Self-assessment/CPD answers

Below, you can find the answers to the self-assessment questions published in this chapter.

Answers

Informed consent and Montgomery implications for clinical practice

Question 1

Correct answer: B. There is a duty to warn of risks known to medical professionals. The outcome as to whether the patient's consent is valid for failure to warn her of the potential of chronic surgical pain will turn on the subjective assessment of materiality. If the medical professionals were aware of chronic surgical pain risks associated with that intervention, then the patient must be told if there was a real risk of that complication occurring. The other options do not fully cover the duty of care towards ensuring her consent is valid and that the potential risks have been discussed, should she agree to the proposed intervention.

Question 2

Correct answer: E. Doctors must provide and share information about all material risks as well as any other risks that the individual patient attaches significance to. The other options do not fall strictly within the Montgomery ruling and is therefore not acceptable or legally required. Sharing all risks (A) may prevent the patient from deciding as they may feel disinclined to shoulder all of the risks. Sharing all serious risks (B) is too subjective as it depends on the meaning of 'all serious risks' as this may not include risks that the patient attaches significance to. Exercise of professional judgement (C) is not recommended as we are now, in accordance with the General Medical Council (GMC) guidance, expected to embrace shared decision-making. Risks to which a patient would attach significance (D) is incomplete as the patient may not be aware of other risks associated with the intervention.

Question 3

Correct answer: C. 'Material risks' are not defined by the courts, rather it provides that a doctor, since Montgomery v Lanarkshire Health Board (2015) is now "under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment, and of any reasonable alternative or variant treatments". The test of materiality is described as "whether in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should be aware that the particular patient would be likely to attach significance to it". The assessment of whether a risk is material cannot be reduced to percentages but must consider a variety of factors in addition to its magnitude: the nature of the risk, its effect on the patient's life, the importance to the patient of the benefits sought by the treatment, the alternatives available, and the risks involved in the alternatives. The other options A, B, D and E are incorrect as they do not fully focus on the risks pertinent and materially important to the patient.

Medical ethical principles against the background of 'European values'

Question 1

Correct answer: A. Most ethical difficulties arise from a conflict between two or more principles. In this case there are elements of autonomy, beneficence and non-maleficence. Although the issues may be clarified, principles alone will not give a clear answer (B) or resolve competitive views (D). Both common morality (C) and cultural factors (E) will impact on the application of the principles.

Question 2

Correct answer: D. This paper mentioned various legally binding (hard-law) and legally non-binding documents (soft-law) documents (ad A). Soft-law documents such as the Helsinki declaration should not be underestimated and can sometimes become legally binding in an indirect way, if mentioned in a legally binding document (ad B). While European Union (EU) law refers to all three normative theories (deontology, consequentialism and virtue ethics), principlism is still clearly relevant for EU medical ethics (ad C). In the EU, health ministers have defined health values (and principles) in 2006 (ad E).

Question 3

Correct answer: D. Solidarity is a general value of the EU, but has also been mentioned by EU health ministers in 2006, when they defined EU health values (ad A). Solidarity has gained importance as a bioethical concept for biomedicine and healthcare (ad B). Solidarity is, amongst others, strongly linked to justice, equity, but also to responsibility (ad C). Although the approach in the EU still differs for example from the US, also individual responsibility becomes more important (ad E).

Ethical aspects of risk communication

Question 1

Correct answer: D. The patient needs to understand that voluntary assisted dying is illegal in the UK, and the doctor cannot hasten his death as a primary goal of management. You can, however, give him the opportunity to express his fears, and know that he has been accurately heard and understood before explaining what can be done to manage his symptoms.

Explaining that doctors cannot shorten life (A) may be perceived by the patient as judgemental on the doctor's part, while omitting to reassure him that a patient's comfort is a primary concern in end-of-life care. Changing the subject (B) is also likely to increase his sense of isolation and desperation. Palliative care (C) is not always effective (and it is highly likely that palliative care has already been explained to the patient). Talking to the relatives (E) contravenes doctor–patient confidentiality and increases the burden of worry for the family. Talking to the family about just how desperate he is feeling and how treatment can be optimized is appropriate.

Question 2

Correct answer: E. This patient clearly needs a great deal of support in this terrible situation. She is likely to rely heavily on her medical team to help her to understand all of her treatment options and to make decisions based on her values and needs. The doctor should be able to provide statistical information in a way that can be understood by a lay person and be familiar with decision support tools and their application. Patients frequently forget information offered in any single consultation, and repetition is important (A). Information sharing should be at the discretion of the patient herself (B). Evidence regarding treatment keeps evolving as new studies emerge so prognosis changes (C), It is not possible to remember everything that is said in a highly emotionally charged consultation (D).

Question 3

Correct answer: D. The number of deaths from coronavirus disease 2019 has been under-reported. Unfortunately, the patient's reasoning is that the numbers reflect a cover-up within the NHS, and that none of the information provided to the mainstream media is correct. The challenge is to gain his trust and provide clear and accurate information, addressing his concerns, while respecting his decision, should he persist in his beliefs.

Working in partnership with patients – what does it mean in clinical practice?

Question 1

Correct answer: C. This is the most open-ended way to find out what "things" have been like for this person. Giving her time to reflect on her general wellbeing gives the doctor the best opportunity to stand alongside her and explore what matters most from her perspective. Questions about weight, exercise tolerance and service needs (A, B and D are closed questions that might elicit yes/no answers. Closed questions are best reserved for later in the consultation. A coping question (E) asks the patient to specify what she is doing, rather than how she is feeling; she may respond with a stoical "as well as can be expected" type of answer.

Question 2

Correct answer: D. As small a step as this may appear to be, it is one step over which the doctor does have control. Close attention to Erich Fromm's listening approach may help them to make important changes that will stay with them inside and outside your professional life. Listening, Fromm said, "is an art – like the understanding of poetry". Listening is the first step to truly working in partnership with patients as individuals. Doctors often resort to moving (A) or leaving (E) getting away from the problem; but nothing really changes in the way they relate to patients. Complaints and providing feedback (A and B) have probably been tried by other doctors a thousand times, without success.

Question 3

Correct answer: E. Working in partnership with patients has a number of benefits. Promoting patient autonomy is desirable for its own sake (self-efficacy, adherence to treatment, patient satisfaction) but also a time saver in the long run. The additional benefit is in making work more fulfilling for the doctor and reducing the risk of burnout.

Ethico-legal considerations in the assessment of capacity

Question 1

Correct answer: C. This is an emergency situation and there is no time to arrange a formal best interests meeting (B). In the absence of evidence to the contrary their best interests are almost certainly met by treating the myocardial infarction. In doing so their capacity may also improve. Due consideration should be given to ensuring that treatment is given in a way that minimized any distress it might cause them. Doing nothing (A) or simply offering supportive treatment (E) could cause the patient to die. There is clear evidence that their capacity is impaired. The Mental Health Act 1983/2007 (D) has no relevance as it is specific to the treatment of mental disorder.

Question 2

Correct answer: D. This patient is clearly unwell both physically and mentally and it is almost certainly in her best interests to be given treatment. Holding her in the department allows time for a psychiatric assessment (C) to be sought and appropriate medical treatment to be commenced. It is likely that this patient requires assessment under the Mental Health Act 1983/2007 (A) for the treatment of her mental disorder with possible transfer to a psychiatric ward (B). However, this would not provide a legal basis for the treatment of her pneumonia. Her mental state needs to be optimized in order to give her the best chance of regaining capacity to make a decision about her continuing medical treatment.

Question 3

Correct answer: A. A meeting with all involved parties should be arranged to discuss the best course of action. Simply basing the decision on the occupational therapy team assessment (C) or the family view (B) is not necessarily in the patient's best interests. While the patient is clearly vulnerable there is no indication that there are safeguarding concerns (E).