I will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them.

Attributed to Hippocrates
4th-Century Greek Physician

ETHICAL PRINCIPLES AND CONCEPTS

1. Define the following terms in relation to the patient and physician-patient relationship: beneficence, nonmaleficence, autonomy, and justice.
   - **Beneficence**: The concept that the physician will contribute to the welfare of the patient through the recommended medical interventions
   - **Nonmaleficence**: An obligation for the physician not to inflict harm upon the patient
   - **Autonomy**: The obligation of the physician to honor the patient’s right to accept or refuse a recommended treatment, based on respect for persons
   - **Justice**: The obligation of the physician to avoid treating patients differently by providing better care or privileges to favored patients or by discriminating against less favored patients, especially on grounds of race, ethnicity, sex, sexual orientation, religion, creed, socioeconomic status, or disability

2. What is fiduciary duty?
   An obligation of trust imposed upon physicians requiring them to place their patients’ best interests ahead of their own interests and, as the patient’s advocate, to protect patients from exploitation or neglect of others in the health care system.

3. What is conflict of interest?
   A situation in which one or more of a professional’s duties to a client or patient potentially conflicts with the professional’s self-interests or when a professional’s roles or duties to more than one patient or organization are in tension or conflict.

4. How should conflicts of interest be addressed?
   - Avoided, if possible
   - Disclosed to institutional officials or to patients affected
   - Managed by disinterested parties outside the conflicted roles or relationships

5. What is conscientious objection?
   Refusal to participate in or perform a procedure, prescription, or test grounded on a person’s sincere and deeply held belief that it is morally wrong.

6. What is a conscience clause?
   A provision in law or policy that allows providers with conscientious objections to decline participation in activities to which they have moral objections, under certain conditions and limitations. The scope of the allowance should only protect the provider’s conscience, not deny a patient legitimate care.

7. Describe futility.
   The doctrine that physicians are not required to provide treatment if there will be no medical benefit from it. It has become a very controversial term in recent times, in part because of inconsistency in definition and usage. In the narrowest definition, “futility” may refer to physiologic futility or the inability of a treatment or intervention to support bodily functions such as circulation or respiration or reverse the ultimate decline and cessation of these functions. More often, though, futility refers to the very low likelihood of an intervention succeeding in restoring physiologic function or health.
Patients and physicians may disagree about the level of probability that could be considered futile, though. Most health care institutions will establish policies for guidance in resolving such disagreements.

**INFORMED CONSENT**

8. How should one request “consent” from a patient?

Consent is not a transitive verb. Sometimes a medical student or resident is instructed to “go consent the patient,” implying that consent is an act that a health professional performs upon a passive recipient who has no role in the action other than passive acceptance. A health professional seeking consent from a patient should be asking the patient for either an affirmative endorsement of an offered intervention or a decision to decline the proposed intervention.

9. What is consent or mere consent?

Consent alone, without a sufficiently robust level of information to justify the adjective “informed.” Although “mere consent” may avoid a finding of battery (which is defined as harmful or offensive physical contact with a person without that person’s consent), it is usually insufficient permission for the physician to proceed with a procedure or treatment.

10. What is informed consent?

Consent from a patient that is preceded by and based on the patient’s understanding of the proposed intervention at a level that enables the patient to make a meaningful decision about endorsement or refusal of the proposed intervention.

11. What are the necessary conditions for valid informed consent?

- Disclosure of relevant medical information by health care providers
- Comprehension of relevant medical information by patient (or authorized representative)
- Voluntariness (absence of coercion by medical personnel or institutional pressure)

12. What topics should always be addressed in the discussion regarding informed consent (or informed refusal)?

- Risks and benefits of the recommended intervention (examination, test, or treatment)
- Reasonable alternatives to the proposed intervention and the risks and benefits of such alternatives
- The option of no intervention and the risks and benefits of no intervention

**KEY POINTS: INFORMED CONSENT**

1. Informed consent involves more than a signature on a document.
2. Before beginning the informed consent process, the physician should assess the patient’s capacity to understand the information provided.
3. The physician should make the effort to present the information in a way the patient can comprehend and not just assume the patient is “incompetent” because of difficulty in understanding a complex medical issue.
4. The patient’s goals and values are also considered in the informed consent process.

13. What are the different standards for the scope of disclosure in informed consent?

- **Full disclosure:** Disclosure of everything the physician knows. This standard is impractical, if not impossible, and is not legally or ethically required.
- **Reasonable person** (sometimes called “prudent person standard”): Patient-centered standard of disclosure of the information necessary for a reasonable person to make a meaningful decision about whether to accept or to refuse medical testing or treatment. This standard is the legal minimum in some states.
- **Professional practice** (also called “customary practice”): Physician-centered standard of disclosure of the information typically practiced by other practitioners in similar contexts. Sometimes the professional practice standard is the legal minimum in states that do not acknowledge the reasonable person standard.
- **Subjective standard:** Disclosure of information a particular patient may want or need beyond what a reasonable person may want to know. This is not a legally required minimum but is ethically desirable if the physician can determine what additional information the particular patient might find important.
14. What are the exceptions to the obligation of informed consent?

- **Implied consent**: For routine aspects of medical examinations, such as blood pressure, temperature, or stethoscopic examinations, explicit informed consent is not generally required, because presentation for care plausibly implies that the patient expects these measures and consent may be reasonably inferred by the physician. Implied consent does not extend to invasive examinations or physical examination of private or sensitive areas without explicit oral permission and explanation of purpose.

- **Presumed consent**: Presentation in the emergency room does not necessarily mean that emergency interventions are routine or that the patient’s consent is implied. The justification for some exception to informed consent is that most persons would agree to necessary emergency interventions; therefore, consent may be presumed, even though this presumption may turn out to be incorrect in some instances for some patients. Such treatment is limited to stabilizing the patient and deferring other decisions until the patient regains capacity or an authorized decision maker has been contacted.

15. What should you do when a patient requests the physician to make the decision without providing informed consent?

When a patient seems to be saying in one way or another, “Doctor, just do what you think is best,” it is appropriate to make a professional recommendation based on what the physician believes to be in the patient’s best medical interests. This does not mean, however, that the patient does not need to understand the risks, benefits, and expected outcomes of the recommended intervention. This type of request is sometimes referred to as requested paternalism or waiver of informed consent. The physician should explain, in terms of risks and benefits of a recommended intervention, the reasons he or she recommends the intervention and why it would seem to be in the patient’s best medical interest and then ask the patient to endorse it or to decline it.

16. What is a physician’s obligation to veracity (truthful disclosure) to patients?

In order for patients to have an accurate picture of their medical situation and what clinical alternatives may best meet their goals in choosing among various medical tests or treatments or to decline medical intervention, patients must have a truthful description of their medical condition. Such truthful disclosure is also essential for maintaining patient trust in the physician-patient relationship. Truthful disclosure, especially of “bad news,” however, does not mean that the bearer of bad news must be brutal or insensitive in the timing and manner of disclosure.

17. Define **therapeutic privilege**.

A traditional exception to the obligation of truthful disclosure to the patient, in which disclosures that were thought to be harmful to the patient were withheld for the benefit of the patient. In recent decades, this exception has narrowed almost to the vanishing point from the recognition that most patients want to know the truth and make decisions accordingly, even if the truth entails bad news. Nevertheless, some disclosures may justifiably be withheld temporarily, such as when a patient is acutely depressed and at risk of suicide. Ultimately, however, with appropriate medical and social support, the patient whose decisional capacity can be restored should be told the information that had been temporarily withheld for her or his benefit.

**CONFIDENTIALITY**

18. What is medical confidentiality?

The private maintenance of information relating to a patient’s medical and personal data without unauthorized disclosure to others. Maintaining the confidential status of patient medical information is crucial not only to trust in the physician-patient relationship but also to the physician’s ability to elicit sensitive information from patients that is crucial to adequate medical management and treatment. The Health Information Portability and Accountability Act (HIPAA, a federal statute) as well as most state statutes provide legal protections for patients’ personally identifiable health information (PHI), but the professional ethical obligation of confidentiality may exceed these minimal protections or apply in situations not clearly addressed by HIPAA or state statutes.

19. What are recognized exceptions to patient medical confidentiality?

- **Duty to warn** (Tarasoff duty): A basis for justifying a limited exception to the rule of patient confidentiality when a patient of a psychiatrist makes an explicit, serious threat of grave bodily harm to an identifiable person(s) in the imminent future. The scope of this warning is limited to the potential victim(s) or appropriate law enforcement agency, and the health care provider may divulge only enough information to convey the threat of harm.
• Reporting of communicable disease to public health authorities (but not others).
• Reporting of injuries from violence to law enforcement.
• Reporting of child or elder abuse to protective social service authorities.

20. **What is the obligation to veracity to nonpatients?**
Physicians are not obligated to lie to persons who inquire about a patient’s confidential information, but they may be required simply to decline to address such requests from persons to whom the patient has not granted access.

### DECISION-MAKING CAPACITY

21. **How do physicians assess decision-making capacity in patients?**
Whereas most adult patients should be presumed to have intact decisional capacity, some patients may be totally incapacitated for making their own medical decisions. Totally incapacitated patients will generally be obvious cases, such as unconscious or sedated patients. But decisional capacity is not an all-or-nothing category, so it is not uncommon for patients to have variable capacity depending on the status of their condition and the complexity of the particular decision at hand. Thus, one crucial aspect of assessing decisional capacity is to determine whether the patient can comprehend the elements required for valid informed consent to the particular decision that needs to be made. Patients with mood disorders, such as acute depression, however, may be incapacitated by their mood, even if they comprehend the information.

22. **What are common pitfalls in assessing patient decisional capacity or competence?**
If one uses the **outcome approach**, the patient’s capacity is determined based on the outcome of the patient’s acceptance of the physician’s recommendation. The physician may incorrectly assume that the refusal of a recommended treatment indicates incapacity. Refusal of a recommended treatment is not adequate grounds to conclude patient incapacity. Nor is patient acceptance of the physician’s best medical advice. If one uses the **status approach**, patients with a history of a mental illness or memory impairment may be considered incapacitated. Psychiatric conditions or other medical conditions that can result in incapacity may have resolved or may be under control with appropriate therapy that mitigates the condition’s impact on patient capacity for decision making. Patients with memory impairment or dementia may also be able to express wishes regarding treatment. Patients who can express a clear preference should have that expression seriously regarded as assent or dissent, even if an authorized decision maker makes the legally sufficient informed consent or refusal.

23. **What is the best approach to assessing patient capacity?**
The **functional approach**, which determines the patient’s ability to function in a particular context to make decisions that are authentic expressions of the patient’s own values and goals. Determining whether a patient is capacitated for a particular medical decision entails assessing whether the patient is able to:
• Comprehend the risks and benefits of the recommended intervention, risks and benefits of reasonable alternative intervention, and the risks and benefits of no intervention.
• Manifest appreciation of the significance of his or her medical condition.
• Reason about the consequences of available treatment options (including no treatment).
• Communicate a stable choice in light of his or her personal values.


24. **What is involuntary commitment?**
Assignment of a person to an inpatient psychiatric facility without patient consent when the appropriate criteria are met. These patients must be unable to provide informed consent owing to a mental illness and, owing to the same mental illness, pose a danger to themselves or to others. Similarly, patients who are seriously impaired by substance abuse may be involuntarily admitted to detoxification units or to longer term rehabilitation facilities.

25. **What are assent and dissent?**
Assent is the obligation prospectively to explain medical interventions in language and concepts the patient can comprehend even if the patient is deemed to be not capable of full informed consent, such as children or mentally impaired adults. The patient’s agreement is elicited, even though the final decision requires parental, guardian, or other legally authorized decision maker’s permission.
Conversely, dissent is the obligation to take seriously the refusal of children or mentally impaired adults when they are opposed to medical interventions or placements, unless the recommendations are so crucial to the patient’s well-being that their dissent must be overridden to avert serious deterioration or harm to their interests.

ADVANCE DIRECTIVES

26. What is an advance directive?
A generic term for any of several types of patient instructions, oral or written, for providing guidance and direction in advance of a person’s potential incapacity. The instructions and authorization in an advance directive do not take effect until the person loses decisional capacity and the advance directive ceases to be in effect if or when the patient regains capacity.

27. What are the types of advance directives?
Designation by a capacitated patient of the person the patient chooses to make medical decisions during any period when the patient is incapacitated, whether during surgery, temporary unconsciousness, or mental condition, as well as irreversible condition of lost decisional capacity. The decisions the designated person can make include withholding or withdrawal of treatment in life-limiting circumstances. This type may variously be called a “durable power of attorney for health care,” a “surrogate health care decision maker,” or a “proxy health care decision maker.”

A living will is a formal expression of a patient’s choices about end-of-life care and specifications or limitations of treatment, either with or without the naming of a person to reinforce, interpret, or apply what is expressed to the patient’s current circumstances.

28. Who are statutorily authorized next-of-kin decision makers?
If a patient has not made a living will or designated a person to make decisions during periods of patient incapacity, state statutes determine the order of priority for persons related to or close to the patient to assume the role of making medical decisions on the patient’s behalf. These are typically called “surrogates” or “proxies,” but they differ from decision makers designated by the patient in the way they are selected, and, in many cases, they bear a greater burden of demonstrating that they know what the patient would want.

29. What are the standards of decision making for those chosen either by the patient or by statute to make decisions for the incapacitated patient?
- **Substituted judgment**: The decision the patient would have made if she or he had not been incapacitated. In some cases, this will not be the same as what others may think is in the patient’s best interest.
- **Best interest**: Choosing what is considered most appropriate for the patient. If there is substantial uncertainty about what the patient would have chosen for herself or himself, then the traditional best interest standard is the appropriate basis for decision making.

END-OF-LIFE ISSUES

30. What are end-of-life care physician orders?
Orders that give direction regarding interventions at the time of death or cardiopulmonary arrest. Patient-directed measures such as advance directives or statutory next-of-kin decisions should be the basis for underlying medical decisions that entail informed consent or refusal issues at the end of life.

KEY POINTS: END-OF-LIFE ISSUES

1. Patients should be encouraged to discuss their wishes for end-of-life care with family members or close friends and physicians while still able to clearly express these wishes.
2. Forms such as Preferences of Life-Sustaining Treatment can designate the patient’s specific requests to accept or decline therapies at the end of life.
3. Patients are frequently unaware of the numerous, complex therapies related to end-of-life care and may not be able to write down what is wanted. Designation of a surrogate decision maker with whom the patient discusses her or his values and goals related to end-of-life care can also ensure the patient’s choices will be respected.
31. How are end-of-life care orders written?
   - **Do not resuscitate (DNR) or do not attempt resuscitation (DNAR):** An order written by the attending physician to prevent emergency cardiopulmonary resuscitation (CPR) for a patient who has refused CPR as a form of unwanted treatment. The decision of an incapacitated patient’s authorized decision maker may also be a basis for a written DNR order by the physician.
   - **Physician Orders for Life-Sustaining Treatment (POLST):** Similar to the concept of DNR, but broadened to include all aspects of end-of-life care based on the choices of the patient or authorized decision maker, including withholding or withdrawal of care and palliative measures. Many states now have statutory acknowledgment that a properly executed POLST form, signed by a physician, should be followed by all health care providers for the patient. Available at www.polst.org. Accessed October 27, 2016.

32. What is brain death?
   The term used to replace the traditional definition of death by cessation of heartbeat and respiration. In the legally operative definition of this term, it refers to whole brain death, cessation not only of higher cortical function but of brainstem function as well.

33. What is physician aid-in-dying?
   The provision of a lethal amount of a medication that the patient voluntarily takes to end his or her life. Oregon, Washington, California, New Mexico, and Vermont have established legislation to allow these prescriptions, and other states are considering the issue. Montana, based on court ruling, also allows physician aid-in-dying.

**Bibliography**