Cases for Evaluation

CASE 1

Informed Consent or Not?

A 64-year-old woman with multiple sclerosis (MS) is hospitalized. The team feels she may need to be placed on a feeding tube soon to assure adequate nourishment. They ask the patient about this in the morning and she agrees. However, in the evening (before the tube has been placed), the patient becomes disoriented and seems confused about her decision to have the feeding tube placed. She tells the team she doesn't want it in. They revisit the question in the morning, when the patient is again lucid. Unable to recall her state of mind from the previous evening, the patient again agrees to the procedure.*

Explain your answers: Has the woman given her informed consent? Should she be judged competent? Should her final agreement to the procedure be sufficient to establish informed consent, or should her earlier waffling and confusion also be taken into account?

*"Informed Consent," *Ethics in Medicine* (University of Washington School of Medicine), http://depts.washington.edu/bioethx/topics/consent.html (17 November 2007).

CASE 2

Informed Consent and Organ Transplants

(AP)—A woman in her 30s who is one of the four organ transplant patients [who became] infected with HIV and hepatitis [because of the transplant] was not told that the infected donor was high risk, and had previously rejected another donor "because of his lifestyle," her attorney said.

Attorney Thomas Demetrio filed a petition Thursday in Cook County Circuit Court on behalf of the woman, asking officials to keep a hospital and an organ procurement center from destroying or altering any records involving the donation.

"She's really a mess right now," Demetrio said of the Chicago-area woman. "She's still in shock."

The patient, identified in court documents as Jane Doe, received a kidney transplant at the University of Chicago Medical Center on Jan. 9, Demetrio said.

Gift of Hope Organ & Tissue Donor Network in Elmhurst and the University of Chicago both knew the kidney donor was high-risk and did not inform the patient, Demetrio said.

University of Chicago spokesman John Easton responded in an e-mail: "We believe we follow guidelines, and of course with the patient's consent we will provide necessary records and documents, as is consistent with our open process."

Gift of Hope did not immediately respond to requests for comment.

The woman had been told the donor was a healthy young man, her attorney said. But on Tuesday, hospital officials disclosed to the woman that he was actually high-risk, a 38-year-old gay man, Demetrio said. CDC guidelines say that gay men who are sexually active should not be used as organ donors unless the patient is in imminent danger of death.

The woman was told she had HIV and hepatitis on Nov. 1, he said.

"The (organ) procurement group knew, the hospital knew, but the most important person did not know," he said. "The people that dedicate their lives to these transplant surgeries, they're just great people, but they need to bring the patient into the mix and let them make an informed decision."

U.S. Centers for Disease Control and Prevention guidelines were violated twice, the attorney said. One violation was not informing the woman about the donor's status and then not testing her afterward for HIV until just recently, after HIV and hepatitis were found during tests on another patient who was being evaluated for a second transplant. . . .

She's been started on an HIV drug regimen "and unfortunately one of the side effects is it's not good for the kidneys," Demetrio said. She's not hospitalized.

Dr. Dan Berger, medical director of a large HIV-AIDS clinic in Chicago, said U.S. doctors have had several years of experience treating HIV-infected patients who went on to get transplant organs. Such patients need an HIV specialist and a transplant

specialist to monitor their medications, which include anti-rejection drugs for the transplant and antiretrovirals for HIV, he said.

The four patients infected by the high-risk donor's organs have extra medical concerns, Berger said.

"When a patient first becomes infected with HIV there's a huge spike in viral load and (at the same time) severe immune compromise," he said. "The fact that they also are on immune-suppressive medications (after transplant) may put them at extreme risk for opportunistic infection."*

If Jane Doe had not become infected with HIV and hepatitis after her transplant, would the failure of the donor network and the university to fully inform her about the donor have been morally wrong? If so, why? Would her consenting to the transplant have been permissible if she had known that the donor was high risk? Should a patient have the right to consent to and undergo risky treatments? Explain.

*The Associated Press, "Atty: Woman Wasn't Told Donor Was a Risk," 16 November 2007.

CASE 3

Adolescent Informed Consent

In mid-summer, a 14-year-old youth was brought to the pediatric emergency department by his mother for evaluation for altered mental status. The mother returned from work to find her son acting strangely. She had last seen him the previous evening, and there were no problems or complaints at that time. Earlier in the week the child had sustained several mosquito bites. The child was now at times lethargic and at other times agitated. There were two episodes of vomiting. There was no history of fever trauma, medications, or known ingestions. The medical history was negative. The social history was significant for a high-achieving honor student who came from a very financially successful household. Physical examination revealed a drowsy and disoriented athletic male. The vital signs were temperature of 37.8° Celsius, heart rate of 107 beats per minute, respiratory rate of 20 per minute, and blood pressure of 123/87 mm Hg. The general physical examination was unremarkable. The neurologic examination revealed a disoriented teenager with ataxia, brisk reflexes throughout, reactive pupils, and intact cranial nerves II through XII. A bedside glucose test and pulse oximetry were both normal. Given the ongoing epidemic of West Nile virus at the time of presentation, the mother was convinced that the child had contracted the insect-borne disease because of the combination of mosquito bites and altered mental status. The mother was absolutely insistent that a spinal tap (lumbar puncture) be performed immediately, to evaluate for the possibility of West Nile virus.

The patient's pediatrician was also concerned and requested a full and thorough evaluation. An intravenous line was started and routine blood evaluations were ordered. The patient seemed at times to be more lucid, but at other times was again disoriented. When interviewed alone, he denied having West Nile virus, but he agreed to tell the physician why he believed this to be the case, but only if his parents were not told. The physician explained that all information given by the patient would be kept in strict confidence. Because of the assurance of confidentiality, the patient disclosed that he had bought a large amount of dextromethorphan on the Internet and had taken it with his friends after school.

Dextromethorphan ingestion, even in large quantities, generally does not require anything but supportive care. The mother, not knowing about the ingestion of this drug, continued to be insistent that further tests be performed, including a spinal tap.*

Who, if anyone, in this scenario should be allowed to give informed consent to treatment (or no treatment)? Why? Should the physician regard the 14-year-old as a mature minor? What actions should the physician take if she regarded him as a mature minor? What actions would the physician likely take if she decided to set aside the issue of informed consent and act only in the patient's best interests?

*Reza Keshavarz, "Adolescents, Informed Consent and Confidentiality: A Case Study," *The Mount Sinai Journal of Medicine* 72.4 (4 July 2005), 232–35.