AIDS

30. One of your clinic patients is a 35-year-old man with AIDS on Medicare who is an active intravenous drug user. He uses heroin and cocaine, but he never shares needles and is reliably present at all his clinic visits. He admits that he is often unable to take his medicines regularly when he is using drugs. He is asking about antiretroviral therapy with protease inhibitors. You have just read that HIV viral resistance to protease inhibitors occurs rapidly when patients are unable to take their medicines reliably.

Should you prescribe protease inhibitors to this patient?<sup>30</sup>

- a. No, because the problem of resistance is a real concern in a patient who cannot take his medicines reliably.
- b. No, because the patient is continuing to use heroin and cocaine.
- c. Yes because the patient wants the protease inhibitors.
- d. Yes, because the doctor is under a duty not to abandon the patient and to continue an ongoing therapeutic relationship and encourage him with information and guidance about his HIV disease and issues of addiction.

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<sup>30</sup> **Answer: d**

This is a difficult and ongoing debate in the care of patients with HIV. Protease inhibitors used in combination with nucleoside analogues have proven a powerful weapon in the fight against HIV. The problem of resistance is a real concern in a patient who cannot take his medicines reliably. Many public health advocates feel that these medicines should not be offered to patients who are admittedly noncompliant because they would be creating resistant clones of virus which could then be passed on to others, or make the individual unable to benefit later if they were able to become compliant. They also argue that the cost of these medications on the health care system is so extreme that they should only be used by those who can fully benefit from them. Others argue the principle of justice which espouses equitable distribution of resources amongst all available people in need, and if the patient wants the medications he should have equal access to them.

There is no answer to this debate at this time. *The only clear principle that should be followed here is that of non-abandonment.* Whatever your choice is with the patient, the physician's responsibility is to remain available to the patient and continue an ongoing therapeutic relationship and encourage him with information and guidance about his HIV disease and issues of addiction.

<http://depts.washington.edu/bioethx/topics/aidsd4.html>

## INFORMED CONSENT

**31. A 64-year-old woman with Multiple Sclerosis is hospitalized. The team feels she may need to be placed on a feeding tube soon to assure adequate nourishment. They ask the patient about this in the morning and she agrees. However, in the evening (before the tube has been placed), the patient becomes disoriented and seems confused about her decision to have the feeding tube placed. She tells the team she doesn't want it in. They revisit the question in the morning, when the patient is again lucid. Unable to recall her state of mind from the previous evening, the patient again agrees to the procedure.**

**Is this patient competent to decide?<sup>31</sup>**

- a. This patient is competent to decide because her underlying disease is NOT impairing her decision making capacity.**
- b. This patient is competent to decide during her lucid periods.**
- c. The patient's decision making capacity is questionable, and getting a surrogate decision maker involved can help determine what her real wishes are.**
- d. In this situation where the patient is changing her decision, the doctor should decide whether or not to place a feeding tube.**

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<sup>31</sup> **Answer: c**

This patient's underlying disease is impairing her decision making capacity. If her wishes are consistent during her lucid periods, this choice may be considered her real preference and followed accordingly. However, as her decision making capacity is questionable, getting a surrogate decision maker involved can help determine what her real wishes are.

<http://depts.washington.edu/bioethx/topics/consntd1.html>

## INFORMED CONSENT

**32. A 55-year-old man has a 3-month history of chest pain and fainting spells. You feel his symptoms merit cardiac catheterization. You explain the risks and potential benefits to him, and include your assessment of his likely prognosis without the intervention. He is able to demonstrate that he understands all of this, but refuses the intervention.**

**Can the refuse the intervention, legally?<sup>32</sup>**

**No, because the patient does not comprehend the severity of his cardiovascular condition.**

**No, because the patient has a documented life threatening cardiac condition.**

**Yes, because he is competent to make this decision, and the doctor has a duty to respect his choice.**

**The doctor can perform the cardiac catheterization after obtaining a court order.**

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<sup>32</sup> **Answer: c**

This patient understands what is at stake with his treatment refusal. As he is competent to make this decision, you have a duty to respect his choice. However, you should also be sure to explore his reasons for refusing treatment and continue to discuss your recommendations. A treatment refusal should be honored, but it should also not be treated as the end of a discussion.

<http://depts.washington.edu/bioethx/topics/consntd2.html>

## INFORMED CONSENT

**33. A 28-year-old man presents to the emergency room with testicular torsion, in extreme pain. Emergency surgery is scheduled, but the urologist will be unable to see the patient for at least one hour. He asks that the patient not be given any pain medication, so that "consent can be obtained" when he sees the patient.**

**Are the surgeon's concerns about informed consent valid?<sup>33</sup>**

- a. Yes, because the surgeon has to obtain informed consent from the patient before surgery and the pain medication will invalidate the consent.**
- b. Yes, because the hospital policy requires the presence of informed consent from a lucid person before surgery.**
- c. The informed consent is not required in this case because it is an emergency.**
- d. The surgeon concerns are not valid because severe pain, by impairing a patient's ability to listen and understand, is an encumbrance to the informed consent process.**

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<sup>33</sup> **Answer:**

The surgeon has the common misconception that informed consent is somehow invalidated by the presence of specific medications. Patients who present for surgery may have taken a variety of medications, many of which can have effects on mental function. The issue is not whether the patient has been premedicated, but whether premedication has impaired the patient's ability to participate in the informed consent process.

The ethical issues involved in this case include assessment of the patient's capacity to make decisions, and whether the patient is deliberately or otherwise, being coerced into consenting for surgery. The patient's capacity to provide consent is determined not by what recent medications have been given, but by whether the patient understands the need for treatment, can listen to and understand treatment options and risks, and can then express a choice regarding their care. Respect for patient autonomy requires that we promote a patient's ability to make an "unencumbered" choice. Severe pain, by impairing a patient's ability to listen and understand, is an encumbrance to the informed consent process. Further, withholding pain medication for the purpose of obtaining consent might be coercive.

<http://depts.washington.edu/bioethx/topics/infed1.html>

## INFORMED CONSENT

**34. A 36-year-old man presents for bone marrow donation for transplantation. His primary care physician contacts the anesthesiologist to report that the patient is extremely anxious about the procedure. The primary doctor requests that the anesthesiologist not discuss risks with the patient, since it might "scare" the patient into not providing bone marrow for a sick cousin.**

**Should you curtail risk discussion?<sup>34</sup>**

- a. Yes because the primary care physician personally contacted the anesthesiologist.**
- b. Yes for the purpose of improving the likelihood that the patient will cooperate with bone marrow harvest.**
- c. No because curtailing the risk discussion to avoid scaring the patient is a distinctly unethical practice.**
- d. None of the above.**

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<sup>34</sup> **Answer:**

This request to curtail discussion of risks is not originating with the patient. To avoid discussion for the purpose of improving the likelihood that the patient will cooperate with bone marrow harvest not only carries some mistaken assumptions about the effects of risks discussions, but it "uses" the patient to meet the ends of another individual, rather than to further his own goals, a distinctly unethical practice.

Since the patient is anxious, it is reasonable to offer to discuss risks with him, but inform him that he has the choice to not have a detailed discussion if he thinks it might unduly stress him.

More importantly, a well-done discussion of risks with this patient can be reassuring, and serve to decrease his anxiety about the upcoming procedure. The patient may be suffering from unreasonable fears about the risks of the procedure. Since the patient is healthy, anesthesia and procedure risks are minimal. He can be reassured that the procedure presents him with less risk than many things he does every day without much concern--such as driving a car to his appointment in your office.

<http://depts.washington.edu/bioethx/topics/infed2.html>

## INTERDISCIPLINARY TEAM ISSUES

**35. An otherwise healthy 54-year-old man presents for radical retropubic prostatectomy, and expresses interest to his anesthesiologist in having postoperative epidural narcotic pain management. The anesthesiologist believes it provides superior pain control, but is informed by the surgeon that the patient "is not to have an epidural."**

**Is the anesthesiologist obliged to "take an order" from the surgeon?<sup>35</sup>**

- a. Yes, because the surgeon is the captain of the team.
- b. No, because the patient requested the epidural narcotic.
- c. No, because anesthesiologists have special knowledge and training which are not shared by the surgeon with regard to the safe administration of anesthesia, which is as far as possible in keeping with the patient's wishes.
- d. None of the above.

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<sup>35</sup> **Answer:**

The answer to both questions is no. Anesthesiologists have special knowledge and training which are not shared by the surgeon with regard to the safe administration of anesthesia. They also have direct obligations to the patient to provide safe medical care which is as far as possible in keeping with the patient's wishes. When medical issues of safety, or specific patient goals are in conflict with the surgeon's desires, the anesthesiologist is first ethically obliged to provide the best care to the patient. But the anesthesiologist would be incorrect to proceed at this point without some discussion with the surgeon, for at least two reasons. First, ignoring the surgeon's communication is disrespectful. Second, the surgeon may have valuable information to impart, such as "my patients achieve very good pain control with intravenous and oral medication, and end up being discharged two days sooner than epidural patients, because they do not require prolonged urinary catheterization from epidural-associated urinary retention." This dialogue between team members can result in improved team relations, and better care for the patient.

<http://depts.washington.edu/bioethx/topics/teamd1.html>

## INTERDISCIPLINARY TEAM ISSUES

**36. A 28-year-old woman presents for diagnostic laparoscopy for pelvic pain. During laparoscopy, the surgeon announces that she intends to proceed to hysterectomy for multiple uterine myomata. The anesthesiologist then declares that he will "wake the patient up" rather than allow the surgeon to proceed, due to lack of consent for the procedure, and questionable medical necessity.**

**Can the anesthesiologist "tell" the surgeon what to do?<sup>36</sup>**

- a. No, the anesthesiologist can not "tell" the surgeon what to do.**
- b. No because the hysterectomy will obviate the need for a second surgery.**
- c. No because the hysterectomy is medically necessary at the moment.**
- d. Yes he can legally and ethically.**

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<sup>36</sup> **Answer:**

The anesthesiologist can stop the surgery, and may even have an ethical obligation to the patient to do so, but should take such action only after discussing several issues with the surgeon. Is the surgery in fact included in the consent? If not, is the surgery medically necessary at this moment (i.e., would delay place the patient's life in significant danger) or can it be postponed until the patient can be awakened and asked for consent?

If the surgery is not emergent, and there is no consent, the anesthesiologist is morally obliged to protect the patient's autonomy and right to give consent. Anesthesiologists have been also held legally liable for harm done to patients during elective surgery for which they did not consent, because the anesthesiologist renders the patient insensate and unable to protect themselves from unwanted intrusion.

Often, in a case like this one, consensus can be obtained from the health care team, which in this case could consult the hospital legal counsel and the hospital ethics committee prior to proceeding.

<http://depts.washington.edu/bioethx/topics/teamd2.html>

## LAW AND ETHICS

**37. A 32 year old woman was admitted to the Trauma Intensive Care Unit following a motor vehicle accident; she had multiple injuries and fractures, with several complications which continued to develop over the first couple of weeks. The patient rapidly developed Adult Respiratory Distress Syndrome, was on a ventilator, and was continuously sedated. Shortly after the patient's admission, her parents were contacted and remained vigilant at her bedside. The parents reported that the patient was one month away from having her divorce finalized. The patient's husband was reportedly physically and emotionally abusive to her throughout their five years of marriage. The parents had not notified this man of the patient's hospitalization, and reported that visit by him would be distressing to the patient if she were aware of it. The patient's soon to be ex-husband is her legal next of kin.**

**Should the husband be responsible for treatment decisions which the patient cannot make?<sup>37</sup>**

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<sup>37</sup> **Answer: a**

There is implied consent by law for provision of "emergency" medical treatment. If a medical emergency exists and implied consent is relied on by the health care providers, it should be documented in the patient's medical record in accordance with legal and institutional standards. It is important to note that the law sets no explicit time limitation on implied consent based on an "emergency."

The patient may have provided her own consent to treatment either at the time of her admission or earlier in her hospitalization. At that time, she may have expressed her ongoing wishes for care. The patient's own previous statements/consent may therefore be the basis for continued consent for her ongoing care.

If there is a need for informed consent for a new treatment decision on behalf of the patient, the patient's previously expressed wishes may still be relevant to her legally authorized surrogate decision-maker and her treatment plan.

If the patient already filed for divorce, it is likely that there is a temporary court order in effect and this order may affirmatively remove the patient's estranged husband from making medical decisions for her. It is common in divorce paperwork to have mutual restraining orders which prevent both spouses from contacting each other.

The patient's parents should be asked to provide the name of her divorce attorney to obtain copies of the relevant legal papers - which can then be placed in the legal section of the patient's medical record. With the husband thus removed as her surrogate decision-maker, it appears the patient's parents would become the highest level class of surrogate decision-maker and could provide informed consent for her care if the patient is unable to do so.

If the patient's husband remains her legal surrogate decision-maker, his decision on the patient's behalf are constrained by legally imposed standards. First, a surrogate is legally required to provide "substituted judgment" on behalf of the patient. This means that the surrogate must act in accordance with the patient's wishes. If substituted judgment isn't possible (i.e., unknown what the patient would want under the current medical circumstances), then the law requires the surrogate to act in the patient's "best interests." Since the medical team has significant input about what would medically be in the patient's interest, a decision by a surrogate which doesn't adhere to this standard should not be automatically followed and may need to be reviewed by the institutional ethics committee, risk management, or legal counsel.

The patient's husband may be willing to waive his surrogate decision-maker role to his estranged wife. If

- a. **No, because there is an implied consent by law for provision of "emergency" medical treatment in such cases.**
- b. **Yes because there is a divorce proceeding.**
- c. **Yes because the law sets an explicit time limitation on implied consent based on an "emergency."**
- d. **Yes because the father is the surrogate decision-makers for the patient.**

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this occurs, then he would agree to remove himself from the list of potential surrogate decision-makers and the next highest level surrogate decision-maker(s) would be contacted as necessary to provide informed consent for the patient.

A final option may be for the patient's parents to file to become the patient's legal guardians for health care decision-making.

<http://depts.washington.edu/bioethx/topics/lawd1.html>

## LAW AND ETHICS

**38. A 72 year old woman was admitted to the Neurological Intensive Care Unit following a cerebral hemorrhage which left her with severe brain damage and ventilator dependent. One year before this event, the patient and her husband had drawn up living wills with an attorney. The patient's living will specified that the patient did not want ventilator support, or other artificial life supports, in the event of a terminal condition or a permanent vegetative state.**

**The patient's husband is her legal next of kin and the person with surrogate decision-making authority. When the living will was discussed with him, he insisted that the patient had not intended for the document to be used in a situation like the present one. By this, the husband apparently meant that although the patient would not be able to recover any meaningful brain function, her condition was not imminently terminal. The husband did not consider his wife to be in a permanent vegetative state.**

**The treatment team allowed a week to pass, with the goal of providing the husband more time to be supported in his grief and to see how ill his wife was. Nevertheless, at the end of this time, the husband was unwilling to withdraw life support measures consistent with the patient's wishes as expressed in her living will.**

**Should the hospital follow the patient's wishes in the living will despite the husband's unwillingness to withdraw life support measures?<sup>38</sup>**

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<sup>38</sup> **Answer: c**

The patient's Advance Directive is strong evidence and significant in determining what the patient would want for substituted judgment. Since the patient's husband (her legal surrogate) only made vague statements as to why he thought she would want continued care under these circumstances and the husband's perspective was contradicted by their adult children - it appears the situation requires further communication efforts, e.g., patient care conference, ethics consult.

If these additional communication efforts fail to resolve the impasse - one legal/risk management approach may be to go forward with withdrawal of life support under the following conditions:

- Verify that the content of the patient's Advance Directive is consistent with a decision to forego further life-sustaining measures. Check, if possible, with those persons who were present when she prepared/signed the document to gather further information about the patient's intentions.

- a. **Yes, because the patient has an Advance Directive (living will).**
- b. **No, because the patient's husband is her legal surrogate.**
- c. **Only if the court orders the withdrawal of life support.**
- d. **Yes after obtaining a review and approval by the hospital ethics committee to withdraw life support.**

- 
- Affirm that the requisite clinical determination(s) were made ("terminal" or "permanent unconscious" conditions) to activate the patient's Advance Directive. Check to make sure the clinical determination is well-documented in the patient's chart.
  - Affirm consensus among the medical team about: the clinical determinations; the appropriateness of withdrawing life support as in the patient's best interests; and that withdrawal is consistent with her Advance Directive.
  - Set a final patient care conference with the family members to review the patient's prognosis and the medical team's decision to withdraw care at a specific future date and time. This advance notice of planned future action allows the patient's husband an opportunity to seek judicial review or arrange for a transfer of care to another medical facility before the withdrawal of care. Under the circumstances, if the husband sought such review or transfer, the patient would need to be continued on life support pending completion of review or transfer. The legal benefit of this notice and time to act is it eliminates any claim that the hospital unilaterally took irreversible action without the family's consent or at least without their acquiescence. This course of action would also break the stalemate of the patient's situation and force a resolution.  
<http://depts.washington.edu/bioethx/topics/lawd2.html>

## Maternal-Fetal Conflict

**39. A 29-year-old woman had an obstetrical ultrasound at 33 weeks to follow-up a previous finding of a low-lying placenta. Although the placental location was now acceptable, the amniotic fluid index (AFI) was noted to be 8.9 cm. Subsequent monitoring remained reassuring until 38.5 weeks, when the AFI was 6 cm. The patient declined the recommendation to induce labor, and also refused to present for any further monitoring. She stated that she did not believe in medical interventions. Nevertheless, she continued with her prenatal visits. At 41 weeks, she submitted to a further AFI, which was found to be 1.8 cm. She and her husband continued to decline the recommendation for induced labor.**

**What would you NOT do in this situation?<sup>39</sup>**

- a. **Recommend induction of labor at term because it is an intervention with demonstrated efficacy and carries low risk to the mother.**
- b. **Inform the mother that the fetus may sustain serious damage.**
- c. **Make effort to persuade the mother to change her mind.**
- d. **To benefit the fetus, disregard the maternal refusal for therapy and induce labor.**

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<sup>39</sup> **Answer: d**

Induction of labor at term is an intervention with demonstrated efficacy and carries low risk to the mother. In this case, it could prevent serious damage to a viable fetus. Informed discussion and persuasive efforts should be continued towards this goal. However, deliberate disregard of maternal refusal for therapy could constitute assault. So long as the fetus is attached to the pregnant woman, her body maintains its life, and bars access to it.

<http://depts.washington.edu/bioethx/topics/maternd1.html>

## Maternal-Fetal Conflict

**40. A 22-year-old woman in her first pregnancy with an unremarkable prenatal course presents with preterm labor at 28 weeks gestation. Her contractions were successfully stopped with terbutaline. Discharge planning was reviewed with her, and she was instructed to follow a regimen of bedrest and oral terbutaline. She reported that she did not intend to comply with these instructions. She believed that God would not allow her to labor unless it was time for the baby to deliver, and she indicated that He had communicated this to her.**

**How would you handle this situation?<sup>40</sup>**

- a. Refer the patient to a psychiatrist.
- b. Conduct extensive, non-coercive discussions to ensure that this patient understands the implications of refusing therapy.
- c. Suggest that she invite her spiritual advisor to meet and talk together about her beliefs and the impact on her fetus.
- d. Both (b) and (c).

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<sup>40</sup> **Answer: d**

The gestational age of this pregnancy places the fetus on the border of viability. Extensive, non-coercive discussions are essential to ensure that this patient understands the implications of refusing therapy. You may suggest that she invite her spiritual advisor to meet with both of you to talk together about her beliefs and the impact on her fetus.

If her refusal persists, in light of her unconventional religious claims, a psychiatric consultation might be requested to evaluate her competency. If competency is documented, the ethical principle of nonmaleficence would support refraining from performing any unwanted interventions. If the patient is found to be incompetent, judicial intervention could be considered.

<http://depts.washington.edu/bioethx/topics/maternd2.html>

## Mistake – Medical Error

**41. An 18-month-old child presents to the clinic with a runny nose. Since she is otherwise well, the immunizations due at 18 months are administered. After she and her mother leave the clinic, you realize that the patient was in the clinic the week before and had also received immunizations then.**

**Should you tell the parents about your mistake?<sup>41</sup>**

- a. **No because the error is a trivial one.**
- b. **No because no harm is done.**
- c. **No because the mother will never find out.**
- d. **Yes because an open and honest approach to errors is most appropriate.**

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<sup>41</sup> **Answer: d**

The error is a trivial one. Aside from the discomfort of the unnecessary immunization, no harm has resulted. Nonetheless, an open and honest approach to errors is most appropriate. While the parents may be angry initially about the unnecessary injection, they will appreciate your candor. On the other hand, should they discover the error and believe you have been dishonest, their loss of trust will be significant.

<http://depts.washington.edu/bioethx/topics/mistksd1.html>

## Mistake – Medical Error

**42. A 3-month-old has been admitted to the hospital with a newly diagnosed ventricular septal defect. She is in early congestive heart failure and digoxin is indicated. After discussing the proper dose with the attending physician, you write an order for the drug. Thirty minutes later the baby vomits and then has a cardiac arrest and dies. You discover that in writing the digoxin order you misplaced the decimal point and the child got 10 times too much digoxin.**

**What is your duty here?<sup>42</sup>**

- a. **Inform the parents about the mistake and say you are sorry.**
- b. **Do not inform the parents.**
- c. **Do not say sorry.**
- d. **Let the liability insurance company handle everything, because a malpractice lawsuit may follow.**

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<sup>42</sup> **Answer: a**

This unfortunate event represents a serious error with profound implications for the patient and family. You owe this family an honest explanation. They need to hear you say that you're sorry. Any attempt to hide the details of the event would be dishonest, disrespectful, and wrong. Though a lawsuit may follow, these parents are less likely to litigate if you deal with them honestly and take responsibility for the error.

<http://depts.washington.edu/bioethx/topics/mistksd2.html>

## Mistake – Medical Error

**43. A 3-year-old presents to the emergency department. She was diagnosed with pyelonephritis by her physician yesterday, treated with an intramuscular injection of antibiotic and sent home on an oral antibiotic. She is vomiting today and unable to keep the antibiotic down. As you prepare to admit her, you feel she should have been admitted yesterday.**

**Should you tell the parents that their physician made a mistake?<sup>43</sup>**

- a. **Yes the parents should be told.**
- b. **The parents should not be told.**
- c. **Discuss the case first with the other treating physician, then tell the parents.**
- d. **Report the incident to the risk manager and not the parents.**

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<sup>43</sup> **Answer: b**

The practice of medicine is not an exact science. Frequently physicians will disagree about what constitutes the most appropriate management in a given case. Often these are legitimate disagreements with more than one acceptable course of action. Simply because you would have managed a patient differently does not mean the other physician made a mistake. In this case, you may wish to discuss the case with the other physician and explain why you manage children with pyelonephritis differently. However, in situations where standard practice varies, the parents should not be told that a mistake has been made.

<http://depts.washington.edu/bioethx/topics/mistksd3.html>

## Neonatal ICU Issues

**44. Melinda is a married 35-year-old pregnant childless woman who has lost four previous pregnancies between 16 and 23 weeks gestation. She currently has reached 23 weeks and 3 days of gestation, her fetus is seemingly healthy, and has an estimated weight of 550 grams (+/-1.2 lbs). She has ruptured her bag of waters and is now having labor that seems unstoppable with tocolytics. Delivery seems inevitable.**

**What is the physician's duty to inform the parents?<sup>44</sup>**

- a. **Inform the parents that the fetus is not viable.**
- b. **Inform the parents that the 23-week-old baby will either die or live with significant handicap.**
- c. **Provide sufficient medical information to the parents about the care and possible outcome of the baby so they can make their own informed choice.**
- d. **Inform the parents to choose passive comfort care mode treatment for the baby rather than aggressive measures.**

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<sup>44</sup>**Answer: c**

This gestational age and estimated birthweight represent the "gray zone" in terms of viability vs. non-viability. Accordingly, the *parents* have a choice to make. They can choose a passive comfort care mode treatment (with non-survival being a virtual certainty) or alternatively, assisted ventilation, pressors, antibiotics, parenteral nutrition, etc. The role of the physician is to provide information and guide the parents through the decision-making process.

This situation 30 years ago would have presented no ethical dilemma. Indeed, the 1972 *Roe v. Wade* Supreme Court case defined the limit of viability as 28 weeks gestation. Any form of aggressive care involving newborn infants below this gestational was thought to be futile. Today, however, aggressive measures at birth are sometimes initiated with a modest degree of success achieved in terms of promoting survival (+/-25%). Notably, survival is accompanied by a long stay in the hospital following delivery (3-4 months), enormous costs(+/- \$250,000), considerable suffering, and morbidity (in at least 50% of the cases there is significant handicap).

<http://depts.washington.edu/bioethx/topics/nicud1.html>

## Neonatal ICU Issues

**45. Barbara is a term female infant from an unexpected pregnancy. She has Down syndrome (Trisomy 21) and also has a complex cardiac lesion that will require at least two major surgical procedures during early infancy for her to have a chance to survive beyond childhood. Barbara's parents, ages 44 and 45, have three other children, all in college. They have considerable ambivalence as to what to do: continue to pursue potentially beneficial though burdensome and costly treatments, or forego such treatments in favor of a more conservative approach.**

**The parents consulted you as their physician. What would you advise the parents to do?<sup>45</sup>**

- a. **The parents should base their decision on the *child's* best interests and weigh the burden of care against the benefits to be anticipated from medical treatment.**
- b. **The parents should make a decision based on Down syndrome.**
- c. **The parents should consider both the Down syndrome and finances.**
- d. **The parents should consider the Down syndrome, the finances and the infant's suffering.**

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<sup>45</sup> **Answer: a**

That the child has Down syndrome should not be a factor in the decision-making process. Nor is it appropriate to allow financial issues to play a major role. The parents, who are the decision-makers, should be apprised of the medical facts (types of surgical interventions required, chances for success). They should also be given a good understanding of the amount of suffering the child will experience during aggressive intervention efforts. They should then come to a decision based on the *child's* best interests. That is to say, does the burden of care outweigh the benefits to be anticipated or vice versa.

<http://depts.washington.edu/bioethx/topics/nicud2.html>

## Parental Decision making

**46. A 4-year-old with an obviously broken forearm is brought to the emergency department by her baby-sitter. Both the baby-sitter and emergency room staff have attempted to reach her parents without success.**

**Can you treat this child without parental permission?<sup>46</sup>**

- a. **No. The parents must consent first.**
- b. **The Baby-sitter's permission would be sufficient without the parent's consent.**
- c. **Because the parents can not be reached, the doctor should first obtain a court order before treating the infant.**
- d. **The doctor should proceed with x-rays and treatment of the child's fractured forearm without the consent.**

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<sup>46</sup> **Answer: d**

Your first duty is to the health and welfare of the child. Having attempted to reach her parents for consent without success, you should proceed with x-rays and treatment of her fractured forearm. Rapid treatment of the child's pain and fracture are clearly in her best interest. When optimal treatment requires immediate intervention, treatment should not be delayed even if consent has not been obtained.

<http://depts.washington.edu/bioethx/topics/parentd1.html>

## Parental Decision making

**47. An ill-appearing 2-year-old with a fever and stiff neck appears to have meningitis. His parents refuse a lumbar puncture on the grounds that they have heard spinal taps are extremely dangerous and painful.**

**What are the physician's legal-ethical obligations in this case?<sup>47</sup>**

- a. **Obtain an ethics consultation.**
- b. **Fully inform the parents, and should they refuse to give permission, the physician is justified in proceeding with the procedure and treatment of the child.**
- c. **Obtain a court order to perform the lumbar puncture and treat the child.**
- d. **Be sure the parents' refusal is fully informed, document the refusal in the chart, and do not perform the lumbar puncture.**

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<sup>47</sup> **Answer: b**

A lumbar puncture is the only way to diagnose meningitis and a delay in treatment could cause significant harm to the child. Complications from the procedure are very rare, and the benefit in this case is likely to be substantial. There is not time to obtain an ethics consult or court order. The physician should attempt to address the parents' misconceptions about lumbar punctures and to reassure them about the safety of the procedure and perhaps offer to use appropriate pain control methods. A second opinion from another physician may prove helpful.

Should these efforts not result in parental permission, the physician is justified in proceeding with the procedure and treatment of the child. While parental authority to make medical decisions for their children is broad, it does not include choices that may seriously harm their children. As long as the physician has used reasonable clinical judgment in determining the need for the lumbar puncture, legal liability should be minimal.

<http://depts.washington.edu/bioethx/topics/parentd2.html>

## Parental Decision making

**48. A 5-year-old child has just had his second generalized tonic-clonic seizure in a 4 month period. You have recommended starting an anticonvulsant. The parents have concerns about the recommended medication and would prefer to wait and see if their son has more seizures.**

**How should you respond to the parents' request?<sup>48</sup>**

- a. Obtain an ethics consultation.**
- b. Obtain a court order to treat the child.**
- c. Report the case as child abuse.**
- d. Fully inform the parents, and should they refuse to give anticonvulsants to the child, the physician should abide by the parents' decision.**

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<sup>48</sup> **Answer: d**

The parents have the authority to make a choice of this sort. In general, courts have been reluctant to overrule against parental wishes in most situations where that decision does not place the child at considerable risk. Though failure to start an anti-convulsant may increase the risk of further seizures, this does not pose a substantial enough risk to the child to justify overriding the parents' wishes, especially given the potential risks associated with the medication. Though you may not agree with their decision, the decision is a reasonable one that does not place their child at substantial risk of increased harm.

<http://depts.washington.edu/bioethx/topics/parentd3.html>

## Public Health Issues

**49. Margaret is a 27-year-old graduate student, recently married, who comes into the student health clinic for a routine pelvic exam and PAP smear. During the course of the exam, the gynecology resident performing the exam obtains the PAP smear, but also obtains cervical cultures for gonorrhea and chlamydia. The examination concludes uneventfully.**

**Several weeks later, Margaret receives a postcard indicating that the PAP smear was normal, with no evidence of dysplasia, but that the cervical culture for gonorrhea was positive. The card instructs her to come into the clinic to discuss treatment, and that "public health authorities" have been notified for contact tracing. The young woman is terrified that her husband will be contacted and complains to the Director of the student health clinic.**

**As the Director of the clinic, how would you handle Margaret's complaint?<sup>49</sup>**

- a. Inform her that the culture was a routine procedure that is performed on everybody who comes for a routine Pap smear.**
- b. Tell her how lucky she is that her gonorrhea was discovered and can now be successfully treated.**
- c. Inform her that the treatment of gonorrhea will benefit her and her husband.**
- d. Apologize to her for the error in obtaining the cervical culture without her consent.**

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<sup>49</sup> **Answer: d**

The routine of obtaining cervical cultures for gonorrhea and chlamydia is motivated by the desire to have accurate information on the prevalence of gonorrhea in the population, and the hope that identification and treatment of asymptomatic carriers could reduce or eradicate gonorrhea as a public health problem. Yet, in this case the patient was not told about the culture being obtained. When health-related information is obtained from individuals, they should have an opportunity to consent to or refuse such collection. In some instances, individuals may conscript to having their rights disregarded, such as in the military. Similarly, other individuals do not have their rights recognized as a result of due process, such as prisoners. In this case, the physician should inform the woman what tests will be performed and why, and how that information will be handled. If she refuses to have the test obtained, her wish should be respected.

<http://depts.washington.edu/bioethx/topics/publicd1.html>

## Public Health Issues

**50. Morley is a 33-year-old man with multi-drug resistant tuberculosis. He is homeless, and has a pattern of missing many of his scheduled clinic visits. Upon starting a multi-drug regimen for his TB, MW initially comes to his scheduled clinic visits, but after a few weeks begins missing them. The physician contacts the social work case manager, who arranges supervised drug administration. Nevertheless, Morley often cannot be found and this approach is deemed to be failing.**

**Should Morley be forced into treatment against his will?<sup>50</sup>**

- a. The patient has a right to consent to or refuse treatment, and should not be forced to receive treatment.**
- b. The doctor has a right to hospitalize and treat the patient.**
- c. Only supervised medication administration is allowed under these circumstances.**
- d. If the patient completely refuses treatment, it would be justifiable to seek court permission to confine and treat the patient against his will.**

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<sup>50</sup> **Answer: d**

This is a case in which the health of the public is clearly threatened. Multi-drug resistant tuberculosis has the potential of causing substantial morbidity and mortality for the population, particularly in large urban areas. Thus the need for the individual patient to be treated for the good of the public is high. Similarly, the patient himself stands to benefit from the treatment. Ordinarily, patients have the right to refuse potentially beneficial treatment, provided they are competent and make an informed decision to do so. The tension created in this case is that the patient's refusal to follow the medication regimen puts others at substantial risk of harm. Hence it may be justifiable to compromise his autonomy to protect the health of others.

In such cases, every effort should be exhausted to enlist the patient's cooperation with the medical regimen. Interventions such as supervised medication administration are often effective ways to achieve the desired result without compromising the patient's autonomy. Failing this, it would be justifiable to seek court permission to confine and treat the patient against his will. In the legal process that ensues, considerations will include the magnitude of harm, the degree to which specific individuals are exposed to harm, and the probability of harm.

<http://depts.washington.edu/bioethx/topics/publicd2.html>

## Physician–Patient Relationship

**51. During a visit to her family physician, a 35-year-old woman discloses that she suffers from anorexia nervosa. She complains of fatigue, dizziness, depression, headaches, irregular menses, and environmental allergies. Each day, she uses 15 to 60 laxatives, exercises for several hours, and eats a salad or half a sandwich. At 5'2", she weighs 88 pounds. She demonstrates a good understanding of the diagnosis and the recommended therapy for anorexia. Despite receiving a variety of resource information, the patient refuses any medical intervention. She continues to present to the family physician, offering a variety of somatic complaints.**

**Does the patient's depression render her incompetent to refuse treatment for her anorexia?<sup>51</sup>**

- a. The family physician may consider the patient incompetent to refuse treatment because of her mental illness.**
- b. The family physician may consider the patient incompetent to refuse treatment but only if a psychiatrist determines that she is.**
- c. The determination of incompetency is not made by physicians.**
- d. Both (a) and (b) are correct.**

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<sup>51</sup> **Answer: c**

The determination of incompetency of an adult is made by a Judge. Since this patient could rationally discuss her treatment options and her reasons for declining therapy, she could not be considered incompetent by a Judge. Respect for autonomy is a central principle of bioethics, and it takes precedence in this case. Although the principle of beneficence could be used to argue for coercion towards treatment, compliance may be better improved by providing an ongoing partnership with the patient. Maintaining a therapeutic relationship with ongoing dialogue is more likely to provide this patient with the eventual ability to pursue therapy.

<http://depts.washington.edu/bioethx/topics/physptd1.html>

## Physician–Patient Relationship

**52. A 16-year-old female presents to a family physician to obtain a referral for family therapy. She is estranged from her mother and stepfather, who see the same physician. For many years, this patient responsibly cared for her four younger siblings while their single mother worked. Since her mother's marriage, the family has become involved in a fundamentalist church. The patient moved out when she felt the social and moral restrictions of the family's religion were too burdensome for her. The patient seemed quite mature; she maintained a 3.5 GPA, along with a part-time job. She demonstrated a genuine desire for reconciliation, and the therapy referral was provided.**

**She also requested and obtained a prescription for contraceptives during the visit, with the assurance that her sexual activity would be kept confidential. In follow-up, she reported that the therapist had informed her that if she mentioned anything about being sexually active with her adult partner, he would be obliged to report her to the state. The patient was very concerned about the conflict between this statement and the family physician's prior assurance of confidentiality.**

**Should this patient's confidentiality be broken?<sup>52</sup>**

- a. The patient's confidentiality may not be broken by the therapist under any circumstances.**
- b. The patient's confidentiality may be broken by the physician but not the therapist.**
- c. The patient's confidentiality must be broken if the sexual activity with the adult partner is considered a crime by law.**
- d. None of the above answers are correct.**

---

<sup>52</sup> **Answer: c**

While the physician has a moral obligation to obey the law, he must balance this against his responsibility to the patient. The medical professional should research the law of the State. For example, the law states that sexual intercourse with a minor is a class C felony, and a reportable offense, if the offender is at least 90 months older than the victim. This patient's relationship did not actually meet the criteria for mandatory reporting. Had this not been the case however, the physician could be justified in weighing the balance of harms arising from the filing of such a report.

There is little justification for informing the family of the young woman's sexual activity. Due to the family's strong fundamentalist beliefs, significant damage would have occurred in the family reconciliation process with this discovery. Although they would clearly disapprove of the patient's actions, her choices carry no risk of harm to them.

<http://depts.washington.edu/bioethx/topics/physptd2.html>

## Medical Research Issues

**53. Mrs. Franklin, an 81-year-old Alzheimer's patient hospitalized under your care has been asked to participate in a clinical trial testing a new drug designed to help improve memory. You were present when the clinical investigator obtained a signed informed consent from Mrs. Franklin a few days ago. However, when you visit Mrs. Franklin today and ask her if she is ready to begin the study tomorrow, she looks at you blankly and seems to have no idea what you are talking about.**

**What should you do?<sup>53</sup>**

- a. The signed informed consent for the clinical drug testing is in doubt, and should not be done.**
- b. The primary investigator should be contacted to discuss Mrs. Franklin's participation in the trial.**
- c. A surrogate who can give consent for her participation may be contacted if the clinical trial is deemed to be in her best interests.**
- d. (a), (b) and (c) are all correct.**

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<sup>53</sup> **Answer: d**

The competence of Mrs. Franklin to give an ethically valid informed consent is in doubt. You should contact the primary investigator to discuss Mrs. Franklin's participation in the trial. There may be a surrogate who can give consent for her participation if it is deemed to be in her best interests. Although she may be considered a vulnerable research subject because of her mental status, Mrs. Franklin does belong to the population the intervention is designed to assist, and her participation may benefit herself and other Alzheimer's patients. However, a careful balancing of risks and benefits should occur.

<http://depts.washington.edu/bioethx/topics/resrhd1.html>

## Medical Research Issues

**54. During the conduct of a large clinical trial of an investigational drug, preliminary analysis of results show that there were three times as many participants in the experimental group who experienced severe nausea and vomiting compared to the control group. Two of the cases were severe enough to require that the participants be hospitalized. This is despite the fact that the preliminary analysis shows that there may be a moderate benefit with the drug.**

**What should be done?<sup>54</sup>**

- a. The large clinical trial should be stopped immediately.**
- b. The adverse events should be reported to the Data Safety Monitoring Board, and the serious adverse events must be reported to the IRB.**
- c. Complete the trial then report in details all the adverse events.**
- d. The adverse events are not serious enough to report.**

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<sup>54</sup>**Answer: b**

All adverse events are reported to the Data Safety Monitoring Board, and serious adverse events must be reported to the IRB. Investigators should consider reevaluating the balance of risks versus benefits. While these adverse events are probably not serious enough to suggest that the trial be terminated, these adverse events should be balanced by significant benefits. These findings may relate to each participant's willingness to continue in the trial, and according to 45 CFR 46.116(b)(5) the findings should be provided to all current and future participants as part of the informed consent process.

<http://depts.washington.edu/bioethx/topics/resrhd2.html>

## Medical Research Issues

**55. After having completed a study that involved the collection of tissue from the subjects, an investigator wishes to perform additional analysis of the archived tissue samples. This nature of this analysis was not explicitly stated in the original consent form.**

**Should the investigator be required to obtain explicit consent for the new research?<sup>55</sup>**

- a. The investigator is required to obtain explicit consent for the new research from the IRB.**
- b. The investigator is NOT required to obtain explicit consent for the new research.**
- c. The investigator is required to obtain a general consent.**
- d. The investigator is required to obtain explicit consent for the new research from the patient.**

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<sup>55</sup> **Answer: c**

Institutional Review Boards have increasingly required that explicit consent be obtained, if practical, before archived tissue can be used for research. Archiving samples for an unspecified “future use” without explicit consent undermines the autonomy of the participants. Even if participants may be willing in general to have surplus tissue used for research purposes, they should still be asked for their consent.

<http://depts.washington.edu/bioethx/topics/resrhd3.html>

## Resource Allocation

**56. A 28-year-old male is admitted with bacterial endocarditis and needs a replacement of his prosthetic heart valve. After his first replacement, he continued to abuse intravenous drugs. The medical team feels it would be "futile" and a waste of medical resources to replace this heart valve yet again.**

**Is the team's judgment appropriate in this case?<sup>56</sup>**

- a. The team's judgment is appropriate in this case.**
- b. If the patient consents to the heart valve replacement, it should be done because it is not "futile".**
- c. If the patient can pay for the heart valve replacement, it should be done.**
- d. Replacing the heart valve is "futile".**

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<sup>56</sup> **Answer: b**

While it is likely that this patient will require additional counseling and support services to improve his health outcomes, replacing the heart valve is not "futile" in this case. It is also likely that the medical team is using biased criteria to judge "wasted" vs. "properly used" medical resources. Thoughtful discussion may provide an opportunity for the team to voice their frustration and think through a treatment plan that will maximally support this patient's recovery.

<http://depts.washington.edu/bioethx/topics/resalld1.html>

## Termination of Life Sustaining Treatment

**57. On a busy night in the ER a member of the hospital board comes in with her sick child and asks that you see him right away. The child has a sore throat and red eye and he appears subdued, but alert. You have a full waiting room.**

**What should you do?<sup>57</sup>**

- a. The ER doctor should see the sick child right away.**
- b. The ER doctor should call the Chief of Staff and ask what to do.**
- c. The ER doctor should call the Hospital Administrator and ask what to do.**
- d. As with the other people waiting in the ER, the sick child should be subject to triage criteria based on medical need.**

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<sup>57</sup>**Answer: d**

Cases where famous or influential people are asking for special treatment ask that we review our ethical criteria for resource allocation. Do some people "deserve" special treatment over others? What would justify such a claim? In this case, the ER staff might be swayed by the powerful position the board member holds in their institution and want to do their best for her. However, the other people waiting in the ER have been subject to triage criteria based on medical need. It would be unjust to waive these criteria on the basis of social position. While this may seem unrealistic, one might also consider the effect on the hospital if the board member faces a long, tedious wait in the waiting room along with everyone else. A complaint voiced by this powerful person may enact change on staffing considerations more effectively than a number of patient complaints. To let her sail through would be to create an impression of smoothness that is most likely not part of the everyday ER experience.

For further discussion of this case, please refer to Douglas S. Diekema's article, "The preferential treatment of VIPs in the emergency department," *American Journal of Emergency Medicine* 1996; 14(2):226-229.

<http://depts.washington.edu/bioethx/topics/resalld2.html>

## Termination of Life Sustaining Treatment

**58. Mr. Steven is a 70-year-old man with end-stage COPD, admitted last month with pneumonia. His course was complicated by respiratory failure needing mechanical ventilation, and multiple efforts to wean him have been unsuccessful. Awake and alert, he now communicates through written notes that he wants the ventilator taken off.**

**Will you honor his request?<sup>58</sup>**

- a. If the patient's decision making capacity is intact, his request should be honored.**
- b. His request should not be honored.**
- c. The surrogate decision maker should make the final decision.**
- d. A court order is necessary because the outcome of taking him off the respirator is death certain.**

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<sup>58</sup> **Answer: a**

The prognosis of full recovery from long-term mechanical ventilation is poor, particularly in patients like Mr. Steven with minimal pulmonary reserve. The approach to his request should start with an evaluation of his decision making capacity. Even though he is awake and alert, you should carefully probe the reasons for his request, with particular attention to making sure he understands the consequences of his decision. If you're concerned about depression or other mental illness affecting his thinking about this decision, you might request a psychiatry consultation. You should ask Mr. Steven if he's discussed this with his spouse or family. If his decision making capacity is intact, you should honor his request.

<http://depts.washington.edu/bioethx/topics/term1fd1.html>

## Termination of Life Sustaining Treatment

**59. Mrs. Hanes is a 62-year-old woman with metastatic breast cancer. She was admitted with dehydration and weakness. Her cancer treatments have failed, as she now has a recurrence. The oncologists are contemplating some new palliative chemotherapy. The nutrition team is concerned about her cachexia and recommends total parenteral nutrition (TPN).**

**Should the patient be started on TPN?<sup>59</sup>**

- a. The patient should NOT be started on TPN.**
- b. The patient should be started on TPN.**
- c. The patient decides whether or not to be started on TPN after being fully informed about all the treatment choices and probable outcomes.**
- d. The treatment with TPN is “futile” in this patient and will serve no purpose.**

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<sup>59</sup> **Answer: c**

Patients with metastatic cancer often suffer from profound cachexia, attributable to the metabolic effects of their cancer and their inability to get adequate caloric intake from eating alone. TPN is able to provide protein and nonprotein nutrients to reverse the catabolic effects of illness. TPN has a number of potential complications, such as those related to infection from the central line catheter site.

In this case, you should carefully evaluate the goals of therapy as they relate to TPN. Is TPN likely to offer the patient any benefit? If her life expectancy can be prolonged with additional chemotherapy, it may be reasonable to give TPN to allow the patient to enjoy that benefit. If additional chemotherapy offers no substantial increase in quantity or quality of life, TPN could become another burden for the patient without any meaningful benefit, and ought to be withheld.

<http://depts.washington.edu/bioethx/topics/termldf2.html>

## Truth-Telling and Withholding Information

**60. A 65-year-old man comes to his physicians with complaints of abdominal pain that is persistent but not extreme. Workup reveals that he has metastatic cancer of the pancreas. The man has just retired from a busy professional career, and he and his wife of 40 years are about to leave on a round-the-world cruise that they've been planning for over a year.**

**Should you tell him his diagnosis?<sup>60</sup>**

- a. Withhold telling the man his diagnosis for fear of psychological harm.**
- b. The man should be told his diagnosis, prognosis, and treatment options before his planned trip.**
- c. It is best to wait until he returns from his trip before telling him the diagnosis.**
- d. Tell the wife the diagnosis, and let her decide when to inform the patient and her husband of 40 years.**

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<sup>60</sup> **Answer: b**

Several factors tempt one to withhold the diagnosis, and these should be recognized. One would be the concern that the patient would suffer psychological harm that would interfere with his planned trip. There is little empirical evidence that this occurs, and lacking some compelling reason to think it would occur with this man, it is insufficient grounds to withhold information. To the contrary, sensitive disclosure would allow the patient and his wife to decide if the trip is still important to them, versus seeing their grandchildren, for instance, and would spare the patient the inconvenience of suffering advancing symptoms while traveling, perhaps necessitating emergency care in a foreign locale. Finally, physicians should not confuse discomfort at giving bad news with justification for withholding the truth. In this case, the man should be told his diagnosis, prognosis, and treatment options.

<http://depts.washington.edu/bioethx/topics/truthd1.html>

## Truth-Telling and Withholding Information

**61. An 80-year-old Asian woman is hospitalized with weight loss, generalized weakness, and a pulmonary mass. Work-up reveals that she has pulmonary tuberculosis. Her family approaches the physician and asks that the patient not be told, stating that in her upbringing in mainland China tuberculosis was considered fatal and to tell her would be like giving her "a death sentence."**

**Should you respect the family's concerns?<sup>61</sup>**

- a. The doctor should explore the patient's belief system then decide accordingly whether or not to inform the patient.**
- b. The doctor should respect and follow the family's request.**
- c. The physician has a duty to inform the patient and the Department of Public Health about the diagnosis.**
- d. It would be justifiable in this case to withhold the diagnosis of tuberculosis based on cultural beliefs.**

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<sup>61</sup> **Answer: c**

Tuberculosis is a reportable disease, and the patient should be informed otherwise she can not provide informed consent to treatment for tuberculosis. Some cultures hold different beliefs about truth-telling in the medical encounter. Some assert that in some Asian cultures, members of the family unit may withhold the truth about terminal illness from elders out of respect and a desire to protect them from harm. If a patient and their family members hold such beliefs, they should be respected, and a mechanism for informed decision making in collaboration with the family negotiated. One must not, however, assume that every patient of Asian ancestry holds the beliefs described here. The physician should make an attempt to explore the patient's belief system. If he finds that the patient does hold such beliefs about the harmful nature of truthful disclosure of the truth, then it might be ethically justifiable to withhold the diagnosis of tuberculosis, but not legally.

<http://depts.washington.edu/bioethx/topics/truthd2.html>