

Chapter 9

Clinical Ethics and Professionalism

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“As physicians, we see the worst and the best of people. At times, they are helpless and angry and make foolish decisions. But when confronting problems that are too large for them people often become heroes.”

Lo

The act of confronting problems, helping patients navigate their way through health, wellness, sickness, and dying, and trying to find a balance among conflicting values, beliefs, ethics, and morals can complicate the doctor–patient relationship. The doctor–patient relationship is complex and is built upon trust. That trust can be affected by many different factors, as discussed in Chap. 8. What happens when the ethical principles that create and strengthen the doctor–patient relationship conflict? In this chapter, we address many of the ethical principles that create a foundation for this relationship. Some of the principles that we explore include beneficence, acting in a patient’s best interests, and doing no harm. Balancing these principles with a patient’s right to make autonomous decisions to guide their own medical care, especially when a patient refuses a recommended treatment, can be difficult. Providing a patient with the appropriate information needed to make informed decisions and give consent to treatment can strengthen the trust held in the doctor–patient relationship, but giving insufficient information or not disclosing health information can harm that relationship, while at other times nondisclosure may be beneficial. Confidentiality is essential in maintaining a trusting relationship; however, there are times when those confidences may need to be broken. Lastly, acting justly and in an unbiased way and treating patients with respect is vital. But, what happens when a physician forms assumptions or biases towards their patient? How do we as

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© Springer International Publishing 2016
D. Alicata et al. (eds.), *Problem-based Behavioral Science and Psychiatry*,
DOI 10.1007/978-3-319-23669-8_9

health-care professionals continue to provide quality health care when we are struggling to find a balance between conflicting ethical principles?

9.1 Introduction to Clinical Ethics and Professionalism

Medical ethics is filled with cases that infuse your day with perplexing questions and sometimes even keep you up at night. Most physicians have experiences that, years later, still evoke crisp memories due to the ethical dilemmas faced. Ethical questions in health care are not unique to physicians, and it is clear that medical students have already begun to think about these issues even before matriculation to medical school.

How and when do you decide that a life is no longer worth living?

When can the decision be made that suffering or pain or lack of any further effective treatment outweighs the precious gift of a person's life?

Why must a physician act in their patient's best interest even to their own personal or financial disadvantage?

Why must physicians act in their patient's best interest even if those actions may put the physicians themselves at personal risk?

Why must our patients' confidences be held in the strictest sense?

This chapter will provide a foundation with which to approach these dilemmas and will review the introductory ethical principles that will help guide your decisions. In some cases, it may seem that an obvious course of action has to be taken, but in most, there is an equally compelling argument to a different course of treatment, action, or plan. It is the goal of this chapter to give an introduction to clinical ethics and professionalism challenges that can, in turn, help patients struggling with these issues by giving a framework and guidance to students and future physicians in helping to resolve these hard cases that keep us up at night.

As a doctor you are allowed into the most intimate and important moments in a person's life. From an infant being born, personal secrets, true fears, to a loved one's death, your patients will allow you to see them at their most vulnerable. Your words have the power to change someone's life...As a relative stranger, you automatically become a most trusted confidant just by your title. (Shah 2011)

Patients and society hold physicians to a high professional standard, one that may be too high for any human to meet. This standard though is commensurate with the level of intimacy and trust that must exist between a patient and a physician.

We hope to provide you with the tools needed to begin to think about ethically or professionally difficult situations, how to work with your patients in order to establish a strong rapport and trusting relationship so you can best help to guide them through these dilemmas, and to develop confidence in your decision-making. After all, when the philosophic debates are over, a decision must be made and a physician must act.

"In medical care, dilemmas can not merely be contemplated, they must be resolved" (Jonsen et al. 2006).

By the end of the chapter, the reader will be able to:

1. Illustrate the importance of the study of ethics to clinical practice
2. Introduce the approach of using clinical cases to evaluate, discuss, and resolve ethical dilemmas
3. Define and describe the ethical principles of respect for persons, non-maleficence, beneficence, and justice
4. Evaluate the dilemmas that may occur when these principles conflict
5. Understand the relationship between informed consent and autonomy
6. Understand the professional's contract with society
7. Describe the ethical, legal, and professional standards that give rise to patient rights to privacy and confidentiality and the duties to maintain privacy and confidentiality

Vignette 9.1.1 Presenting Situation: Ann J.

A long-time patient of yours, Ann J., is coming in today to discuss the results of her tests and scans. Ann is a 52-year old who has managed to avoid the typical health problems of her peers through a health-conscious lifestyle. She is postmenopausal and has never been on hormone replacement therapy (HRT). She is well educated, reads up on current health issues, and sees you only for recommended checkups, flu shots, and the occasional sinusitis. A couple of weeks ago, she noticed a lump in her right breast while showering.

Mammogram shows a BI-RADS 4 lesion; a subsequent core needle biopsy confirms an estrogen receptor (ER) + ductal carcinoma. Ann comes in with her husband, apprehensive that you asked for an office visit rather than just giving her results in a phone call. After you confirm that she does in fact have stage II breast cancer, you discuss treatment options and the necessary referrals, arrangements, and benefits/risks for those treatment options, including side effects and likely survival rates. You recommend that Ann be referred to a breast surgeon and an oncologist for a lumpectomy and radiation. Given that her tumor is ER positive, you tell her that the oncologist may recommend that she be on tamoxifen for several years after the tumor is removed. Ann is understandably stunned and overwhelmed by all of the information you just gave her, but you assure her that you will be there for her and are willing to try to answer any questions she might have.

Ann sees the breast surgeon and an oncologist, who recommend lumpectomy and radiation followed by at least 5 years of tamoxifen. She agrees readily to the lumpectomy; however, she has done some research of her own. She and her husband are opposed to her taking unnatural, laboratory-produced chemicals or radiation into her body; they feel that her excellent health to this point has been secondary to her avoidance of such things. She has looked into an alternative natural herbal therapy offered by a physician out of the country. Her insurance will not pay for this treatment; however, she has the means and desire to pursue this treatment on her own. She contacts you to advise you of her plans and asks if you would be willing to research the alternative treatment for her before she goes.



Please proceed with the problem-based approach using the worksheet located in the appendix of Chap. 1!

Table 9.1.1

FACTS	HYPOTHESES	INFORMATION NEEDED	LEARNING ISSUES

9.2 Learning Issues

9.2.1 *Basic Medical Ethics Terms*

Beneficence:

The obligation of a clinician to provide medical care that benefits their patient (Jonsen et al. 2006). Risks as well as benefits to the patient should be considered, and only treatment that provides a net benefit to the patient should be performed (Lo 2013).

Non-maleficence:

The obligation of a clinician to avoid providing medical interventions that cause harm to their patient, also referred to as “do no harm.” The concepts of beneficence and non-maleficence should be considered together.

9.2.2 *Medical Decision-Making*

The way that treatment and medical decisions have been made has evolved throughout the past 50 years. These medical decision-making modalities often involve trying to find a balance between beneficence and non-maleficence, as well as the concepts of paternalism and autonomy. Historically paternalism was the dominant model and the way that most physicians practiced. Paternalism is best described by the old adage “the Doctor knows best.” It is the concept that a person in authority knows best, and therefore their opinion can/should override the patient’s preferences. In paternalism, beneficence is valued over autonomy (Jonsen et al. 2006). In the 1960s and 1970s, however, with societal and social changes, patients began to demand more involvement in the medical decision and choices that were made regarding their own bodies, and what is known as the “Age of Autonomy” began.

Autonomy, taken literally, means “self-rule” (Lo 2013). And autonomous decision-making refers to a physician’s duty to respect a patient’s preferences (Jonsen

et al. 2006). Autonomy requires that a patient is, first, informed and, second, can then act on that information and make a decision regarding their treatment plan.

In recent years, a new model of decision-making has emerged—shared decision-making. Shared decision-making combines paternalism and autonomy and involves dialog between physician and patient to make a decision together. In an ideal situation, a clinician gives the patient all of the medical information necessary for the patient to make the best, informed decision for themselves, but, additionally, the physician gives the patient their recommendation as to the medical treatment option that they feel would be best for that patient. The clinician should take into account what they know of the patient’s values when giving their professional opinion (Jonsen et al. 2006). Shared decision-making does not necessarily mean that both parties are in perfect agreement; however, it is the clinician’s obligation to do their best to ensure that their patient is well informed and allow the patient to participate in and direct their treatment choices.

9.2.3 *Refusal of Medical Treatment*

Ann is an example of an informed patient who is choosing not to follow the advice of her physicians. Her physician researched treatment options and gave Ann as much information possible regarding her treatment options, as well as a recommendation for what he felt was in her best interest, but Ann exercised her right to make an autonomous decision regarding what she was willing and not willing to put into her body. A physician who respects her autonomy should respect Ann’s right to make this decision. While there may be times that a physician feels that a patient is making an unwise or bad decision, adults of sound mind may exercise their right to make such a decision.

Vignette 9.1.2: Continuation

You take some time to research ER + breast cancer treatments; however, the majority of the information available with regard to the treatment Ann wishes to utilize is either provided by the treatment center or anecdotal in nature. Given the lack of peer-reviewed clinical research with regard to this treatment, you tell Ann that you are not able to recommend the alternative treatment at this time. You advise her to follow the recommendations of her oncologist and inform her that the studies you found supported the oncologist’s recommendations. Ann thanks you for your time, but tells you that she will be leaving the country within the week to obtain the alternative treatment, and she will be looking for a primary care physician who is more on board with alternative medicine. A few days later, your staff notifies you that another physician has requested her records.

Nine months later, you are the attending on the hospital rotation, and Ann is admitted for altered mental status and shortness of breath (SOB). Computed tomography (CT) scans show a single large lesion in Ann’s frontal lobe

and multiple smaller lesions in Ann’s lungs and liver; it appears that her breast cancer has metastasized. Ann is not able to make decisions for herself given her altered mental state, but her husband is desperate to have any and all treatments given to his wife. He is sure that resection of the brain lesion accompanied by radiation and treatment with tamoxifen will result in a return of her mental function and shrinkage of the lung and liver lesions with an ultimate cure. Neurosurgery is consulted; their note states that “surgical resection of Mrs. J.’s brain tumor, given the multiple metastases seen on CT, is futile and not worth the inherent risk of the procedure.” Ann’s husband is understandably upset and demands that you explain how any treatment that would prolong her life could be futile.



Please proceed with the problem-based approach using the worksheet located in the appendix of Chap. 1!

Table 9.1.2

FACTS	HYPOTHESES	INFORMATION NEEDED	LEARNING ISSUES

9.3 Learning Issues

9.3.1 Futility

Futility has multiple meanings; the simplest of which is termed physiologic futility, which occurs when there is a physiologic impossibility that medical intervention will be effective. Ethically more difficult definitions include probabilistic futility. This is defined as an effort to provide a benefit to a patient, which reason and experience suggest is highly likely to fail. Finally, qualitative futility is the judgment that the goal that might be attained is not worthwhile. Considerations of these latter definitions of futility may include factors such as likelihood of success, quality of life, and use of resources (Jonsen et al. 2006; Lo 2013).

In Ann’s case, the neurosurgeon made a decision of probabilistic futility. In his experience, he felt that surgery was likely to fail. In his despair, Ann’s husband was requesting medical treatments that to our knowledge are inconsistent with her beliefs, wishes, and goals of care. Are her previous preferences important in knowing how to proceed with her case?

9.3.2 *End-of-Life Decision-Making*

Ideally, a well-informed patient makes their own decisions about end-of-life care. However, many patients have not and/or would not like to think about end-of-life issues, such as resuscitation, artificial respiration, fluids and nutrition, and withdrawal of life support. It is important for a clinician to explain to their patient what these interventions will be like for them and the risks/benefits associated with each intervention. Unless a patient has indicated their wishes with regard to end-of-life care, the patient may receive interventions that they would not otherwise desire. Advanced directives are a legal means for patients to express their wishes regarding end-of-life care and can speak for a patient after the patient is no longer able to speak for themselves. Without an advance directive, a patient's loved ones are required to make those decisions for them.

Vignette 9.2.1 Presenting Situation: Mr. Jones

You are working on the hospital wards on a Saturday when a patient comes in. Mr. Jones is a 72-year-old male patient with a past medical history of chronic obstructive pulmonary disease (COPD) and no other diagnosed medical conditions, largely due to the fact that he has never really sought medical care before. He presents with chest pain and describes the pain as a feeling of heaviness and pressure that spreads across his chest and up into his jaw. The pain has been occurring with activity for several weeks but has occurred at rest for two nights this past week. He has an impressive smoking history: He has smoked >2 packs per day since he was 15 years old. He quit smoking 7 years ago when he was diagnosed with COPD but has not had any further medical treatment since that time. The electrocardiogram (EKG) is largely normal, and troponins are negative; however, the resting angina is concerning for acute coronary syndrome. You consult the cardiologist, who recommends that the patient go for angiogram and possible stenting. You happen to be outside the room when the cardiologist's staff obtains consent from your patient for the procedure, and you notice that none of the major complications of catheterization are mentioned: myocardial infarction (MI), stroke, or even death. In fact, the procedure is not explained well; it is explained to the patient as a very minor procedure that is necessary to prevent death. After the consent form is signed, you go in to talk to your patient; he is very concerned. He asks you if there is any way that medicine could be tried prior to angiogram and/or stenting. "Is this procedure really safe? Is there any chance I could die?"



Please proceed with the problem-based approach using the worksheet located in the appendix of Chap. 1!

Table 9.2.1

FACTS	HYPOTHESES	INFORMATION NEEDED	LEARNING ISSUES

9.4 Learning Issues

Informed Consent “The willing acceptance of a medical intervention by a patient after adequate disclosure by the physician of the nature of the intervention with its risks and benefits and of the alternatives with their risks and benefits” (Jonsen et al. 2006).

Informed consent does not consist of simply getting a signature on a piece of paper authorizing consent for a procedure. Rather, informed consent is a process; one in which the treating physician presents the relevant facts and information regarding a recommended treatment or procedure to a competent patient so that the patient can make a voluntary choice to accept or refuse treatment. In this process, the physician explains the recommended procedure along with the risks, benefits, and alternatives that accompany the procedure, thus allowing the patient’s decision to be an informed one. The patient then shows that they have an understanding of the information presented, assesses the treatment choices, and expresses a preference for one of the options proposed by the physician, either giving informed consent or refusal.

The notion of informed consent originates from the legal and ethical right the patient has to direct what happens to their body and from the ethical duty of the physician to involve the patient in their health care. This can be seen in early court cases dating back to the early 1900s.

“Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault for which he is liable in damages” (Schloendorff v. Society of New York Hospitals 1914).

Legal Versus Ethical Requirements for Informed Consent

The legal intention of informed consent documentation is to protect patients from unwanted medical procedures or treatments. The ethical intention of obtaining informed consent is to enable the patient to define their own treatment goals and to protect the patient’s autonomy (Hall et al. 2012).

Required Components to Informed Consent

It is difficult to find any single measure of what is required in a conversation obtaining informed consent; however, most agree on the following five basic elements that should be included in the discussion: diagnosis, treatment, risks, and benefits of the treatment; alternative treatments with their risks and benefits; as well as the risks and benefits and expected outcome for a patient if they were to opt for no treatment at all.

Standards for Obtaining Informed Consent

Legal standards for obtaining informed consent and how much information needs to be disclosed in order to inform a patient varies from state to state, and every clinician should be aware of the required components specific to where they work. However, there are some general standards that all physicians should be aware of. In years past, most states used the *reasonable physician standard*: What would a reasonable and prudent physician tell a patient (regarding a specific treatment or procedure)? Today most state laws have changed their requirements to the *reasonable patient standard*: What information would a reasonable patient need to know to make a rational decision? Taking these standards one step further is the *subjective standard or individual preference standard*. This would involve a patient being informed on the basis of his individual attitudes/beliefs/culture/lifestyle/goals of care. The information provided is specifically tailored to a particular patient's need for information and understanding. This standard requires that the physician get to know their patient reasonably well enough to know some of their preferences, beliefs, values, and goals. For example, while a 0.001 % change of numbness and decreased mobility of the patient's pinky finger following a procedure may not be a risk factor that would be important to mention to most patients, if the patient is a world famous concert pianist, using the subjective standard, it may be a risk that needs to be discussed. While the reasonable patient standard may be legally and ethically sufficient, the subjective standard is ethically ideal.

Vignette 9.2.2: Continuation

Mr. Jones obtains an angiogram that shows too many stenosed regions to reasonably place any stents. A quintuple bypass is performed the next day, your day off, and when you come back, Mr. Jones is in the intensive care unit (ICU) recovering from his open-heart surgery. Over the next several weeks, due to his underlying COPD, Mr. Jones is having a difficult time coming off the ventilator, and, out of necessity, has been sedated. All attempts at weaning him off the ventilator have been unsuccessful. Mr. Jones will need a tracheostomy; however, Mr. Jones is unable to consent to any further procedures.



Please proceed with the problem-based approach using the worksheet located in the appendix of Chap. 1!

Table 9.2.2

FACTS	HYPOTHESES	INFORMATION NEEDED	LEARNING ISSUES

9.5 Learning Issues

9.5.1 *Informed Consent and Surrogate Decision-Makers*

If a patient lacks decisional capacity or becomes incapacitated and is not able to speak for themselves, most states have specific laws specifying who the patient's surrogate decision-maker should be. Traditionally, a patient's spouse is the first surrogate, followed by members of the patient's family: adult children, parents, siblings, and then sometimes will continue to extended family members, friends, or neighbors. If a patient does not have available next of kin, a guardian can be appointed by the court. In all cases, the surrogate is to act in accordance with the patient's wishes, if known (Jonsen et al. 2006).

9.5.2 *Informed Consent and Emergencies*

As may often occur in an emergency situation, a patient may not be able to give consent, and/or there is not sufficient time to obtain informed consent. In those situations, where a delay in treatment could cause severe disability or even death, it is acceptable for clinicians to presume that the patient would give consent if given the opportunity.

Vignette 9.2.3: Conclusion

Several days after the tracheostomy, Mr. Jones is finally weaned off the ventilator. He is extremely weak and very anxious about the length of time it is taking him to recover and worries about how he will manage at home. You try to reassure him by telling him that home health nursing services can be provided to help him with any of his daily needs. He continues to have difficulty breathing and requires supplemental oxygen, but breathing treatments seem to give him some relief.

Several more weeks later, Mr. Jones is finally discharged. You arrange for home health to come and check on him daily for a few weeks. Two days following discharge, Mr. Jones presents at the emergency department (ED) with SOB and hypoxia. A complete workup reveals that Mr. Jones now has pulmonary edema secondary to congestive heart failure (CHF), and additionally continues to suffer from his preexisting COPD. Mr. Jones’s son requests to speak to you privately about Mr. Jones’s prognosis prior to disclosing it to his father. You have a long discussion with Mr. Jones’s son about the newly diagnosed CHF and his prognosis. His son is understandably upset at this turn of events. He asks about treatment and palliation options. You describe in detail the medical management of CHF along with best and worst case prognoses. At the end of your discussion, Mr. Jones’s son implores, “Please don’t tell him about this. Dad was having a tough time before all of this happened, and I’m afraid that after hearing the worst case scenario you just described, he might just lose any hope for recovery and will have no motivation to take the medications you prescribe. If you tell him about his condition like you just told me, it would be the same as killing him—it would take away his will to live. Maybe you could just tell him the best case scenario and really stress to him that the medications will help?”


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Table 9.2.3

FACTS	HYPOTHESES	INFORMATION NEEDED	LEARNING ISSUES

Ethics of Nondisclosure—Arguments Both for and Against

In their article addressing therapeutic privilege, Richard et al. (2010) argue that there is an inherent ambiguity present in full disclosure: In respecting the patient’s right to the truth and autonomy by fully informing the patient, there is a risk of increasing the suffering of the patient, thus violating the principle of beneficence. They propose a process whereby the benefits of nondisclosure or the disclosure of biased, partial, or altered information is viewed in the context of minimizing the patient’s suffering and/or increasing the patient’s overall well-being. In the situation with Mr. Jones above, this would entail the clinician asking themselves whether nondisclosure would prevent suffering and then further exploring whether the benefits of nondisclosure outweigh the consequences of withholding the truth. The clinician also needs to consider other courses of action and whether the patient would consider the withheld and/or altered information to be important.

However, as mentioned previously, the doctor–patient relationship is one based largely on trust—the physician is “one who owes to another the duties of good faith, trust, confidence, and candor” (Edwin 2008). Ethically, Edwin argues that the patient’s right to autonomy, obligations of fidelity, and the need for trust in the doctor–patient relationship override any argument for nondisclosure (Edwin 2008). Indeed, “trust is fundamental to a moral community and arguably ‘the fundamental virtue at the heart of being a good doctor’” (Stirrat and Gill 2005). It is impossible for this trust to be built on untruthfulness. In addition, the argument that full disclosure might upset the patient and impair their ability to make a truly informed decision is flawed, as people will get upset throughout their lives, but this does not mean that they are unable to make a rational decision. Edwin also argues that the assumption that the patient would not like to know the full truth is paternalistic and should therefore be rejected out of hand.

In the case of Mr. Jones, as well as many other similar cases, perhaps a good option might be to ask Mr. Jones how much information he would like to have regarding his illness, prognosis, and treatment options, thus giving him the autonomy to still direct his medical care as much or as little as he desires.

Vignette 9.3.1: Mr. L.

Mr. L. is a 43-year-old male who presented to the ED due to a prolonged unrelenting cough that has recently worsened to hemoptysis. Chest X-ray (CXR) showed a cavitory lesion in the left upper lobe. A sputum sample is sent for acid-fast-bacillus (AFB) smears, and he is presumptively diagnosed with tuberculosis (TB).

Further history reveals that he is currently homeless after the factory he was working in closed just over a year ago. He has been living in various shelters and out of his car, and on occasion with various friends and acquaintances. He has been able to pick up a few odd jobs working as a handyman but has not been able to find any steady work. The ED physician discusses with Mr. L. his diagnosis of TB and the course of treatment that will be required. Mr. L. voices concern over his inability to pay for his medications, particularly because he will need to take medication for 9 months. He does not have a primary care doctor. The social worker comes to meet with him and gives him information about other shelters and places to stay, as well as sets him up with the county TB clinic where he will be able to receive his medications for directly observed therapy (DOT) daily and can follow up with the doctors there with regards to his treatment. He is given his first dose of medications and is discharged from the ED with an appointment at the clinic next morning.

After his discharge, the medical student who was observing the case asks the attending, “How contagious is TB exactly? Do other people who were in the ER tonight including health-care workers need to be concerned about possible exposure? Furthermore, do the shelters where he has been living need to be notified or the friends that he has stayed with? And if the shelters are notified will that make it more likely that he will be turned away and will not have a roof over his head?”


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Table 9.3.1

FACTS	HYPOTHESES	INFORMATION NEEDED	LEARNING ISSUES

9.6 Learning Issues

9.6.1 Confidentiality and the Doctor–Patient Relationship

Confidentiality refers to prevention of disclosure of information that has been provided to the physician and/or other health-care entities by the patient to other parties. Confidentiality is a cornerstone to the doctor–patient relationship and is a longstanding tradition in medicine. Patients reveal sensitive personal information to their health-care providers, including information about emotional problems, drug use, and sexual activity. Keeping this information confidential not only shows respect for patients, it engenders more beneficial treatment for the patient, as the patient will be encouraged to seek medical care and to freely disclose sensitive matters related to their illness. Confidentiality can also help prevent discrimination and/or stigmatization of people with certain medical conditions. Confidentiality is not only an ethical obligation but it is also mandated by state and federal law. However, it is important to remember that while confidentiality is a vital and extremely important aspect of the doctor–patient relationship, confidentiality is not an absolute right. The discussion of confidentiality in the health-care field often focuses on what and when a physician can disclose to third parties.

9.6.2 Legal Requirements of Maintaining Confidentiality

The Health Insurance Portability and Accountability Act (HIPAA) was enacted by the US Congress in 1996. There are many different parts to this act including provisions protecting health insurance coverage for people after losing their jobs and established national standards for electronic health-care transactions. It was one of the first of its kind protecting insurance coverage for people with preexisting medical conditions. But one of the most well-known aspects of HIPAA was that it mandated that the federal government issue health privacy regulations and address the security and privacy of health data. These regulations documented in the HIPAA

Privacy Rule are what most people commonly know as Health Insurance Portability and Accountability Act (HIPAA) regulations.

The HIPAA Privacy Rule involves federal regulations that regulate the use and disclosure of protected health information by virtually all health-care service providers. It requires that health-care providers and businesses that have access to health information protect patients' health information.

In most cases, health-care providers must obtain a patient's written authorization prior to use or disclosure of their health information, with some specific exceptions. HIPAA regulations are not meant to impede access to information that is necessary to provide quality patient care. Patient authorization is not required to use or disclose information for facilitating medical treatment, obtaining payment, and improving health-care operations such as quality improvement, quality assurance, outcome assessments, or educational purposes. However, when in the above instances, any health information is disclosed, every reasonable effort needs to be made to disclose only the minimum necessary information required to achieve its purpose.

It is also important to note that the law may hold physicians liable for unwarranted disclosure of medical information. It provides for civil and criminal penalties for noncompliance.

Vignette 9.3.2: Continuation

The following morning, Mr. L. presents to the county clinic for his DOT. He continues to promptly report daily for 10 days. The last couple of days he has complained to the nurse that he has been having stomachaches, occasional vomiting, and headaches, and he has voiced concerns that these symptoms may be a side effect of his medication. He has also become increasingly upset about these daily appointments, stating that having to drive across town every single day is causing his gas usage to significantly increase. The clinic nurse addresses and treats some of the side effects that he seems to be having, and enrolls him into an incentive program that helps pay for his gas expenses if he continues to show good compliance with the program for one more week. The next day, however, he does not show up for his appointment. The nurse notifies the doctor in charge at the clinic, who decides to give him one to two more days to re-present for his medications. Three days later, he still has not returned for his treatment medication, and the hospital laboratory calls to notify the clinic that Mr. L.'s test results came back. He is not only positive for AFB but it is also a multidrug resistant strain.

The health department is notified, and they begin trying to find Mr. L. in order to resume his treatment and also to notify close contacts of their potential exposure.



Please proceed with the problem-based approach using the worksheet located in the appendix of Chap. 1!

Table 9.3.2

FACTS	HYPOTHESES	INFORMATION NEEDED	LEARNING ISSUES

9.7 Overriding Confidentiality to Protect Others

The ethical principle of non-maleficence requires both patients and physicians to avoid harming other people and prevent harm to others. A patient’s right to confidentiality can at times be justifiably overridden by the right of other members of society to be protected. In general, violating a patient’s confidentiality is justifiable when the potential harm to third parties is serious, the likelihood of harm occurring is high, there is no alternative for warning or protecting those at risk, breaching confidentiality will prevent harm from occurring, and harm to the patient (by breaching confidentiality) is minimized (Lo 2013).

In some situations, physicians are required by law to break confidentiality in order to report the name of a patient to appropriate public health officials. Physicians, hospitals, and laboratories are required to report specific infectious diseases to public health officials. The diseases that mandate reporting vary by state but most often include highly transmissible infectious diseases such as TB, gonorrhea, chlamydia, syphilis, HIV or AIDS, influenza, and some enteric pathogens.

Aside from infectious diseases and the threat that they pose to maintaining public health, there are several other situations in which confidentiality may be breached to protect others. These include providing warning to persons at risk of being harmed by a patient, wounds and injuries secondary to a weapon or incurred in the course of a crime, conditions that impair a patient’s ability to drive, and abuse (child, elder, domestic; Jonsen et al. 2006; Lo 2013; Bourke and Wessely 2008).

Vignette 9.3.3: Conclusion

Due to the severity of having a multidrug resistant strain, the health department felt it was of utmost importance to locate Mr. L., and consequently, when notifying the most recent shelter where he has stayed, they did not keep patient identification confidential and simply notified them of possible exposure and the need to have all contacts tested. They revealed Mr. L.’s name along with a description of his appearance, as well as the nature of his disease. Unfortunately, the shelter director stated that she had not seen Mr. L. in several days,

but she had overheard him talking to some other occupants of the shelter that he was thinking about driving to another state to try to find work. The director of the health department decided that more significant actions needed to be taken in order to find Mr. L. and restart his treatments. He therefore took out an advertisement in the local newspaper as well as ran a segment on the local news showing a picture and the name of Mr. L., pleading to the general public to help locate this man, as he has a potentially deadly, very serious disease.

The next morning the clerk at a motel in a neighboring state called the health department stating that she thinks that the man who was on the news is staying at her motel. The police are called and they escort Mr. L. from his motel room to the nearest hospital. At the hospital, an angry Mr. L. insists that the doctor discharge him, and when the doctor refuses to do so stating that he will be held isolated in the hospital in order to ensure treatment, Mr. L. states that his “constitutional rights” have been violated and he plans on suing the health department for breach of confidentiality when they released his name and diagnosis over the television, as well as suing the hospital for holding him against his will.



Please proceed with the problem-based approach using the worksheet located in the appendix of Chap. 1!

Table 9.3.3

FACTS	HYPOTHESES	INFORMATION NEEDED	LEARNING ISSUES

In recent years there have been several instances involving isolation or quarantine of individuals with contagious illnesses. Specifically this was seen during the severe acute respiratory syndrome virus (SARS) epidemic, cases of multidrug resistant TB, and most recently with the Ebola virus. Additionally, this can and may be seen with the concern for the use of infectious agents for bioterrorism. The use of quarantine and isolation, particularly when done forcibly and against someone’s will, can be ethically problematic. Some feel that quarantine measures are necessary in order to protect public health and are essential to prevent and control communicable disease spread; however, others believe that it violates a person’s right of liberty, self-determination, and autonomy. The American Medical Association has developed a report addressing this particular issue (American Medical Association 2006). In this report they state, “The medical profession, in collaboration with public health colleagues, must take an active role in ensuring that those interventions are based on science and are applied according to certain ethical considerations.” Their recommendations for the medical profession are as follows:

- “Seek an appropriate balance of public needs and individual restraints so that quarantine and isolation use the least restrictive measures available that will minimize negative effects on the community through disease control while providing protections for individual rights.”
- “Help ensure that quarantine and isolation are based upon valid science and do not arbitrarily target socioeconomic, racial, or ethnic groups.”
- “Advocate for the highest possible level of confidentiality of personal health information whenever clinical information is transmitted in the context of public health reporting.”
- “Advocate for the availability of protective and preventive measures for physicians and others caring for patients with communicable diseases.”
- “Encourage patients to voluntarily adhere to scientifically grounded quarantine and isolation measures by educating them about the nature of the threat to public health, the potential harm that it poses to the patient and others, and the personal and public benefits to be derived from quarantine or isolation. If the patient fails to comply voluntarily with such measures, the physician should support mandatory quarantine and isolation for the non-compliant patient” (American Medical Association 2006; Bostick et al. 2008).

Vignette 9.4.1 Presenting Situation: Pat

Pat is a 37-year-old patient who presents to your office to establish care with you as a new primary care physician. The patient was approximately 20 min late for the appointment today. Medical history includes obesity, high blood pressure, diabetes, and chronic lower back pain. The patient reports no new complaints and that the appointment was made primarily because of a need for a refill of pain medications. Social history reveals that the patient is a current smoker (two packs per day), drinks daily, denies illicit drug use, is unmarried, but lives with a significant other of 3 months in the motel down the street. The patient does not currently work and reports to be on disability. New primary care is being sought because “my last doctor and I didn’t really see eye to eye.”



Please proceed with the problem-based approach using the worksheet located in the appendix of Chap. 1!

Table 9.4.1

FACTS	HYPOTHESES	INFORMATION NEEDED	LEARNING ISSUES

9.8 Learning Issues

9.8.1 *Drug-Seeking Behaviors and the Ethics of Continuing Their Care*

It is important (and often difficult) to assess if a patient is actually drug seeking versus seeking relief from increasing pain. Further complicating this assessment is the frequent overlap between patients with genuine pain issues *and* coexisting medication misuse. As a health-care provider, it is imperative that you do not facilitate a drug habit; however, it is equally vital that you address any legitimate pain your patient is having. Indeed, pain is a common reason for patients to seek health care. Pain agreements are a way to equitably manage pain issues with patients. Components of a pain agreement may include an agreement to avoid improper use of pain medications, agreements to only obtain pain medication from one provider (you), limitations on replacing medication, agreement for random drug screening, appointment terms, and terms for disciplinary termination of the pain contract (Fishman et al. 1999). As physicians can be liable for both facilitating a drug habit *and* for failure to address a patient's medical issues, a pain contract may help protect them legally. It is important, however, to have equal implementation and enforcement of pain contracts in order to avoid bias. Many patients with uncontrollable chronic pain could benefit from a referral to a pain management clinic, if one is available.

9.8.2 *Making Judgments*

Physicians are taught to assess patients and to use their clinical judgment. As a clinician's judgment plays a significant role in the treatment that each patient ultimately receives, clinicians should recognize that all patients deserve responsible clinical judgment. Responsible clinical judgment does not stem from visceral, knee-jerk reactions to a patient, rather it is deliberative. Clinicians must be careful to avoid "snap" judgments with regard to a patient's race, ethnicity, background, or any other irrelevant characteristic (McCullough 2013).

9.8.3 *Justice Issues that Come from Making Assumptions*

Because there are many potential justice issues that can stem from clinical assumptions, it is vital to make every attempt to take a thorough and objective clinical history and to perform an appropriate physical exam relevant to the patient's complaint. Forming a treatment plan based on subjective assumptions rather than more objective assessments can result in an inappropriate treatment plan. For example, an assumption that a patient is unreliable can deny the patient appropriate, albeit

more complicated treatment. An assumption of a patient’s motives (such as labeling a patient as just seeking pain medication, as in this case) can deny the patient appropriate and needed treatment. An assumption about a patient’s assets and access to health-care resources may result in a patient not being notified of resources available to them. Assuming that a patient will not comprehend technical information about their condition can result in a patient making a less informed treatment decision. At its worst, an assumption about a patient can cause a clinician to dismiss vital physical complaints. Physicians should attempt to refute or confirm their assumptions, prior to any negative impact that can occur with regard to medical decision-making. Clinicians must learn to skillfully navigate the fine line between clinical judgment and assumption (Rhodes 2005).

Vignette 9.4.2: Continuation

Feeling somewhat rushed and irritated by the fact that he was late to his appointment, you hurry through your history, skipping over the nonessential parts such as the social history, and move on to do a quick physical examination. When examining his back, you see a large tattoo and shake your head. As you continue your exam, you come across another tattoo on his upper arm. This one catches your eye, and you notice it is a military rifle, standing upright on the ground next to a pair of soldier’s boots and a helmet resting on the end of the rifle.

Further discussion with him reveals that he is a veteran of the US Army where he was a lieutenant. He was wounded while in Afghanistan when an improvised explosive device (IED) was detonated near the vehicle he was in. Two of the four occupants were wounded severely, while the other two died. All were under his command. He suffered a significant back injury, which has left him in chronic pain. Since leaving the army, he has been seeking a job and is excited that he has an interview the next day for a position for which he can use his degree in communications. He is somewhat nervous about the interview, though, since he travels by public transportation and does not want to be late.



Please proceed with the problem-based approach using the worksheet located in the appendix of Chap. 1!

Table 9.4.2

FACTS	HYPOTHESES	INFORMATION NEEDED	LEARNING ISSUES

9.9 Learning Issues

9.9.1 *How Perception of Patients, Misconceptions, and Stereotypes Affect Patient Care*

Fiester (2012) states that anywhere from 15–60% of patients are deemed “difficult” patients; patients with more complaints or conditions (this patient in this vignette had multiple) are more likely to be deemed “difficult” by their health-care provider. Interestingly, however, it is physicians who score lower on empathy scales that are more likely to perceive patients as difficult. At a glance, the patient described above could be described as difficult, especially given his less than amicable separation from his previous health-care provider and his stated purpose of seeking narcotics. How would this patient’s care have been affected if the provider had not noticed his military-related tattoo and assumed the worst? Patients often complain that doctors do not listen to them; clinicians need be aware of their preconceived perceptions and utilize listening skills that will help clinical facts overcome these preconceived perceptions (Fiester 2012).

9.9.2 *All-Around Review of the Doctor–Patient Relationship and Professional Interactions*

The doctor–patient relationship is one of implicit trust; it is the obligation of the clinician to provide appropriate treatment in a manner that respects the patient as a person and acts in the patient’s best interest, all while utilizing health-care resources appropriately. The clinician is obligated to respect a patient’s autonomy, treat patients with empathy and dignity, keep confidences, avoid deceiving their patients, and to be of their word. Treatment plans should be guided by the best interests of the patient and tempered with judicious allocation of limited health-care resources (Lo 2013). Please refer to Chap. 8 for further discussion of the doctor–patient relationship.

9.10 Review Questions

1. Your patient refuses to comply with a recommended treatment regimen due to concerns of potential side effects and the belief that alternative treatment modalities will be as effective as the ones prescribed by you. In respecting their decision to pursue alternative treatments you are respecting their right to:
 - a. Practice paternalistic medicine
 - b. Make autonomous decisions
 - c. Justice and equality in health care
 - d. Confidentiality and adherence to HIPAA regulations

2. *Short answer:* The differences between legal and ethical standards for informed consent are:
3. *True or false:* Confidentiality is an important component to the doctor–patient relationship but is only an ethical obligation. It is not legally required of physicians.
4. *Short answer:* What are some things that you as a health-care provider can do in order to try to prevent yourself from falling into the trap of forming biases or opinions about a patient that could adversely affect the care that they receive from you?

Appendix A: Tables with Possible Vignette Answers

Table 9.1.1: Ann J.

Facts	Hypotheses	Information needed	Learning issues
Previously healthy, postmenopausal 52-year-old woman	Given Ann’s history of living a very natural lifestyle and her belief that her health until now has been attributed to avoidance of chemicals and toxins, Ann will not agree to radiation, tamoxifen, or chemotherapy if they were indicated	What are the survival rates for stage II breast cancer with the recommended treatment?	What is beneficence and non-maleficence?
ER + stage II breast cancer	Ann will refuse most offered standard medical treatments	What are the survival rates for no treatment at all?	What is a physician’s obligation to their patient regarding researching alternative treatments?
Well educated		What is the alternative treatment that she is seeking?	How can medical decisions best be made?
Recommended to have lumpectomy, radiation, and tamoxifen		How much data and research has been done on this treatment?	What are paternalism, autonomy, shared decision-making?
Opposed to taking chemicals or radiation			Is there a difference in physicians’ legal vs. ethical duties towards informing their patient about treatment options?
Wants to pursue alternative treatments and has the financial means to do so			

ER estrogen receptor

Table 9.1.2

Facts	Hypotheses	Information needed	Learning issues
Ann's breast cancer has progressed and metastasized due to her lack of standard treatment	If a surgeon or physician feels that an intervention is futile, they cannot be forced to operate	What now are the survival rates for widely metastatic breast cancer?	What does futility mean, and what are the types of futility?
She lacks decisional capacity at this time	Ann will die due to the advancement of her cancer	Does Ann have an advance directive?	End-of-life decision-making
Her husband is making her medical decisions		Have she and her husband discussed whether she would now accept conventional treatments for her cancer?	Termination of treatment against the wishes of a patient or their family
He wants anything possible to be done to save her life		Would surgery be more harmful than helpful? What would radiation and tamoxifen add to her survival at this late date?	
The neurosurgeon feels surgical resection of her brain tumor would be futile			

Table 9.2.1: Mr. Jones

Facts	Hypotheses	Information needed	Learning issues
72-year-old male with COPD and angina	Mr. Jones needs an angiogram for diagnostic purposes and possibly for therapeutic reasons as well	What are all of the risks of angiogram?	What is the definition of informed consent?
Cardiology recommends angiogram, but the procedure and the risks/benefits are not explained	He does not understand fully what the procedure will entail or what the risks may be	What are the benefits of angiogram?	What are the legal and ethical requirements of obtaining informed consent?
		How much information do you need to give a patient to obtain their consent?	What are the components of informed consent?
			What are standards for obtaining informed consent?

COPD chronic obstructive pulmonary disease

Table 9.2.2

Facts	Hypotheses	Information needed	Learning issues
Mr. Jones is intubated and sedated	Someone else will need to authorize and give consent to performing a procedure upon Mr. Jones	Does Mr. Jones have any family members?	Under what conditions can surrogate decision-makers provide informed consent?
His physicians now recommend another procedure (tracheostomy)		What are the medical indications for a tracheostomy tube?	Who are the decision-makers for patients who lack decisional capacity?
		What is his prognosis given his recent major surgery as well as his underlying COPD?	What happens with informed consent in emergency situations?
		What are the risks and benefits of the procedure?	

COPD chronic obstructive pulmonary disease

Table 9.2.3

Facts	Hypotheses	Information needed	Learning issues
Mr. Jones now has pulmonary edema due to CHF	Mr. Jones's physician will need to decide how much information he needs to disclose to Mr. Jones	What is Mr. Jones's prognosis?	What are the ethics of nondisclosure?
He still suffers from baseline COPD	Mr. Jones may have a poor outcome if he learns of his grave prognosis and loses hope in recovery	What is his predicted life expectancy?	Are there cultural components to nondisclosure?
Mr. Jones's son does not think he will do well if he is made aware of the possibility of a very grim prognosis and asks you to refrain from telling his dad the worst case scenario		What is a physician's obligation to informing a patient of their current health status?	How can patient autonomy and right to direct their own medical care be balanced with appropriate care?
		Can informed consent be obtained if a patient is not truly informed about their diagnoses and prognosis?	

CHF congestive heart failure, *COPD* chronic obstructive pulmonary disease

Table 9.3.1: Mr. L.

Facts	Hypotheses	Information needed	Learning issues
43-year-old homeless male diagnosed with tuberculosis	Given his financial and social situation, compliance with a lengthy medical treatment course may be difficult, and his ability to obtain follow-up care may be concerning	How contagious is tuberculosis?	How does confidentiality affect the doctor–patient relationship?
He does not have a primary care physician		Do close contacts need to be tested or treated? Do casual contacts need to be tested or treated?	What are HIPAA laws and confidentiality requirements for health-care providers?
He is unemployed and unable to pay for his medication		What responsibility does a physician have towards protecting their patients’ right to privacy and confidentiality?	
		What responsibility does a physician have towards protecting other individuals or society in general when it comes to individuals with infectious diseases?	

HIPAA Health Insurance Portability and Accountability Act

Table 9.3.2

Facts	Hypotheses	Information needed	Learning issues
Mr. L. had been compliant with his medical treatment regimen until he started to experience a number of adverse effects from his medication	The inconvenience of reporting for daily treatment and the adverse effects that the drugs are causing will likely affect Mr. L.’s continued compliance	How can a physician or government agency notify close contacts without violating confidentiality laws?	Where is the overlap between confidentiality and public health notification?
Mr. L. has multidrug resistant TB	Because he has multidrug resistant TB, the health department will want to notify any close contacts to get them tested and treated if needed	What are the “exceptions to the rule?” Are there times when it may be justified to break a patient’s confidences or reveal personal health information?	Are there times when breaches in confidentiality may be justified?
Mr. L. has been lost to follow-up			
The health department has been notified			

TB tuberculosis

Table 9.3.3

Facts	Hypotheses	Information needed	Learning issues
Mr. L. has multidrug resistant tuberculosis and not only stopped taking his medication but also was lost to follow-up and moved to another state	His lack of compliance caused a significant concern for the health and welfare of the general public	Have Mr. L.'s rights been violated?	Can a public health agency act ethically while potentially violating an individual's right to autonomy and self-determination?
The health department informs the media in order to locate Mr. L.		Is it the action of the public health officials justified in order to protect the greater good?	Has there been any precedent for this type of action?
			What are the AMA recommendations regarding quarantine and isolation?

AMA American Medical Association

Table 9.4.1: Pat

Facts	Hypotheses	Information needed	Learning issues
37-year-old patient	Possible drug-seeking behavior	How long has the patient been taking pain medications?	What is a pain agreement?
Multiple medical problems	Possible addiction	Which pain medication is the patient taking?	How should physicians approach the care of patients that are concerning for misuse of medications? What ethical issues arise in the care of these patients?
Needs pain medications	Worrisome for mental health disorders	What other medications is the patient taking?	How do the assumptions made about a patient relate to issues of justice?
Previous problems with a physician	"Difficult" patient	Is the patient adherent to the overall medication regimen?	
		What is the patient's gender or ethnicity?	

Table 9.4.2

Facts	Hypotheses	Information needed	Learning issues
US Army veteran with trauma history	Previous assumptions about patient as a “drug seeker” may have been incorrect	What are his current support systems?	How is patient care affected by a physician’s perception of patients, misconceptions, and stereotypes?
Back injury was combat related		Why is he not seeking care at the VA?	What influence does physician bias have on patient care decisions?
Actively seeking new employment			
College graduate			

VA Veterans Administration

Appendix B—Review Question Answers with Explanations

Review Questions

1. Your patient refuses to comply with a recommended treatment regimen due to concerns of potential side effects and the belief that alternative treatment modalities will be as effective as the ones prescribed by you. In respecting their decision to pursue alternative treatments you are respecting their right to:
 - a. Practice paternalistic medicine
 - b. Make autonomous decisions
 - c. Justice and equality in health care
 - d. Confidentiality and adherence to HIPAA regulations

Answer: B. Your patient is exercising their right to make autonomous decisions regarding their health care. Autonomous decision-making refers to a physician’s duty to respect a patient’s preferences.

2. *Short answer:* The differences between legal and ethical standards for informed consent are:

Answer: The law requires that patients be informed regarding their illness and recommended treatments or procedures. It in general gives physicians some guidance for minimum standards and information that needs to be provided to patients. Ethical guidelines, however, push those standards a little farther. Ethical ideals recommend that informed consent be individualized to include information that may be considered important to each particular patient based upon what the physician knows about that patient’s beliefs, culture, life goals, etc.

3. *True or false:* Confidentiality is an important component to the doctor–patient relationship but is only an ethical obligation. It is not legally required of physicians.

Answer: False. Confidentiality is an essential component to the doctor–patient relationship, and while it is considered an important ethical obligation, it is also mandated by state and federal law with very specific and limited exceptions to the rule.

4. *Short answer:* What are some things that you as a health-care provider can do in order to try to prevent yourself from falling into the trap of forming biases or opinions about a patient that could adversely affect the care that they receive from you?

Answer: Make every attempt to obtain a thorough and objective clinical history. Avoid creating preconceived notions or assumptions based upon gender, race, culture, appearance, etc. Attempt to refute or confirm any assumptions that you may have made prior to any negative impact that can occur with regard to medical decision-making. Finally, be aware of personal biases and perceptions that you may hold, and utilize listening skills that will help clinical facts overcome these preconceived perceptions.

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