ISSN 2077-9445

Revista Redbioética / UNESCO

Red Latinoamericana y del Caribe de Bioética / UNESCO

Año 13, Vol. 1, No. 25, enero - junio de 2022

Knowledge and Resolution of Ethical Challenges by Emergency Physicians in Argentina

Conocimientos y resolución de desafíos éticos por parte de médicos de emergencia en Argentina

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Abstract

Objective: To assess the knowledge in ethics, and the ability of physicians working in emergency services in Argentina to address ethical challenges. Method: anonymous, self-administered survey distributed via e-mail between June and August 2021. We inquired about demographic aspects, undergraduate and postgraduate training in ethics, self-perception of training in ethics and ability to resolve ethical challenges. We explored the frequency with which participants perceived themselves exposed to ethical conflicts and how they resolved them. Finally, five clinical cases that presented an ethical conflict were presented. At the end of each case, two questions were asked with four multiple choice answers. Results: 144 physicians took part in the study, 56.2% were women, the median age was 41.62 years (SD 9.56) and they had an average of 13.28 (9.52) years since graduation. 23.6% stated that they had no training in bioethics while 18.8% reported some postgraduate training in bioethics, 58.3% of the respondents perceived their training as at least good or superior, 76.4% referred being exposed to ethical dilemmas at least frequently in their professional practice. The resolution of clinical cases obtained a final score of 5.02/10. Conclusions: this research suggest that emergency physicians face ethical challenges frequently. Although they perceive themselves adequately trained to resolve them, he score obtained for case resolution was low. Medical training programs should enhance the quality of this curriculum

Resumen

Objetivo: el conocimiento en ética y la capacidad de los médicos que trabajan en los servicios de emergencia en Argentina para enfrentar los desafíos éticos. Método: encuesta anónima, autoadministrada, distribuida vía correo electrónico entre junio y agosto de 2021. Se indagó sobre aspectos demográficos, formación de grado y posgrado

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en ética, autopercepción de formación en ética y capacidad de resolución de desafíos éticos. Exploramos la frecuencia con la que los participantes se percibían expuestos a conflictos éticos y cómo los resolvían. Finalmente, se presentaron cinco casos clínicos que presentaron un conflicto ético. Al final de cada caso, se realizaron dos preguntas con cuatro respuestas de opción múltiple.

Resultados: participaron del estudio 144 médicos, el 56,2% eran mujeres, la mediana de edad fue de 41,62 años (DE 9,56) y tenían una media de 13,28 (9,52) años de egreso. El 23,6% manifestó no tener formación en bioética mientras que el 18,8% refirió alguna formación de posgrado en bioética, el 58,3% de los encuestados percibió su formación como mínimo buena o superior, el 76,4% refirió estar expuesto a dilemas éticos al menos con frecuencia en su ejercicio profesional . La resolución de casos clínicos obtuvo una puntuación final de 5,02/10. Conclusiones: esta investigación sugiere que los médicos de emergencia enfrentan desafíos éticos con frecuencia. Si bien se perciben adecuadamente capacitados para resolverlos, la puntuación obtenida para la resolución de casos fue baja. Los programas de formación médica deberían mejorar la calidad de este plan de estudios.

Resumo

Objetivo: avaliar o conhecimento em ética e a capacidade dos médicos que trabalham em serviços de emergência na Argentina para enfrentar os desafios éticos.Método: pesquisa anônima, autoadministrada, distribuída por e-mail entre junho e agosto de 2021. Indagamos sobre aspectos demográficos, formação de graduação e pós-graduação em ética, autopercepção de formação em ética e capacidade de resolução de desafios éticos. Exploramos a frequência com que os participantes se perceberam expostos a conflitos éticos e como os resolveram. Por fim, foram apresentados cinco casos clínicos que apresentaram conflito ético. Ao final de cada caso, foram feitas duas perguntas com quatro respostas de múltipla escolha.

Resultados: participaram do estudo 144 médicos, 56,2% eram mulheres, a idade mediana foi de 41,62 anos (DP 9,56) e tinham uma média de 13,28 (9,52) anos de formação. 23,6% afirmaram não ter formação em bioética enquanto 18,8% referiram alguma formação pós-graduada em bioética, 58,3% dos inquiridos perceberam a sua formação como pelo menos boa ou superior, 76,4% referiram ter sido expostos a dilemas éticos pelo menos frequentemente na sua prática profissional . A resolução dos casos clínicos obteve pontuação final de 5,02/10. Conclusões: esta pesquisa sugere que os médicos emergencistas enfrentam desafios éticos com frequência. Embora se percebam adequadamente treinados para resolvê-los, o escore obtido para a resolução dos casos foi baixo. Os programas de treinamento médico devem melhorar a qualidade deste currículo

Introduction

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. Recognizing the need for bioethics knowledge and skills in 2015 Romenell report (Carrese 2015) described the objectives that should be met by ethics education at both undergraduate and postgraduate training.

Physicians at Emergency Departments (ED) works in environments where decisions were decisions have to be made quickly, based on partial information and sometimes, without information of the patients' medical and personal history (Pauls 2002). The Emergency Physicians (hereinafter physicians) are exposed to ethical challenges that t that have to be solved under the conditions mentioned above (American College of Emergency Physicians 2017) To respond to these challenges, physicians must know the basic principles of ethics and develop moral reasoning skills.(Marco 2011, American College of Emergency Physicians 2017)

After the publication of the Romanell report (Carrese 2015) the American College of Emergency Physicians (ACEP) have published documents detailing the knowledge and skills that emergency physicians should possess in order to face ethical dilemmas. In Argentina, Emergency Medicine has

been recognized as a specialty since 2001. We have not found defined the requirements that physicians must complete to address ethics challenges in their clinical practice.

In the international literature, there is little information on the bioethical training of emergency physicians and how they resolve conflicts in daily practice (Iglesias Lepine 2000, Imbernón 2011, Padela 2018) in Argentina were unable to fin publications on this subject. This project was conducted to assess the knowledge in ethics, and the ability of physicians working in emergency services in Argentina to address ethical challenges.

Methods

Emergency medicine specialists from Argentina were invited through email to participate in a one-time self-administered online survey. Potential study participants' email addresses were obtained from the Argentine Society of Emergency Medicine (SAE for its Spanish acronym) mailing list. The Survey Monkey™ software platform was used to conduct the online survey

Over the course of 11 weeks between June and August 2021, an introductory email with the link to the survey was sent, plus up to four reminders to those potential participants who had not responded. Participation was voluntary and no compensation was given to the respondents. To ensure anonymity, no coding numbers or identifying information were included on the survey. The survey took approximately 10 minutes to complete. The institutional review committee of the Sanatorio Finochietto approved the study protocol.

After the signature of the informed consent to participate in the study, survey questions included physicians' demographics including their training, years since graduating from medical school undergraduate and post graduate training in ethics with responses from very good, good, fair, poor or very poor. Physicians were asked to rate the perceived quality of such training, their capacity to resolve ethical challenges, the frequency with which participants were exposed to ethical conflicts in daily practice (daily, frequently, sometimes, seldom, and never), how they resolved them and whether they were aware of the existence of a Bioethics Committee in their institution.

Finally, participants were exposed to 5 different ethics challenge vignettes. The vignettes were constructed based on Padela's study with U.S. residents. Then were translated to Spanish and adapted according the local regulations: Law 26.529/09 Patients' Rights in their Relationship with Health Professionals and Institutions and the modifications made by Law Nº 26.742/12 Patients' Rights, Clinical History and Informed Consent . Each vignette assessed a different topic: informed consent, determination of decision-making capacity (autonomy), adequacy of therapeutic effort and advance directives. Each vignette was followed by two multiple-choice questions with only one correct answer each (Annex 1). One point was assigned for a correct answer and zero points if the participant selected an incorrect option. With the score obtained at the end of the questionnaire, an overall score was made, which was then converted to a 10-point scale. Subsequently, two groups were constructed, one of "low qualification" which included those who had obtained a score equal to or lower than 5 points (equal to or lower than 70% of the maximum obtained: 8 points out of a possible 10) and a group of "high qualification" with those who had obtained 6 points or more. Knowledge was the primary outcome and the scores from low and high qualifications were compared according age, sex, training and training in ethics received, perceived quality of the training in ethics received, and capacity to resolve ethical challenges.

Statistical analyses were performed with the Stata program, version 131.0 (StataCorp; CollegeStation, Texas, United States). Continuous variables are expressed as the mean (SD) and categorical variables as counts and percentages. Differences between high and low-performance groups' characteristics were compared using the Student's t-test for con-

tinuous variables and the chi-square test for categorical variables.

Results

Of 1049 physicians invited to participate, 80 did not receive the invitation. Of the 969 who received the e-mail, 232 opened the message and presumably read it, 148 responded to the proposal and 144 accepted to participate. The response rate of those who opened the email was 62%.The average age was 41.62 years (SD9.56, 56.2% were women and average they had 13.28 (9.52) years since graduation (table 1). While 23.6 % of physicians reported no previous training in ethics, 58.3% reported good or very good previous training. Respondents were exposed to ethics challenges on a daily or frequent basis. (Table 2), decisions about end of life and appropriate therapeutic effort were the topics most frequently faced (90.3% and 86.8%, respectively), 51.4% resolve these challenges by consulting with a colleague. Only 38.2% were aware of the existence of an Ethics Committee in the hospital where they worked.

The percentage of participants who answered the questions correctly showed variations between domains. (Table 3). The case that explored informed consent obtained the highest percentage of correct answers (Q1: 92%, and Q2: 74%) and the case that explored Directives in advance the lowest (35% and 6% respectively).

The variables that were associated with obtaining a high score as compared to obtaining a low score were age (p= 0.014) and years of training. (p = 0.022). This association was not observed when analyzing by gender, level of training, specific training in ethics or self-perception of training and ability to resolve cases (Table 4).

In this study we found that in Argentina, emergency physicians do not correctly solve many of the ethical challenges that may arise in daily practice. The total score was slightly lower than that published by Padela and very similar to the results of Imbernon , although the latter also analyzed theoretical knowledge.

A significant number of participants stated that they had not received training in ethics at all. This is striking because training in, bioethics is mandatory in Argentina since 1999 and is included in the curriculum (Comisión Nacional de Evaluación y Acreditación Universitaria de la República Argentina 1999). As the average age of the participants was 42 years old, it is likely that many were graduates when this requirement was implemented.

For a couple of decades now, work has been done on the adequacy of therapeutic effort specifically in emergency medicine. Evidence suggests, however, that emergency physicians may be reluctant to forego treatment efforts without clear support for this decision from policy, practice standards and guidelines, or law. (Marco 2000) A recent publication by Simon (Simon 2017) suggests that physician perception of futility is a driver of distress, which is magnified by the pressure of making decisions on short notice. This results in a possible explanation why the adequacy of therapeutic effort and the end of life is the recurring theme of ethical conflict. In our study, the dilemma of the end of life and the adequacy of the therapeutic effort was mentioned, by a large majority of the participants, as an ethical challenge in their professional practice.

Patient autonomy and the informed consent process arise as conflicts in a significant number of participants. According to our design, we cannot define whether the difficulties encountered arise from ascertaining and ensuring the patient's decision-making capacity (autonomy) or from understanding informed consent only as an administrative-legal requirement rather than as a process of communication and interrelationship that ends with a bioethical agreement. Thus, the case related to informed consent was the best resolved case followed in the assessment of decision-making competence, although a very low percentage of participants adequately followed through with the behavior. Likewise, the need to identify a sub-

stitute decision-maker was correctly chosen by a large majority of participants.

Although the clinical challenges did not explore confidentiality, this topic turned out to be a conflict for about half of the professionals. Although the design of the study does not allow us to identify the causes, it is already known that the architectural design of the Emergency Departments can be a determining factor (Mlinek 1997) , in addition to widespread practices such as the discussion of clinical cases in common spaces, leaving the clinical record, laboratory test results or diagnostic images in view of staff not involved in direct care of the patient , hold telephone or email conversations without guaranteeing privacy, obtaining and disseminating of photographs or videos without protection measures, and providing reports to third parties without authorization. It is therefore essential that physicians understand and accept their moral and not only legal duty to protect the privacy and confidentiality of patients as a starting point for improvement (Moskop 2005).

Similar to that published by Imbernon more than 8 out of 10 of the participants resolve conflicts with their colleagues and superiors. It is possible that this is directly related to the fact that emergency physicians face ethical dilemmas in real time that can occur at any time of the day or night. This way of resolving conflicts associated with the existing dichotomy between self-perception with the training and capacity to face and resolve dilemmas and the final results of the resolution of the action paths of the clinical cases generate an alarm for the correct care practice.

Coinciding with the frequency of recognition by professionals as frequent conflicts, the resolution of cases at the end of life and the adequacy of effort were the ones that had the most incorrect answers. This suggest that lack of knowledge about the use of advance directives exist and may be an issue to explore in future investigations.

Age and years of professional practice seem to have a positive influence on decision making, but no relationship was found with training or self-perception, which seems to be due to learning based on “experience” and not on formal education. This would suggest that the experience gained over years of practice has played an important role in the population studied and would contribute to support the idea that experienced supervisors are needed at all times in Emergency Departments.

We do not know if all the institutions where the participants work have a Ethics Committee, but the lack of knowledge by the participants suggests that physicians of the of the emergency services, due to the characteristics of their activity previously mentioned, may not perceive the Committees as a resource to help with their needs. To help closing this gap various strategies have been proposed such as the incorporation of an emergency physician in the bioethics committee, the development of guidelines and protocols and the dissemination and training of professionals in specific topics related to emergency medicine (Baker 2020).

This study has limitations that need to be acknowledged. The first is the representativeness of the sample due to the low response rate; this rate is usually found in online surveys (Hayslett 2004, Nulty 2008, Sinclair 2012) however, it is possible that only a group of professionals more interested in the subject opened the e-mail, so the result could be better than what occurs among physicians who are not interested in the subject. The completion of this study during the COVID-19 pandemic may also have had an influence since it generated a wide dissemination of bioethical issues related, fundamentally, to the allocation of resources.

This research shows that emergency physicians recognize the significant frequency with which they are exposed to moral conflicts. These professionals feel trained to resolve them, which is consistent with the results obtained, so it is imperative to generate educational strategies at different levels to improve training. It would also be necessary to implement mechanisms to create effective relationships between emergency services and bioethics committees.

Table 1. Characteristics of participants

Age years (DS)	41.62 (9.56)
Years since graduation (DS)	13.28 (9.52)
Gender	
Male	61 (42.4)
Female	81 (56.2)
Prefer not to say	2 (1.4)
Training completed	
In residency	15 (11.1)
Residency	29 (21.5)
Specialist	80 (59.3)
Master degree	9 (6.7)
Doctorate	2 (1.5)
Postgraduate training in Ethics	
Within a postgraduate course	41 (28.5)
Postgraduate course en Ehtics	7 (4.9)
Doctorate in Ethics	1 (0.7)
Any training in Ethics	44 (30.6)
Undergraduate training in Ethics	
No training 34 (23.6%)	34 (23.6)
Course in school of medicine 99 (68.8%)	99 (68.8)
Course and additional training undergraduate	3 (2.1)
Perceived capacity to resolve ethical challenges	
Excellent	1 (0.7)
Very good	17 (11.8)
Good	66 (45.8)
Fair	50 (34.7)
Poor	10 (6.9)

Table 2. Ethical challenges in daily practice

	N 144 (%)
Frequency of confrontation ethical challenges	
Daily	36 (25.0)
Frequently	74 (51.4)
Sometimes	28 (19.4)
Seldom	6 (4.2)
Never	0 (0.0)
Topics of the Ethical Challenges	
Autonomy	93 (64.6)
Adequate Therapeutic Effort	125 (86.8)
Confidentiality	64 (44.4)
End of Life	130 (90.3)
Informed Consent	78 (54.2)
Who is consulted when confronted with an ethical dilemma?	
Ethics Committee	10 (6.9)
The primary care physician of the patient	6 (4.2)
Peers from the Emergency Department	74 (51.4)
The supervisor or chief	45 (31.2)
No consultation with anyone	9 (6.2)

Table 3. Proportion of participants who answered correctly the ethics challenges. N=44

# Case – Description of the clinical situation	Topic	Participants who responded correctly (%)	Participants who responded correctly (%)
# 1: Patient in coma	Autonomy	36(25)	114(79)
#2: Patient with cognitive impairment	Advanced directives	50 (35)	4 (6)
#3 Ppatient with terminal Congestive Heart Failure	Futility of treatment	58 (40)	73 (51)
#4 Patient in coma	Surrogate	128 (89)	14 (10)
#5 Patietn confussed	Informed consent	132 (92)	106 (74)

Table 4 Variables associated with obtaining a high vs low score

	High score* (N=97)	Low score** (N=47)	p
Age			
Mean (SD)	42.98 (9.80)	38.81 (8.46)	**0.014**
Gender			0.120
Male	41 (42.3%)	20 (42.6%)	
Female	56 (57.7%)	25 (53.2%)	
Prefer not to say	0 (0.0%)	2 (4.3%)	
Training completed			0.441
In residency	11 (12.1%)	4 (9.1%)	
Residency	21 (23.1)	8 (18.2)	
Specialist	53 (58.2%)	27 (61.4%)	
Master's degree	4 (4.4%5)	5 (11.4)	
Doctorate	2 (2.2%)	0 (0.0%)	
Years of practice			**0.022**
Mean (SD)	14.55 (9.98)	10.68(7.98)	
Some PG training in Bioethics			0.309
NO	70 (72.2)	30(63.8)	
YES	27 (27.8)	17 (36.2)	
Some training (degree or PG) in Bioethics			0.382
NO	18(18.6%)	6 (12.8)	
YES	79 (81.4)	41 (87.2)	
Self-perception of training and competence in bioethics			0.196
Good, very good or excellent	53(54.6)	31 (66.0)	
Fair or poor	44 (45.4)	16 (34.0)	

* Number of participants who obtained a high score

** Number of participants who obtained a low score

Annex 1. Description of clinical cases

CASE 1

Mrs. G. is a 45-year-old woman with mild cognitive impairment. She routinely performs her activities of daily living, but often needs help with shopping, cooking, and handling money. She presents to the Emergency Department with several days of fever, headache and confusion accompanied by her brother. On admission, her vital signs are within normal limits. As part of her clinical evaluation, you should perform a lumbar puncture.

What represents the best course of action?

A) Assume presumed consent for the lumbar puncture given the patient's severity and history of disability.

B) Discuss the need for and risks associated with lumbar puncture with Mrs. G and seek her consent prior to performing the procedure.

C) Identify a surrogate representative by reviewing her medical history, discussing with her brother and with professionals at her facility as necessary.

D) Request consent from her brother by reviewing the benefits and risks of the procedure with him.

Correct answer: B

Suppose Mrs. G were to arrive in a coma, who would be the most appropriate proxy for the patient in this case?

A) The patient's foster father who is her legal guardian and sees her once a year.

B) The patient's mother who has not seen her in 30 years.

C) The attending physician.

D) The patient's brother who has been her caregiver for the past 30 years.

Correct answer: D.

CASE 2

Mrs. P. is admitted by ambulance to the Emergency Department for severe respiratory distress secondary to exacerbated chronic congestive heart failure. She currently lives in a nursing home. She is 77 years old, has hypertension, moderate Alzheimer's disease and severe aortic stenosis with heart failure. Her medical record has a note of an advance directive from 15 years ago in which she indicated that in the event she was unable to make decisions about her care her wish was that all available medical interventions be undertaken to preserve her life. At the time the advance directive was written, Mrs. P. had mild hypertension controlled by diet, no signs of Alzheimer's disease, and was working full time. Her 19-year-old granddaughter, M., is her next of kin. M. was not mentioned in Mrs. P.'s advance directive and says that she and her grandmother have never discussed end of life. Noninvasive ventilation has not improved Mrs. P.'s condition and she is evolving hypoxic, tachypneic, and hypotensive and is unable to engage in conversation due to

her deteriorating cognitive status. You are considering intubation, but feel that there is little or no chance of successfully weaning her from the ventilator once the acute episode is over.

1. Is Mrs. P.'s advance directive mandatory in deciding whether to intubate?

A) yes

B) no

C) don't know

Correct answer: B.

2. Regarding the decision not to resuscitate what is the most appropriate course of action?

A) Continue to treat the patient according to her advance directive.

B) Discuss invasive measures with the patient's granddaughter. Respect the granddaughter's wishes.

C) Decide that the patient is "DNR" due to the poor prognosis of her current illness and diminished quality of life even if successfully resuscitated after the event.

D) Decide that the patient is "do not resuscitate" because of her poor prognosis, discuss with the granddaughter the risks and benefits of invasive measures, and orient her to what end-of-life care entails.

Correct answer: D.

CASE 3

Mr. J. is a 65-year-old patient who was playing cards with friends in the afternoon when he began complaining of chest pain and shortness of breath. His friends transported him to the Emergency Department, but while en route Mr. J. lost consciousness for almost twenty minutes. Dr. R. and his team met the patient at the door and admitted him to the Shock Room. The patient was in asystolic cardiac arrest, had no palpable heart rhythm or blood pressure, no respiratory movements, and a temperature of 36.5 degrees Celsius. In reviewing the patient's medical history, Dr. R. notes that Mr. J. has no advance directives and has had coronary angiography with stent placement and four-vessel bypass, also has end-stage heart failure and is not a candidate for heart transplantation. Dr. R. believes that resuscitation would not be appropriate since the possibility of a successful outcome is highly unlikely.

Is it ethically justifiable for Dr. R. not to perform resuscitative maneuvers on this patient?

A) yes

B) no

C) Don't know

Correct answer: A.

2. Which of the following statements is true regarding life support?

A) In this particular case, initiating or not initiating life support is morally equivalent.

B) A documented advance directive is not required for a physician to ethically not initiate life support.

C) If there is a disagreement between the family and the physician regarding the futility of a measure or intervention, the family's wishes always determine the steps to be taken.

D) Physicians always agree when treatments will be clinically futile.

Correct answer: B.

CASE 4

A 45-year-old male patient with a history of hypertension is admitted to your Emergency Department after being assaulted in a bar. Per referral from the ambulance system, the patient was intoxicated and was struck in the head with a bottle during an altercation with another man. Upon arrival, the patient has significant bleeding from a scalp wound and a Glasgow scale score of 7/15 and is immediately intubated. A CT scan shows a subdural hematoma with 1 cm midline displacement. The patient's wife and cousin arrive as he is preparing to place a catheter for intracranial pressure monitoring. The nursing staff informs you that both individuals are alcoholic and belligerent, and are demanding to see the patient. When they arrive in the Shock Room they are informed of the situation. She laughs and responds that "he's fine", "he doesn't need all that stuff", and that "he probably wouldn't want it anyway".

Can the wife of the patient in this condition participate in the decision making process?

A) yes

B) no

C) don't know

Correct answer: B.

Should you place the catheter for intracranial pressure monitoring?

A) Yes. You must act in the patient's best interest and consent is unnecessary in the present situation.

B) No, because your wife has stated that such invasive measures would be against the patient's wishes.

C) No. You should temporarily suspend the procedure while you attempt to discuss with the wife the seriousness of the situation and the necessity of the procedure.

D) No because his wife is the patient's legally authorized representative and her wishes should be respected.

Correct answer: C.

CASE 5

A 64-year-old female patient with a history of multiple sclerosis with neurogenic bladder is brought to your Emergency Department for fever and headache. During your initial evaluation you explain that her fever is most likely due to a urinary tract infection, but that she may need a lumbar puncture as part of the diagnostic process. She has some questions about the procedure, which you answer and agree to perform if necessary. In the next few hours, the lab shows urinary tract infection and she has a normal CT scan of the brain. You have started IV fluids and empiric antibiotics. When you approach the patient, you find her confused and out of bed. She does not seem to remember your earlier conversation about a lumbar

puncture and cannot understand the details of the procedure or your procedure and its indications when you try to explain them again.

1.) At this point, does the patient have the capacity to consent to or refuse the procedure?

A) yes

B) no

C) don't know

Correct answer: B.

Which of the following is correct regarding obtaining informed consent?

A) It is not necessary for the patient to understand the medical indications.

B) It is necessary that the patient has retained the ability to understand and process the information.

C) It is not necessary for the patient to retain the capacity to deliberate on the risks and benefits of the practice to be performed.

D) It is necessary for the patient to be able to understand that he/she does not have the right to refuse the proposed treatment or procedures if life-threatening.

Correct answer B.

Recibido **29-10-2022**
Aprobado **15-1-2023**

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