Informed Consent: Exceptions to Disclosure

Question: An unconscious man is brought to an emergency department in vascular collapse. He had been thrown off a motorcycle and ruptured his spleen. The surgeon recommended emergency surgery and blood transfusion, but no next of kin was readily available to give consent. An old wrinkled card in his wallet indicated the patient is a Jehovah’s Witness and should never receive blood, but there is a diagonal line drawn across that part of the card. Which of the following is best?

A. All interventions require informed consent, so in this case the surgeon should not operate.

B. Because this is an emergency, no consent for operation or blood transfusion is necessary, as long as you get two supporting doctor signatures.

C. If the man’s spouse can be located and she gives consent for transfusion, then it’s okay.

D. Operate on the patient, but respect his disavowal of blood even if it means death.

E. If the patient desperately needs a life-saving blood transfusion, it should be given, because his wishes are not entirely clear.

Answer: E. Some of the other choices have merit, but the best answer is E. This is because of the dire nature of the patient’s condition, the critical and immediate need for blood, and most of all, the reasonable belief that the line across the wrinkled card represents a revocation of reasonable belief that the line across the card was never discussed with him, purportedly because of his serious underlying cardiac status and extreme apprehension over his condition.

In addressing the therapeutic privilege defense raised by the defendant, the Hawaii Supreme Court held that “the doctrine recognizes that the primary duty of a physician is to do what is best for his patient, and that a physician may withhold disclosure of information regarding any untoward consequences of a treatment where full disclosure will be detrimental to the patient’s total care and best interest” (Nishi v. Hartwell, 473 P.2d 116 [Haw. 1970]).

In the well-known case of Canterbury v. Spence, the U.S. Court of Appeals in the District of Columbia also articulated the therapeutic privilege exception to informed consent, in order to enable the doctor to withhold risk information if such disclosure would pose a serious threat of psychological detriment to the patient. However, the physician is still required to disclose any information that will not prove harmful to the patient (Canterbury v. Spence, 464 F.2d 772 [D.C. Cir. 1972]).

Medical Societies Sign New Conflict of Interest Code

BY ALICIA AULT

Fourteen medical specialty societies have signed a voluntary pledge to be more transparent in dealings with pharmaceutical and medical device manufacturers and other for-profit companies in the health care field.

The pledge, issued by the Council of Medical Specialty Societies (CMSS), was the result of at least a year of negotiations, said Dr. Allen S. Lichter, who is chair of the CMSS Task Force on Professionalism and Conflict of Interest and the chief executive officer of the American Society of Clinical Oncology (ASCO).

“CMSS’s mission is encouraging and supporting a culture of integrity, voluntary self-regulation, and transparency,” said Dr. James H. Scully Jr., CMSS president and chief executive officer of the American Psychiatric Association. “This code provides a clear benchmark for maintaining integrity and independence.”

The societies adopting the CMSS Code for Interactions with Companies agree to establish and publish conflict of interest policies as well as policies and procedures to ensure separation of program development from sponsor influence. They also must disclose corporate contributions and board members’ financial relationships with companies, and prohibit financial relationships for key association leaders.

The initial signers included the American College of Physicians (ACP), American Academy of Family Physicians (AAFP), American College of Neurologists (AAN), American College of Radiologists (ACR), Accreditation Council for Continuing Medical Education (ACCM), American College of Emergency Physicians (ACEP), American College of Obstetricians and Gynecologists (ACOG), American College of Radiology (ACR), American Society for Radiation Oncology (ASTRO), and ASCO.

Dr. Daniel J. Ostergaard, the AAFP’s vice president for professional activities, said that the CMSS code gives his organization a chance to see where it might improve its current policies on disclosure and ethical conflicts. He said that the AAFP has a long history of seeking to conduct itself ethically. “I feel very confident that my colleagues at AAFP have always been addressing the issues pretty directly and with transparency,” Dr. Ostergaard said in an interview.

The AAFP’s board members and counsel will spend the next few months determining how to bring its policies into compliance with the CMSS code, he added. Adoption of the code will not impact the controversy over the AAFP’s refusal of Coca-Cola in the fall of 2009 to conduct a consumer awareness campaign about beverages and sweeteners. Dr. Ostergaard said that the code related specifically to health-related companies and that Coca-Cola did not purport to be health related.

Dr. Lichter called the code a “very important milestone” because it will create consistency where there has been none. Many previous efforts to reduce conflicts have been done in private, but this effort is very much a public undertaking, designed to reassure the public and regulators that professional societies are acting ethically.

It is also, however, just a first step, he said. The code is not meant to be the last word; it represents a minimum set of guidelines. Some organizations may choose to be more restrictive, Dr. Lichter said.

According to the CMSS, the code was developed by a task force that includes representatives from 14 of the 34 CMSS member organizations. The 25-page code is available on the CMSS Web site at www.cmss.org/codeforinteractions.aspx.