

Family Medicine Bioethics Curriculum

Clinical Cases and References

**Ethics Committee of the
College of Family Physicians of Canada**

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The College
of Family Physicians
of Canada



Le Collège des
médecins de famille
du Canada

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FAMILY MEDICINE BIOETHICS CURRICULUM

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Introduction

This resource material is intended to facilitate ethics education in family medicine training programs. It may be used by teachers or learners; in small group discussions or in formal teaching sessions; in whole or in part. It is not the definitive work in ethics education, nor is it complete. It may be useful to foster education and discussion in an area that many family physicians find intimidating. It is hoped that users may themselves be stimulated to develop their own cases and teaching modules, which may be incorporated into subsequent versions of this material.

There is a sample teaching module entitled "Problem-Solving: Analytical Methodology in Clinical Ethics" provided to give direction as to how to organize the teaching of ethics for family physicians. There is also a demonstration case analysis included here as an example of a typical approach to working through a specific problem area. This is followed by a list of topic areas in ethics relevant to family physicians and connected to clinical cases from real life, designed to stimulate discussion in each of the topic areas.

Guidelines for Ethics Education

The College's Committee on Ethics supports the development and implementation of teaching programs in the ethics of family medicine to meet a formal requirement for such teaching in residency training.

The Committee does not advocate for a single proscriptive ethics curriculum. Rather, it advocates for an integrated approach, based on the Four Principles of Family Medicine and the patient-centered model, that addresses the needs and objectives of ethics education for clinicians. It supports the development of innovative teaching initiatives that are sensitive to and reflect the needs, circumstances, and resources unique to each program.

The Committee on Ethics proposes the following set of minimum guidelines which should be used as a framework in developing any such teaching program.

Terms of Reference

1. The goal of ethics education should be to improve patient care and professional conduct.
2. The perspective of the teaching program, should be one of clinical relevance and should therefore focus on ethical issues confronted daily in family practice (such a program presupposes a more theoretical undergraduate exposure to ethics in medicine). To this end, it should be:
 - Integrated as much as possible into existing clinical training of family physicians.
 - Developed in parallel with a faculty development program, so that teachers of family medicine can effectively accomplish this integration.
 - Provided in a multi-disciplinary context.

3. The inter-dependent objectives of such a program should include:

a) The teaching of behaviors which reflect the values, attitudes and character traits required of a good family physician. Such teaching would emphasize empathy, compassion, caring and critical self-reflection as fundamental attributes of a family physician.

b) The teaching of interpersonal communication skills to:

- reflect these values and attitudes;
- promote an effective physician-patient relationship; and,
- facilitate conflict resolution.

c) The teaching of analytical skills in a systematic and comprehensive manner suitable to the identification and resolution of ethical issues inherent in family practice.

d) The teaching of a knowledge base of the relevant bioethics and medico-legal literature pertaining to ethical issues inherent in family practice.

4. The implementation of the program may be best achieved through a plurality of pedagogic tools, which may include:

- small group (formal and bedside) teaching sessions which are case-based and related to resident or faculty experience;
- clinical mentoring;
- individual tutoring through specialized rotations;
- direct observation and review; and,
- directed reading & research.

5. There should be a formal evaluation of the attitudes, knowledge and skills pertinent to the ethics of family medicine.

Demonstration Case Analysis

This case analysis briefly demonstrates a typical approach to ethics analysis. The purpose of this sample analysis is to allow readers to recognize the usual general categories addressed in ethical analysis, and to provide examples of the sorts of questions that might be considered in each category.

Demonstration Case – See Case B – Topic 15. The “difficult” patient, noncompliance, belligerence, somatization

1. What are all the alternatives? (i.e. what are the possible actions to be taken?)

- Discharge from the practice.
- Maintain the status quo.
- Develop a new strategy for interaction (e.g. make an explicit contract with the patient).

2. What principles or values are involved?

- Professional beneficence: defining one’s professional duties, the extent of the duty to care, duty of non-abandonment of patients in need.
- Professional autonomy: defining the limits of acceding to a patient’s wishes.
- Principle of justice: is anything useful being achieved in the relationship? Is the relationship therapeutic?
- Patient autonomy: the right to choose a physician, the extent of the right to define the nature of the relationship.

3. Fact gathering:

Factual data:

- Are there other difficulties, especially those impacting on the patient’s behavior?
- Is the patient just refusing to discuss other difficulties, or is she unable to do so because of deeper psychological problems?
- What about the history of the divorce?
- Job? Children? Marital relationship? Abuse? Level of function? Financial situation?

Analytic data: (the doctor steps back from the case)

- Objective assessment of the doctor/patient relationship: is it salvageable?
- What is the goal of the relationship? Is it ventilation? Cure? Are there goals sufficient to justify continuing to care?

4. Evaluating the alternatives in terms of principles and values:

Discharge:

-This ought to mean transfer to another physician's care: there is a need to address what should be done in emergency circumstances prior to transfer, what time limits apply in terms of "warning" – this alternative maximizes beneficence (as defined by the doctor, although perhaps not by the patient) and professional autonomy while minimizing patient autonomy and possibly justice.

Status Quo:

-Simply accept an unsatisfactory relationship by doing nothing and avoiding further examination of the problem. (The patient may like this choice, but at the cost of physician frustration and damage to professional beneficence. Patient autonomy may support this option, but most clinicians would suggest this patient doesn't really know what she wants.) Maintaining the status quo favors patient autonomy, albeit an impaired sort of autonomy, while beneficence is likely compromised in the sense little good seems to be accomplished.

-Retaining the status quo might involve reframing the relationship for oneself.

New Strategies:

1. Contract (bilateral): e.g.: no more than once-weekly visits, with no abuse of staff (several principles are jointly satisfied to some degree: duty to care, patient autonomy, physician autonomy, beneficence, justice).

2. Conditional relationship (unilateral): "I'm only willing to see you on an emergency basis, etc." (primarily maximizes physician autonomy, therefore less acceptable).

3. Redefining goals: e.g.: accept that the goal is to prevent the patient from seeking inappropriate care elsewhere by maintaining the relationship that the patient, if not the doctor, finds helpful. If the hope is to get somewhere further with this stalled relationship, this redefinition (i.e. patient satisfaction, not cure) may be necessary.

Options 1. & 3. are mutually compatible.

5. Choosing (rank order the alternatives):

- Which action best balances conflicting or competing ethical principles? (preference is for the option that satisfies the most principles)
- Must consider which action is the one most participants can live with. Clinicians cannot be expected to endlessly attempt to satisfy or placate unrealistic or overly demanding patient preferences – after awhile, one would not want to come to the office.
- Recognize that rank ordering implies that several (or all) of the alternatives may be ethical, but we still have to choose.

6. Beyond case analysis:

- In real life (unlike in case analysis) the next step is to act.
- The action's effects and outcomes have to be rigorously analyzed.
- Resolutions have to be realistic and not impose excessive moral burdens on clinicians (recognizing the real world needs of clinicians and office staff for basic things like politeness from patients is not at all irrelevant to the 'best' resolution of moral dilemmas in practice).
- Analysis of outcomes is time efficient and educational – it can lead to easier (and speedier) resolution of future dilemmas

Clinical Cases And References

Topics of Specific Interest to Family Medicine

1. Resource allocation and the family physician's role as gatekeeper

Case A

Mr. B is a 37-year-old male patient of yours with a long history of schizophrenia and, more recently, end-stage idiopathic cardiomyopathy who has been refused consideration for the cardiac transplantation waiting list. Mr. B has been unemployed for a number of years due to his illnesses. He is on maximal medications for his heart disease and continues to decline. Mr. B's psychiatric condition is currently under control with an expensive new oral neuroleptic. The Government Assisted Drug Plan has recently been overhauled and may no longer cover this drug. What are your responsibilities?

Case B

An 85-year-old patient of yours, Ms S, with moderate dementia, residing in a nursing home, develops a fever and seems delirious. You are concerned about urosepsis and want to refer her to the ER of a local hospital. The casualty officer encourages you to keep Ms S where she is, treating her empirically, fearing she'll become a bed-blocker. What ought you do?

References:

1. [McKneally MF, Dickens BM, Meslin EM, Singer PA. Bioethics for clinicians: 13. Resource allocation. CMAJ 1997; 157:163-7.](#)
2. McSherry J, Dickie GL. Swords to ploughshares. Gatekeepers turned advocates [editorial]. *Can Fam Physician* 1998;44:955-6, 962-4. [Article in English, French]
3. Gass DA. Gatekeeping in primary-health care. Challenging a sacred myth [editorial]. *Can Fam Physician* 1997;43:1334-5, 1338-9. [Article in English, French]
4. Bodenheimer T, Lo B, Casalino L. Primary care physicians should be coordinators, not gatekeepers. *JAMA* 1999; 281:2045-9.

Other References:

1. Pellegrino ED. Managed care at the bedside: how do we look in the moral mirror? *Kennedy Inst Ethics J* 1997; 7:321-30.

2. Relationships with specialist colleagues

Case A

Dr. K is a family physician and has been referring to a general internist colleague in the same community for several years. The internist, Dr. S, is highly respected in the community but beginning to wind down his practice after forty years of service. Recently, Dr. K has noticed that he has had to make repeated requests for consultation reports, and when received, several of these have contained obvious contradictions and misinformation. Some of his patients have suggested that Dr. S seems distracted and aloof, while others have remarked on his unusual energy and fondness for ribald humor.

Dr. K is concerned about this apparent change in his colleague's behavior and wonders if he should do anything about it. He considers reporting to the College of Physicians and Surgeons, but reasons that there is no hard evidence of any wrongdoing or gross negligence. He decides, instead, to simply stop referring to this colleague. However, the next day he receives word from one of his patients that Dr. S has suggested that the patient no longer see Dr. K because "he doesn't know what he's doing." Today, Dr. K feels a bit more inclined to take action. What should he do?

Case B

Dr. H is a family physician in a small northern community. He is working in the emergency department of the local health center one evening when a 63-year-old patient with abdominal pain arrives. This patient is well known to local health care providers and has a long history of alcoholism, bleeding stomach ulcers, diabetes, and hypertension. After physical examination and screening bloodwork, Dr. H concludes that the patient most likely has a recurrence of his ulcer, and is worried about perforation. There are no surgical facilities available, so Dr. H contacts the surgeon on-call at the nearest tertiary center. After discussion of the case, he is told to send the patient in by air transport.

The following day, Dr. H is surprised to see the patient arrive back from the city for readmission to the local hospital. He hands over a note from the surgical resident which simply states: "gastroenteritis – stable. Suggest rehydration." This diagnosis seems unlikely to Dr. H, and he doubts whether sufficient workup was obtained at the tertiary hospital. His calls to the surgeon involved are not returned, and the resident cannot be located. What should be done?

References:

1. Joint Task Force College of Family Physicians of Canada, Royal College of Physicians and Surgeons of Canada. The relationship between family physicians and specialist/ consultants in the provision of patient care. CFPC; RCPSC; 1993.
2. [Walsh A, Davine J. Teaching effective consultation and referral. CFPC Section of Teachers of Family Medicine Newsletter 1999 Spring; 7\(1\).](#)
3. Kvamme OJ, Olesen F, Samuelson M. Improving the interface between primary and secondary care: a statement from the European Working Party on Quality in Family Practice (EQUIP). Qual Health Care 2001 Mar; 10(1): 33-9.
4. Jacobson JA. Keeping the patient in the loop: ethical issues in outpatient referral and consultation. J Clin Ethics 2002 Winter; 13(4): 301-9.
5. [Lord RW. Conflict with a consultant. Am Fam Physician 2004 Apr 1; 69\(7\): 1814, 1817.](#)
6. [Schneeweiss R. A consultant takes over. Am Fam Physician 2000 Oct 1; 62\(7\): 1709-10.](#)

3. Continuity of care, on-call responsibilities

Case A

Dr. S is doing a six-month locum in a small rural community where she is the only physician. Her contract is turning out to be less than ideal, with fee-for-service billings amounting to significantly less than suggested during preliminary discussions with her employer. Her on-call duties are becoming onerous, more because of the unending and tiresome attachment to a pager than because of stressful work. She has had little opportunity to make friends in the town and finds herself spending most evenings dictating charts at the hospital or sitting in front of the television in her small rented apartment.

She begins to drive the eighty miles to the city on quiet evenings, taking the pager with her and spending the night at her boyfriend's, returning early the following morning. This has worked quite well, so far, although she was a little nervous about one patient who presented to the rural hospital with chest pain. After speaking to the nurse by telephone, she had arranged for the patient to be sent by ambulance to the nearest tertiary center, and he had subsequently received appropriate medical intervention for his myocardial infarction. The attending cardiologist had not been aware that Dr. S was calling from in the city rather than eighty miles away. Comment.

Case B

Dr. Y is a young male physician in a busy urban practice. He is well liked by his patients and often receives word-of-mouth referrals because of the good care he provides. He has been seeing Jessy for her regular medical care for the last year or so, and recently delivered her first baby. The infant was healthy and the family was quite impressed with Dr. Y's kindness, dedication and attention to detail.

Seven months after her delivery, Jessy's pregnancy test was again positive, and this news is met with disappointment, anger and anxiety. She returns to Dr. Y's clinic the following week and states that she wishes to have an abortion. Dr. Y becomes upset with this request, the first such scenario he has encountered in his fledgling practice, and emotionally voices his moral opposition to the procedure. Jessy, in turn, becomes angry and tearful, asking for a referral to another physician who might carry out her request without hesitation. Dr. Y refuses to provide this referral, saying instead that Jessy ought to take all of her care elsewhere if that's how she feels. Comment.

Case C

'Medical Partners' is a 6-person GP group in the suburbs of a large urban centre that has been increasingly unhappy with their after-hours clinic. As their practices have grown (now covering over 12,000 patients), they have found it increasingly difficult to serve their own full rosters as well as the patients who come to the after-hours clinic – after 10 years, many of them are tired of evening and weekend clinics. Although it may cost them financially, they decide to end their personal after-hours coverage and send patients who call in to the local hospital's ER.

When Dr. W, the director of the local ER, hears of their decision, he is quite concerned. The ER is already very busy and he worries about the quality of care he can provide if even more patients come to his ER.

References:

1. Hutten-Czapski P. Rural hospital service trends: a country doctor's view. *Canadian Family Physician* 1998; 44:2041-43.
2. [Freeman G, Hjortdahl P. What future for continuity of care in general practice? *BMJ* 1997; 314:1870-73.](#)
3. [Neuberger J. Primary care: core values & patient priorities. *BMJ* 1998; 317:260-2.](#)

4. Relationships with the primary health services team, alternative models of primary care

Case A

Dr. P receives a faxed memo from the Home Care offices in her community containing the names and detailed care plans for several of her patients. She notices that a few of them have been referred to Physiotherapy, apparently by the Home Care nurse, and one or two are seeing a podiatrist for unclear reasons. Two patients have been interviewed by the Coordinated Assessment Unit with regard to admission to long-term care facilities and a third has been referred to an optometrist for "assessment of cataracts." The memo requests that she call in several of her patients for "medication review."

Dr. P believes she is capable of providing holistic care and feels that her role as primary care provider is being eroded. She acknowledges that some benefit may be obtained by the arrangements being made, but wishes she had been consulted before hand. She senses that all this community intervention is beginning to border on meddling paternalism, and wonders if some of her elderly patients are being manipulated by the system. What should she do?

Case B

Dr. X is new to this community and has placed a newspaper advertisement regarding his practice. He claims to have training and expertise in homeopathy, traditional Chinese medicine, naturopathy, acupuncture, moxibustion, reflexology, yoga, meditation, and therapeutic touch. He offers a free initial consultation and guaranteed results, backed by numerous personal testimonies.

Dr. Y is a conventional family practitioner who is well known for his interest in alternative and complementary therapies. His approach is scientific, however, and he tends to be highly critical of modalities lacking good experimental evidence for their efficacy. Dr. Y's patient, Jerome, has fibromyalgia, depression, and work-related stress. He tells Dr. Y that his current treatment isn't helping much and he would like a referral to Dr. X for a more "natural" approach. What should Dr. Y say?

References:

1. Purtilo RB. Rethinking the ethics of confidentiality and health care teams. *Bioethics Forum* 1998 Fall-Winter; 14(3-4): 23-7.
2. Irvine R, Kerridge I, McPhee J, Freeman S. Interprofessionalism and ethics: consensus or clash of cultures? *J Interprof Care* 2002; 16:199-210.
3. Best A, Herbert C. Two solitudes of complementary and conventional medicine. Where are we going? *Can Fam Physician* 1998; 44: 953-5, 960-2. English, French.

5. Confidentiality and privacy, duty to warn, electronic health record

Case A

A 22-year-old male patient of yours, Mr. W, is completing his commercial pilot's certification. He has done extremely well for himself, having left home at an early age due to family discord, and has put himself through school. Recently, however, Mr. W has become more depressed and, though not suicidal, you think he needs medication and counseling from a psychiatrist. This he refuses to do as he doesn't want to end up "like his mother" (in his words -- he sees her as debilitated from a lifetime of psychiatric illness and many medications). Flying is almost the only positive thing in his life and he feels if he concentrates on that he will be OK. What ought to be done?

Case B

Ms R, a 39-year-old married female patient in your practice, reveals that she has been physically abused more than once by her husband, Mr. R. He, too, is your patient and you are quite surprised by Ms R's confession as he seems so placid. What ought you to do?

References:

1. [Ferris L, et al. Defining the physician's duty to warn: consensus statement of Ontario's Medical Expert panel on Duty to Inform. CMAJ 1998; 158:1473-9.](#)
2. Hébert P. Confidentiality & its limits. Ch. 3 in *Doing Right: A Practical Guide to Ethics for Physicians & Medical Trainees*. Toronto: Oxford University Press, 1996.
3. [Singer PA et al. Ethics and SARS: Lessons from Toronto. BMJ 2003; 327:1342-4.](#)

Other References:

1. Ferris L, et al. Guidelines for managing domestic abuse when male and female partners are patients of the same physician. *JAMA* 1997; 278:851-7.

6. Boundary issues, sexual impropriety, gifts from patients, patients as friends

Case A

The provincial College of Physicians and Surgeons has just sent all doctors a newsletter on the subject of receiving gifts from patients. In it the registrar states, "patients like to show their appreciation with gifts. However, if the gift is more substantial than a hand tatted doily, the physician will have an ethical problem."

You have just assisted at another successful delivery of a healthy baby. The delighted and grateful parents give you a gift of:

- a) a bottle of single malt whiskey worth \$60-; OR
- b) a \$100- bill; OR
- c) use of their resort condo at Whistler for a weekend

Is there an ethical difference in the different gifts?

Would it be different if the parents were rich or poor?

What is 'too big' a gift? Why?

Is the College correct? Why or why not?

Case B

A close friend wants to become your patient. You've been told this is not a good idea and initially refused him. He says he can talk to you about issues he would find difficult talking to others about. You also 'know his background far better than some stranger'. He urges you to reconsider.

What are the ethical issues here?

What should you do?

References:

1. Rourke LL, Rourke JT. Close friends as patients in rural practice. *Can Fam Physician* 1998; 44: 1208-10,1219-22.
2. Yeo M, Longhurst M. Intimacy in the patient-physician relationship. Committee on Ethics of the College of Family Physicians of Canada. *Can Fam Physician* 1996; 42: 1505-8.
3. Linklater D, MacDougall S. Boundary issues: what do they mean for family physicians? *Can Fam Physician* 1993; 39: 2569-73.

7. Advance care planning, substitute decision-making

Case A

John is a 42-year-old male, previously married and divorced, who is brought to the Emergency Department by ambulance after being struck by a taxi while crossing the street at a controlled intersection. He is assessed and found to be unstable: massive internal bleeding is suspected and preparations are made for immediate transfer to the operating room.

At that moment, John's homosexual partner of twelve years arrives and states that John tested positive for HIV about four years earlier and has been hospitalized for PCP infections twice over the past year. He also states that although they have only discussed it in general terms, it is his belief that John would not want to be admitted to ICU and certainly would want no surgery for whatever reason. He declines to provide consent for the procedure.

As the surgery resident speaks with John's partner, John's 17-year-old son arrives. He looks at the partner with obvious hatred, and when told that permission to operate has been refused, becomes verbally aggressive, stating that he will sue the doctors, the hospital, and everyone else in the resuscitation room if every attempt is not made to save his father's life. What should be done?

Case B

Joan is a 30-year-old woman with ALS (amyotrophic lateral sclerosis). She has told you, her family physician, many times that she does not want aggressive treatment because she does not want a prolonged death. Recently, she completed an advance directive stating that she declined all "extraordinary life-preserving measures", and accepted "comfort measures" only. She is now brought to the hospital by her family because of deterioration in her respiratory status.

When she is offered ventilation in ICU, she accepts and the reason she gives is that she is afraid she might die. After one week, she is extubated and transferred to the ward where she emphatically states that under no circumstances would she ever consent to ventilation again. Two days later, her respiratory status declines, she begins to have difficulty breathing, and again agrees to intubation and admission to ICU.

After 10 days in ICU, she hands you a note stating that she can no longer bear the suffering. The note indicates that she wants the treatment discontinued. Her respiratory condition is improving, however, and her family insists that she be treated. They believe that Joan is once again reacting to frightening circumstances and will end up being happy with continued treatment, as she has in the past. They threaten to sue if ventilation is discontinued. Joan refuses psychiatric assessment. What should be done?

References:

1. Martin DK, Emanuel LL, Singer PA. Planning for the end of life. *Lancet* 2000; 356: 1672-6.
2. [Emanuel LL, von Gunten CF, Ferris FD. Advance care planning. *Arch Fam Med* 2000; 9: 1181-7.](#)
3. Larson DG, Tobin DR. End-of-life conversations: evolving practice and theory. *JAMA* 2000; 284: 1573-8.

Topics of General Interest

8. Relationships with the pharmaceutical industry, conflicts of interest

Case A

You have been asked to participate in a post-marketing study by a pharmaceutical company to investigate a new indication for a drug. The disease that the product is being investigated for has no adequate therapy at the present. The proposal has passed the local ethics board at your hospital. As part of the study, the drug company will give you a computer and modem so that you can send your results directly to the company headquarters. At the end of the study, you will get to keep the computer and the company has indicated that it will be developing educational software that will be sent to you for free. Should you participate in the study?

Case B

You are involved in a drug trial of a new antibiotic. Of your 4 patients in the trial, 3 developed moderately severe diarrhea. When you report this finding to the pharmaceutical company, they are polite but don't seem interested in your concerns. How would you deal with this problem?

References:

1. CMA policy on "Physicians and the Pharmaceutical Industry (Update 2001)" CMAJ 2001;164(9):1339-41.
2. [Ogle K. Collaborating with pharmaceutical research – Family physicians beware! Can Fam Physician 2002 Sep;48:1415-17.](#)
3. [Lewis S, Baird P, Evan RG et al. Dancing with the Porcupine: rules for governing the university-industry relationship. CMAJ 2001;165\(6\): 783-5.](#)
4. [Moynihan R. Who pays for the pizza? Redefining the relationships between doctors and drug companies – 1: Entanglement. BMJ 2003;326:1189-92.](#)
5. [Moynihan R. Who pays for the pizza? Redefining the relationships between doctors and drug companies – 2: Disentanglement. BMJ 2003;326:1193-96.](#)

Other References:

1. Katz D, Caplan AL, Merz JF. All Gifts Large and Small: Toward an Understanding of the Ethics of Pharmaceutical Industry Gift-Giving. Am J Bioethics 2003; 3(3):39-46.
2. [What's wrong with CME? \(editorial\) CMAJ;2004;170\(6\):917.](#)
3. Watkins RS, Kimberly J. What residents don't know about physician-pharmaceutical industry interactions. Acad Med 2004;79:432-37.

9. Medical research, “use” of patients, scientific integrity

Case A

A pharmaceutical company offers you, as a family physician, a monetary recompense for each patient that you refer to their local centre for a study on hypertension they are conducting. You are not an investigator and you simply have to supply the names, addresses, and a few simple medical facts about the patients. For this they offer you 150\$ per patient name. May you refer patients to them?

Case B

You are asked to participate in a study of a new “triptan” used to treat migraines. (Triptans, as a class of medications, are already available by prescription in Canada -- they are commonly used to abort migraines.) Patients in the study will be randomized to the study drug or to placebo. If, after two hours, the patient still has pain, he/ she may take a potent rescue analgesic. Is this study ethical?

References:

1. Bulger R. Toward a statement of the principles underlying responsible conduct in biomedical research. *Acad Med* 1994; 69:102-107.
2. [Weijer C, Dickens B, Meslin E M. Bioethics for Clinicians: 10. Research Ethics. CMAJ 1997; 156:1153-7.](#)

Other References:

1. Freedman B. Equipoise and the Ethics of Clinical Research. *N Engl J Med* 1987; 317(3): 141-5.
2. Jones R, et al. Primary care research ethics. *Br J Gen Pract* 1995; 45:623-6.

10. Reproductive issues, fertility, contraception, abortion

Case A

You have thought over the issues and have made up your own mind that you are in favour of abortion 'on demand' so long as this represents the patient's genuine wish. Until now this has not posed any particular moral dilemmas for you in practice. One day a patient who has two children, both boys, comes in to see you. She tells you she wants one more child. She and her husband definitely want a girl. She has already arranged an ultrasound in the USA, in a nearby border town. The radiologist there has agreed to tell the patient the sex of the fetus. The patient wants an abortion, if the fetus is male, and wants your commitment in advance to help her obtain the abortion in this event. You are shocked and refuse to assist her. The patient says, 'you always told me you were 'pro-choice', and that it was the patient's right to decide whether to have an abortion or to have the child. Well we have decided. If it's a boy we want an abortion. Why can't I count on you? Why have you changed your mind?'

How do you answer your patient? What reasons do you give?

Case B

A 42-year-old woman, who has been your patient for 5 years, has been diagnosed in the past as having a 'borderline personality'. She is in a new relationship of 3 months. She informs you that she has tried without success to become pregnant and wants a referral to a 'fertility clinic', as this is her 'last chance' to have a child. What are the ethical concerns in this case?

How do you deal with the patient's request?

References:

1. [Shanner L, Nisker J. Bioethics for Clinicians: 26. Assisted Reproductive Technologies. CMAJ : 2001;164\(11\):1589-94.](#)
2. Adams KE. Moral Diversity Among Physicians and Conscientious Refusal of Care in the Provision of Abortion Services. J Am Med Wom Assoc : 2003 Fall;58(4):223-26.

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2. [Chervenak FA, McCullough L. Curbside Consultation: A Group Practice Disagrees About Offering Contraception. Am Fam Physician 2002;65\(6\):1230-33.](#)
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11. Genetics issues, diagnostic testing, presymptomatic screening

Case A

Rhonda is a 44-year-old female who has just undergone unilateral mastectomy and positive axillary lymph node excision. She was discovered to have breast cancer three months earlier after noticing a lump in her breast on self-examination. She made self-examination a regular practice because of her strong family history: both her mother and maternal grandmother died of breast cancer while in their fifties and her sister is now receiving chemotherapy for the same disease.

Rhonda's 18-year-old daughter, Jennifer, is quite concerned that she too will develop this disease and has done a great deal of reading about it. She approaches her family doctor and requests that genetic testing be performed. She knows that if she possesses one of the two genes she has read about, her chances of developing the disease are at least 80%, while they fall to around 10% if her genetic inheritance is "normal." The test is quite expensive and uninsured, but Jennifer says she will somehow manage to come up with the money from working part-time as a waitress.

Jennifer's mother does not want her to have the test performed. "What good would it do?" she asks, saying that we are "stuck with our genes " and can't do much about it. Jennifer counters with her plan to request bilateral mastectomy and oophorectomy if she tests positive. Rhonda is astounded by this: "You can't possibly mean that! You're not even married yet, you haven't had any kids! You would be ruining your life if you did such a thing!" Jennifer replies that it would be better than dying at a young age of cancer. At this, her mother breaks down crying. She has felt fine since her surgery and is regaining strength daily: she is convinced that her disease is cured, and unable to understand Jennifer's drastic proposal. They agree to seek their family physician's advice.

Case B

Jerry is a healthy 40-year-old male recently contacted by a cancer research team. The researcher invites him to participate in an ongoing study of hereditary colon cancer. He is told that he has been identified as being at risk because of an earlier chart review identifying both his grandfather and father as "index cases", or patients with known colon cancer. Jerry's grandfather died of this disease several years earlier. His father is still alive at age 76 and recently underwent a hemicolectomy following a diagnosis of colon cancer one month earlier.

Jerry is receptive to this request and understands the significance of his family history. He is also aware that if he tests positive for the gene, he might be offered regular colonoscopy and genetic counseling, improving his chances for normal survival. He agrees to participate and appointments are made for various meetings with counselors, research assistants, and laboratory workers. Before long, the physician leading the research team contacts him with unpleasant news: he has indeed tested positive, and follow-up is being arranged.

Jerry is optimistic by nature, but proceeds to organize his future as carefully as possible. After long discussions with his wife, he decides to increase his level of life insurance considerably. His insurance company requires a statement concerning his current health, so Jerry arranges for a complete physical exam with his family doctor. During this session, he purposefully neglects to mention anything about the research finding or his participation in the study, but his doctor is aware of the research underway, and expresses surprise that Jerry has not been contacted, given his strong family history of colon cancer. Jerry

reluctantly admits his involvement and begs his doctor to avoid any documentation of this subject until after he has qualified for extra life insurance. What should be done?

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12. Incompetent colleagues, reporting responsibilities

Case A

You are a member of the hospital's Complications Committee in a small town. You have become aware that one of your colleagues, who is diligent, compassionate and well liked by both patients and physicians, has been making serious errors in clinical judgement. You initially tried to make him aware of the committee's concerns and suggested he ask for help any time he had any difficulty. Unfortunately, he is unaware when he is getting into trouble and has not asked for help appropriately. More cases of incompetent care are occurring. The last straw was a case of appendicitis that was missed. The patient was hospitalised with 'acute back strain'. Over the next 2 days he developed increasing RLQ abdominal pain and tenderness, nausea and vomiting, fever and increasing WBC count – all meticulously noted by the physician himself in the chart. The diagnosis of acute abdomen was made by the radiologist who noted partial bowel obstruction on the lumbar spine x-ray.

There is a lot of rancour among the physicians in the town. You are concerned that any attempt to deal with the problem will be perceived as 'politics' by both fellow physicians and patients.

How do you deal with this issue?

Case B

While you are scrubbing for surgery, your friend, the well respected gynecologist tells you that since his divorce his finances are in a shambles and he is meeting with tax officials tomorrow to discuss payment of his back taxes. The hysterectomy is difficult and the surgeon panics. In fact, you, the family physician, have to guide him in the case. His surgical technique is clearly poor. During surgery, the patient becomes hypotensive, but post-operatively does remarkably well. The patient is very grateful to the surgeon.

How do you handle the issue of possible incompetence?

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13. Economic constraints, models of remuneration, professional freedom

Case A

You have just listened to a speech by the deputy minister of health. The main message is that the 'fee-for-service' system of physician remuneration is fundamentally flawed because physicians are motivated to 'over-serve' patients. This means unnecessary visits, procedures and surgery for the patients and unnecessary economic costs for society. The minister says that salaried or capitation (payment per patient per year) systems are more 'ethical' methods of remuneration.

Do you agree? Is one system of payment inherently less 'ethical' or more flawed than another? Is there any payment system which prevents physicians acting in their own economic self-interest?

Case B

Your patient has a large obstructing ureteric calculus and has been booked for lithotripter treatment in 4 months time. In the meantime he develops a urinary tract infection, possibly early pyelonephritis on the affected side. You contact the urologist to have the patient seen as soon as possible for emergency lithotripter treatment. The urologist replies that you should treat the patient with oral antibiotics first, because there are other 'more urgent' patients on the list. You have always understood that a urinary infection in the presence of obstruction is potentially dangerous and will not clear until the obstruction is removed. The urologist won't budge.

What do you do? What are the ethical issues raised by this case?

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14. Assessment of decision-making capacity, incompetence, placement issues

Case A

Your elderly patient with severe Parkinson's disease comes to you with concerns that his 2 sons having been trying to get control of his money. The lawyer he has consulted phones you to ask you to attest to his competence. On mini-mental testing the patient scores 25 out of 30 –in the borderline zone. You are not sure if the patient's story is true or whether he is becoming paranoid. You consult a geriatric specialist, but unfortunately, this proves no help in sorting out the problem.

What do you do?

Case B

Your patient has become demented and an increasing burden to his elderly second wife. She is exhausted, feels she can't go on, and insists that he must be placed in an extended care facility. His son, who lives in California, and doesn't much care for his stepmother, is adamant that his father should be cared for at home.

How do you resolve this conflict?

How do you determine what is in the best interests of the patient?

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15. The “difficult” patient, noncompliance, belligerence, somatization

Case A

Rick is a 31-year-old male who is paraplegic as a result of falling asleep on the railway tracks three years earlier. He has been a regular recipient of health care resources since his accident. In August, one-and-one-half years ago, he was admitted to hospital for treatment of extensive infected pressure ulcers. He received flap surgery, but transferred on his own to his wheelchair two days later, breaking open the flap repair. It was redone in September, but again broke down within two weeks, this time because of his refusal to allow hospital staff to routinely care for the surgical wound. Infection set in again but eventually resolved to the point where Rick could be discharged home with a contract from his plastic surgeon regarding what behaviors would be expected from him in order to receive any further treatment. He was readmitted in December, having followed the contract, and had another flap repair which was successful.

Last July Rick was again admitted to hospital with extensive pressure ulcers. His admission notes indicated several complicating factors including malnutrition, osteomyelitis, pathologic fracture of the right femur, narcotic addiction, and antisocial personality disorder. When first admitted, Rick refused treatment, but the psychiatrists were consulted and they deemed him incompetent to make health care decisions, likely due to the effects of his widespread infection and drug addiction. No family members or living relatives could be located so he was treated and as the infection diminished, he indicated his desire for continuing treatment.

During his hospitalization, Rick’s behavior was a constant irritant for all members of the health care team. He swore at the nurses, using graphic and vulgar language. He allowed appropriate management of his medical problems on some days, but refused all contact on others. Syringes, needles, and evidence of other street-drug use were sometimes discovered beneath his bed or on his nightstand. He often lit cigarettes in the ward washroom, but loudly denied that he ever used drugs or nicotine when interviewed by unsuspecting first-year medical students. At times he would wheel his chair to the basement where he would be discovered playing poker with hospital staff in the middle of the night. Disreputable looking strangers would occasionally visit and hushed conversations behind closed curtains were partially overheard and described by other patients in his ward as “business transactions.” The key to the ward narcotics cabinet disappeared twice during his stay in hospital, necessitating expensive lock changes and other security mechanisms.

The staff became increasingly frustrated and angry. There were threats of abandonment and the plastic surgeon called you requesting transfer of the patient to your care. Two other patients, roommates of Rick’s, contacted the hospital administration with complaints of the disruption he was causing. The administrators called an urgent meeting to discuss the problem, inviting several members of the district ethics committee. What should be done?

Case B

Lisa is a 42-year-old female attending a family medicine teaching unit. She is a regular patient there, appearing on short notice several times per month. While previously quite healthy, she has developed numerous symptoms since her divorce three years ago. Her appearance in clinic is now dreaded by staff and physicians alike: seeing her name on the schedule sheet for the day is often enough to remind family medicine residents that they have urgent duties elsewhere. Lisa’s behavior and attitude is increasingly antagonistic. She is rarely on time for her appointments and frequently arrives late in the day, demanding to be seen urgently for seemingly minor complaints. When interviewed in the examining room

she is often initially defiant, angry and verbally abusive, but by the end of the session is tearful and self-deprecating.

Lisa's family physician, Dr. T, has thoroughly investigated the many complex symptoms described by Lisa. These have included chest pain, dizziness, blurred vision, headaches, arm and leg pains, nausea, bloating, diarrhea, constipation, and insomnia. There appears to be no easily recognizable organic cause, so therapy has been primarily supportive. Dr. T has gently suggested that there may be other social, emotional or interpersonal difficulties at the root of Lisa's physical symptoms, but she angrily responds by saying "You think this is all just in my head!" She goes on to complain that no one understands her or takes her seriously, that doctors don't care about people with complicated illnesses such as hers, and that she would rather be dead than carry on one more day with pain like this. A complete screen for major depression is repeatedly performed by the family medicine resident and is found to be negative each time.

Lisa refuses referral to psychiatrists or psychologists. She tells Dr T that she trusts him and wants to remain a patient in the clinic. He responds that he feels frustrated with his inability to help her with her symptoms and thinks she may be better off seeing a different doctor. Lisa begins to cry and says that she has seen numerous physicians in the past, most of them "mean, rude, or too busy to talk." Dr. T begins to feel increasingly trapped and demoralized by this relationship and wonders if there is some ethical way out. What should be done?

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#15 - Case A is based on one provided by Dr. Alister Browne, Division of Health Care Ethics, UBC, and is used with permission.

16. End of life issues, euthanasia, physician-assisted suicide

Case A

Ms E is an 88-year-old woman who is alert and capable but apartment bound due to severe PVD & a prior stroke that has left her partially paretic. You see her on one of your regular house-calls. She worries greatly about suffering another stroke and being sent to a nursing home. Ms E asks you to prescribe something that she can take on her own to end her life "just in case" things worsen. How should you respond?

Case B

Ms N is a 22-year-old female patient of yours who develops a persistent cough and weight loss. She has a large mediastinal mass -- likely a lymphoma. With traditional therapy the chance of cure is at least 85%. She refuses all further testing and treatment -- opting to see a herbalist recommended by her sister. Recently, Ms N has refused a return visit with the surgeon who advised an open-lung biopsy. What are your responsibilities?

Case C

Mr. P is bed-bound due to prior strokes, dementia, and now renal failure. He is on peritoneal dialysis. Due to poor oral intake resulting in a low albumin level, he is fed by an N-G tube but repeatedly pulls it out yelling, "No! No! No!" (He cannot have a PEG due to his peritoneal dialysis). The patient must be in restraints when the tube is re-inserted. Mr. P's family insists on the tube being in place. "Each day he is alive is a blessing," they say. They also refuse to consider any other limits to care, such as a "No CPR" order and expect that everything will be done. Are you obliged to follow the family's wishes?

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17. Informed consent, risk, harm, benefit, consent in pediatrics

Case A

Your patient, an 8-year-old girl, has had leukemia for 3 years and has had a difficult time. The parents can no longer tolerate her pain and suffering and want to desist from all further 'invasive' treatment. The pediatric oncologist says she still has a 20% chance of cure. He wants to get a court order to force the child to have treatment. The parents insist that 'enough is enough'.

What are the ethical issues here?

What is the 'right' thing to do?

Case B

You have finally convinced your skeptical patient to take a low dose medication for her poorly controlled hypertension. At the pharmacy the patient receives, along with her pill, a printed list of all the potential side effects of hydrochlorothiazide. At the next visit your patient informs you that she has not taken the medication, nor will she because of 'potential dangerous side effects', and shows you the long list provided by the pharmacist.

Is the pharmacist wrong in providing 'complete' information and frightening the patient?

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18. Medical error, truth-telling

Case A

You are examining Jillian M, a 10 month old baby, in your office while her parents are briefly out of the office. Momentarily distracted, you allow the baby to fall off the examining table. Although crying, the child seems unharmed. What ought the physician say to the parents who were not in the room at the time?

Case B

You send Ms T, a 27-year-old female with symptoms of visual blurring, to a neurologist. The letter you get from him says she has acute optic neuritis but that he has told her she has an "inflammatory eye condition that may recur." He specifically has not told her she may develop M.S. as not all people with A.O.N. develop M.S. and he doesn't want to cause her needless worry. What ought you to say to the patient?

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19. Cross Cultural Issues

Case A

Dr. X has been seeing Mrs. Chris for over a year. Mrs. Chris has moved to Canada from Taiwan after she has married a Canadian businessman. For the past 6 months, Mrs Chris has presented with various minor complaints on a very frequent basis. Dr. X suspects a hidden agenda but it is very difficult to confront Mrs. Chris, as most of her visits are conducted through an interpreter. During one visit, when Mrs. Chris has gone to the bathroom to produce a urine specimen, the interpreter tells Dr. X that there are rumours in the community that her husband has frequently locked Mrs. Chris in the bathroom. She also tells you that Mrs. Chris is fearful of voicing her concerns to authorities for fear of losing her "status" in Canada. As well, it is not considered appropriate in the Chinese culture to talk about issues at home with "outsiders". Apparently, she is also in the process of applying for her family to come to Canada.

What are the ethical issues in this case?

How should Dr. X discuss / manage this case?

Case B

Dr. Y is the postgraduate program director of the Department of Family and Community Medicine at an urban teaching hospital. At the department's open house this year, she is confronted with questions regarding existing department policies with regard to cultural diversity. Specifically, a medical student of Islamic faith, interested in family medicine, is concerned about having to perform intimate examinations of women patients of his own origin. As well, a candidate of the Catholic faith wonders if he can expect understanding and accommodation from fellow residents and staff physicians, should he choose not to prescribe any "artificial" family planning means.

What constitutes the ethical tension here?

How ought Dr. Y respond?

Case C

Dr. Z is approached by Chi Min, her medical student, to act as a reference person for his residency application. Dr. Z has always thought of Chi Min as a responsible and hardworking student with excellent scores on his written examinations. However, she has found Chi Min to be "quiet" and "timid", and therefore concerned about whether he can form effective therapeutic relationships with his patients. She understands that Chi Min's family has immigrated to Canada from Mainland China six years ago. She is uncertain about how she should evaluate Chi Min in a culturally sensitive fashion.

Is there an ethical issue here?

Case D

Mr. Nguyen has brought 3 year old Mary to Dr. A office today with complaints of fever and cough for 3 days. On examination, Dr. A finds Mary to have multiple bruises on her back. Dr. A. is concerned about child abuse and confronted Mr. Nguyen. Concerned about being reported to Children's Aid, he becomes very anxious and he started to cry. He also explained to Dr. A that the marks are secondary to "coining", a traditional method used in the treatment of respiratory illnesses.

What are the ethical quandaries at hand in the scenario?

What should Dr. A do?

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