Ethics and Professionalism in Surgery

Clinical Principles and Surgical Judgment

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Chapter 16

Foolad Eghbali, MD
Associate Professor of Surgery
Iran University of Medical Sciences
Tehran, Iran

Learning purpose

Ethical judgment connects what an operation can accomplish with what ought to be offered, recommended or declined. The surgeon must identify the patient's goals, evaluate benefit and harm, respect appropriate decision making authority and explain a defensible course of action.

This chapter develops ethical foundations, consent and capacity, innovation, surrogate decisions, treatment limits, professional identity and contemporary challenges. An integrated algorithm, review tables and 100 extended ethical judgment questions connect these subjects to surgical practice.

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Primary source Angelos P, Mellinger JD. Ethics and Professionalism in Surgery. In Sabiston Textbook of Surgery, 22nd edition, Chapter 16, electronic pages e214 to e221. The chapter is designated online only in the contents and is included in the supplied PDF at pages 256 to 263.

1 Recognizing an ethical problem

Separate technical uncertainty from ethical disagreement

A difficult operation is not automatically an ethical dilemma. Technical judgment asks which approach can achieve a defined clinical objective. Ethical judgment also asks whether that objective is appropriate, who should authorize treatment and whether the burdens are justified for this patient. The questions overlap, but they are not identical.

Question	Primary uncertainty	Useful next step
Can this lesion be removed safely?	Feasibility and procedural risk	Obtain relevant clinical evidence and expertise
Would removal offer a worthwhile outcome?	Meaning of benefit and burden	Clarify the patient's goals and likely recovery
Who may authorize treatment?	Decision making authority	Assess capacity and any appropriate surrogate role
Is the request within acceptable care?	Professional obligation and limits	Explain medically appropriate options and reasons
How should competing claims be treated?	Fairness and consistency	Use relevant transparent allocation processes

Identify what the disagreement is actually about

A patient and surgeon may agree on prognosis but disagree about how much disability is acceptable. Conversely, an apparent conflict of values may result from different understandings of survival, pain relief or likely recovery. Establish the facts and the meaning of the desired outcome before labeling either party unreasonable.

Ethical analysis must lead to an action. Listing autonomy, beneficence, nonmaleficence and justice is a starting point, not a complete explanation. State which obligations are in tension and why the proposed plan handles that tension better than the alternatives.

Clinical pearl Ask whether more clinical information would resolve the disagreement. If the facts are already shared, the next conversation may need to address goals and values rather than another investigation.

Common pitfall Treating a patient's disagreement with the surgeon as proof that the patient cannot decide. A choice can be unwelcome to the clinician without establishing impaired capacity.

Source Sabiston Chapter 16, e214 to e215; PDF pages 256 to 257. The comparison table is an original teaching synthesis.

2 Four principles in surgical practice

Principle	Practical meaning	Question for the surgeon
Respect for autonomy	Take the patient's informed voluntary choices seriously	Whose values and authorization are directing care?
Beneficence	Seek a clinically meaningful good for the patient	What benefit can this intervention actually deliver?
Nonmaleficence	Avoid unjustified or disproportionate harm	Which burdens and preventable injuries are being accepted?
Justice	Treat comparable claims fairly and consider effects on others	Are relevant patients being treated consistently?

Autonomy requires participation rather than abandonment

The surgeon should explain acceptable options and provide a recommendation that reflects clinical knowledge and the patient's priorities. Respecting choice does not mean asking a patient to solve an unexplained technical problem alone. Nor does it require performing every requested intervention.

Benefit is an outcome rather than a technical event

Removal of tissue, closure of a wound or completion of a bypass can be technically successful without producing the benefit the patient sought. Relief of obstruction, preservation of independence and prolongation of life may matter differently to different patients. Identify the intended result and whether the intervention can reasonably achieve it.

Avoiding harm does not mean avoiding every operation

Surgery commonly introduces pain, risk and temporary disability. Nonmaleficence asks whether those burdens are justified by the expected benefit and whether avoidable harm has been reduced. An operation with some risk may be appropriate; an operation without a reasonable beneficial objective may not be.

Justice extends beyond the immediate encounter

Fairness concerns the treatment of similarly situated patients and the distribution of shared resources. The clinical recommendation should not quietly change because a patient is more influential or easier to advocate for. Resource constraints should be addressed through relevant transparent processes rather than disguised as a different clinical prognosis.

Exam pearl The principles are not a fixed priority list. Their relationship must be explained in the actual case.

Source Sabiston Chapter 16, e214 to e215; PDF pages 256 to 257. Applications and wording are original.

3 Balancing principles without a fixed hierarchy

Distinguish refusal from a demand for treatment

When a patient with decision making capacity refuses an offered operation after appropriate discussion, the surgeon must take that refusal seriously. When the patient requests an operation that cannot reasonably achieve the intended benefit, respect for the person does not create an obligation to provide that operation. Both situations require communication, but they are not mirror images of the same obligation.

Situation	Ethical issue	Reasoned response
Several medically appropriate options	Different acceptable burdens and benefits	Let informed patient priorities guide the choice
Requested intervention lacks a reasonable beneficial objective	Autonomy conflicts with harm and professional limits	Explain the concern and offer appropriate alternatives
Potentially beneficial intervention is refused	Patient values differ from the recommendation	Assess understanding and voluntariness and address concerns
Patient cannot participate during an emergency	Urgent need with missing authorization	Use the appropriate emergency decision pathway
Scarce resources affect access	Individual need intersects with other claims	Apply relevant fair processes consistently

Explain why an operation is not recommended

A defensible recommendation connects expected outcomes with the treatment goal. Explain what surgery is likely and unlikely to achieve, what burdens it adds and which alternatives remain. Avoid using a broad label such as futile as a substitute for that explanation. The chapter emphasizes that judgments about futility depend on the goal being considered.

Do not make prognosis more certain than the evidence

The statement that an operation cannot achieve a particular goal differs from saying its chance is low or uncertain. Make the distinction explicit. If reasonable clinicians disagree, additional expertise and ethics consultation may clarify the basis of disagreement. Uncertainty does not justify either promising success or concealing material limitations.

Clinical pearl A patient can reasonably prefer the more extensive of two acceptable treatments. The surgeon's preference alone does not make the other option ethically unacceptable.

Source Sabiston Chapter 16, e215 to e216; PDF pages 257 to 258. Practical refusal discussion is consistent with AMA consent guidance; legal requirements remain jurisdiction specific.

4 Virtue character and professional trust

Ask what kind of surgeon the decision expresses

Principle based analysis identifies obligations. Virtue based ethics also examines character and the habits that shape action under pressure. Compassion, honesty, humility and practical judgment influence whether the surgeon recognizes uncertainty, invites a second opinion or admits a limitation when doing so is inconvenient.

Professionalism links individual conduct with the trust granted to surgery as a profession. Patients permit direct bodily intervention and entrust their safety while sedated or anesthetized. That vulnerability creates obligations extending beyond technical competence and courteous presentation.

Professional quality	Observable surgical expression	Threat under pressure
Integrity	Describe outcomes and limitations honestly	Overstate certainty to secure agreement
Humility	Recognize limits and seek relevant help	Conceal inexperience or dismiss concerns
Compassion	Understand the burden in the patient's terms	Reduce the person to a procedural problem
Accountability	Accept responsibility for follow up and improvement	Shift ownership when outcomes become difficult
Collaboration	Respect team expertise and listen to safety concerns	Use hierarchy to silence relevant information
Commitment to learning	Review practice and maintain competence	Treat past qualification as sufficient forever

Three complementary ways to develop professionalism

The chapter describes virtue based professionalism, behavior based professionalism and professional identity formation. The first develops internal values and character; the second clarifies observable expectations and feedback; the third examines how participation in a professional community shapes identity. These approaches can complement each other.

A behavioral checklist may identify a missed obligation, but reliable practice also depends on motivation and culture. Similarly, a declared good intention does not excuse harmful behavior. Later units will examine role modeling, the hidden curriculum, feedback and remediation in greater detail.

Exam pearl Professionalism is not simply politeness. It includes how the surgeon handles vulnerability, limits, competing interests, responsibility and disagreement.

Source Sabiston Chapter 16, e217 to e220; PDF pages 259 to 262. The table applies the chapter concepts to original surgical examples.

5 Structured ethical judgment

Use a structured conversation to turn a disputed request into a reasoned recommendation. This framework is an original teaching application, not a validated score or a universal legal process.

Step	Question	Action
1 Establish urgency	What harm follows from waiting?	Protect immediate safety while clarifying decisions
2 Establish facts	What is known and what remains uncertain?	Separate evidence from assumptions
3 Define goals	What outcome is the treatment meant to achieve?	Use the patient's priorities where available
4 Establish authority	Can the patient decide and who may act if not?	Support participation and verify the relevant pathway
5 Identify the conflict	Which obligations pull toward different actions?	Explain the tension rather than recite labels
6 Compare options	Which strategies can achieve a justified objective?	Include alternatives and appropriate nonintervention
7 Recommend and review	Why is this plan preferable and who owns follow up?	Communicate, document and revisit when facts change

Capacity is not a diagnostic label

Assess the person's ability to participate in the particular decision and address reversible communication barriers. A diagnosis, intoxication history or disagreement may raise concern but should not be used as an automatic conclusion about every decision. Seek appropriate assessment when capacity is uncertain.

Emergency need is not blanket permission

When urgent treatment is necessary and the patient cannot participate, an emergency pathway may permit necessary intervention if an appropriate decision maker is unavailable. Relevant known preferences and directives still matter. Once participation becomes possible, the continuing treatment plan requires renewed communication and appropriate authorization.

Resolve uncertainty about authority explicitly

Surrogate priority, documentation and the treatment of disputed decisions depend on applicable law and institutional policy. Do not transplant the textbook's jurisdiction specific examples into a universal family hierarchy. Seek ethics or legal support when authority or conflict cannot be resolved through the clinical team.

Source Sabiston Chapter 16, e214 to e216; PDF pages 256 to 258. Capacity and emergency qualification supplement: AMA Code of Medical Ethics, Opinions 2.1.1 and 5.2.

6 Extended case in surgical judgment

An informed request that challenges the recommendation

A 68 year old man with progressive metastatic abdominal cancer asks for an extensive operation to remove the primary tumor. He has weight loss, limited mobility and repeated admissions, but remains alert and able to describe his illness. The oncology and surgical teams agree that the proposed resection is very unlikely to prolong survival and would carry substantial recovery burden. He has no current obstruction, perforation or uncontrolled bleeding. His daughter says that respecting autonomy means performing the operation he requests. During a private discussion he explains that his real aim is to remain comfortable enough to attend an important family event in three weeks. He believes tumor removal is the only way to achieve that goal because nobody has explained the nonoperative symptom plan. The surgeon thinks resection is technically possible but unlikely to help him return home in time. A palliative care consultation is available today, and the patient is willing to hear alternatives.

Reason through the decision

Decisive issue The requested operation and the patient's actual goal are not equivalent. Technical feasibility does not establish that resection can deliver the outcome he values.

First clarify the shared clinical facts and uncertainty, then explain the expected recovery burden in relation to the three week goal. Offer a specific symptom and support plan rather than a bare refusal. Invite his daughter with permission and distinguish respect for his choices from an obligation to perform an intervention lacking a reasonable beneficial objective.

The recommendation may be against resection while remaining actively committed to treatment of symptoms and support. If another medically appropriate option can achieve the goal, discuss its burdens and limitations. If disagreement persists, seek additional review rather than using authority or the word futile to end the conversation.

Competing approaches and their limitations

Approach	Why it is less appropriate
Operate because the patient requests it	Treats autonomy as an unlimited claim to any intervention
Refuse and end the encounter	Abandons explanation of goals and available care
Ask the daughter to decide	Displaces a patient who can participate
Promise the symptom plan will achieve the event goal	Substitutes a new unjustified guarantee for honest uncertainty

Source Original scenario applying Sabiston Chapter 16, e214 to e216. It is a teaching case, not a report of an actual patient.

7 Chapter framework and assessment standard

Planned sequence

Unit	Core reasoning task
Ethical foundations	Recognize and balance competing obligations
Informed consent and refusal	Support understanding, voluntariness and meaningful authorization
Innovation and learning curves	Disclose novelty, uncertainty and relevant experience
Assent capacity and surrogate decisions	Identify participation and decision making authority
Substituted judgment best interests and futility	Connect choices to goals and appropriate decision standards
Professionalism and professional formation	Integrate character, behavior, identity and accountability
Contemporary challenges and remediation	Address disagreement, culture, feedback and professional lapses
Integrated assessment	Apply the chapter through extended MCQs and structured oral cases

Teaching and assessment format

English teaching notes use concise explanations, comparison tables and clinical or examination pearls. Cases should test prioritization and judgment through relevant uncertainty, competing risks, changing information and patient goals. Longer narratives must add information that changes reasoning rather than merely increase reading length.

The completed assessment plan is 100 single best answer cases with extended stems, generally about 140 to 200 words or longer when clinically useful. Options should represent competing management strategies. Each explanation states the decisive reasoning and discusses every distractor. Ten structured oral stations will include staged updates, model answers, 20 point checklists, separate global ratings and safety concerns.

References for this opening unit

Angelos P, Mellinger JD. Ethics and Professionalism in Surgery. Sabiston Textbook of Surgery. 22nd edition. Chapter 16, e214 to e221; supplied PDF pages 256 to 263. Primary discussion used here: e214 to e220.

AMA Code of Medical Ethics. Opinion 2.1.1, Informed Consent. https://code-medical-ethics.ama-assn.org/ethics-opinions/informed-consent

AMA Code of Medical Ethics. Opinion 5.2, Advance Directives. https://code-medical-ethics.ama-assn.org/ethics-opinions/advance-directives

The ethical framework, comparisons and case analysis are original educational syntheses. Jurisdiction specific consent and surrogate requirements should be identified in the relevant clinical setting.

8 Informed consent as a clinical process

Informed consent links a discussion to a patient's voluntary authorization of a particular intervention. The signed form records part of that process; it does not establish that the patient understands the proposal or has agreed to its actual scope. Agreement to admission, imaging or anesthesia should not be assumed to authorize every surgical intervention.

Element	What the surgeon must establish	Practical failure to detect
Capacity	The patient can make the decision at this time	A diagnosis is substituted for an actual assessment
Relevant information	Options and consequences are explained meaningfully	A risk list omits what matters to the patient
Understanding	The patient can explain the choice in their own terms	Silence is mistaken for comprehension
Voluntariness	The choice reflects the patient's wishes without coercion	Family agreement conceals patient objection
Authorization and scope	The agreed intervention and important limits are clear	A signature is treated as unlimited permission

The surgeon remains responsible for the discussion

The ACS 2026 statement distinguishes the surgeon's responsibility for the management conversation and its documentation from the administrative act of collecting a signature. Team members can support communication, but a completed form should not replace a discussion of surgical options, benefit, adverse outcomes and alternatives.

Consent must remain connected to the actual plan

Revisit the discussion when new findings change the proposed procedure, material risk or expected recovery. Check the patient's current decision before proceeding, especially if the record and the patient's account conflict. A previously signed form does not override a later withdrawal of permission.

Clinical pearl Ask the patient to describe what operation is planned, why it is offered and what concerns them most. A mismatch is an opportunity to clarify before treatment.

Source Sabiston Chapter 16, e215; PDF page 257. Supplement: ACS Statement of Principles Underlying Surgeon Responsibility Towards the Patient, revised June 9, 2026, particularly paragraphs 4 to 5.

9 Disclosure understanding and the wish not to know

Discuss outcomes in the patient's terms

Explain the diagnosis and uncertainty, the purpose and nature of surgery, expected benefit, important harms, reasonable alternatives and the likely consequences of forgoing treatment. Recovery burden can be as material as mortality: a stoma, loss of independence or prolonged rehabilitation may determine the patient's choice.

Use understandable language and check interpretation rather than asking only whether the patient has questions. Numerical estimates need a clear outcome and context. Do not promise success, treat population averages as certainty or imply that choosing against the recommendation will end access to all care.

A preference for less detail differs from concealed information

Sabiston emphasizes that autonomy includes the opportunity to receive information and that some patients genuinely prefer to rely heavily on a recommendation. Confirm this preference with the patient rather than accepting a relative's request to conceal the diagnosis. Anxiety may call for paced explanation and support rather than either forced detail or silence.

Situation	Appropriate response	What should not be assumed
Patient requests fewer details	Explore the preference and establish sufficient understanding	A brief statement grants unlimited authority
Family asks that diagnosis be concealed	Clarify the patient's own communication wishes	Family anxiety supplies permission to withhold
Patient is overwhelmed	Pace information and offer support or another conversation	Distress automatically means incapacity
Basic information is persistently declined	Clarify scope and seek advice if validity remains uncertain	A signature settles every unresolved issue

Guidance supplement on minimum understanding

GMC guidance adds practical caution when a patient declines detail: establish basic understanding of the proposed option, its aim, invasiveness, burdens and serious risks as relevant. If even basic information is refused, consent validity requires careful judgment and appropriate advice; this is not an automatic permission to proceed or an automatic finding of incapacity.

Source Sabiston Chapter 16, e215. Supplements: AMA Opinion 2.1.3, Withholding Information from Patients; GMC Decision making and consent, paragraphs 65 to 68. Their professional and legal contexts should be distinguished.

10 Assessing decision making capacity

Assess the decision and the time

Begin with the adult patient's participation, not a presumption of inability. Capacity can differ between decisions and fluctuate with illness or treatment. Dementia, mental illness, intoxication, severe pain or inability to speak may prompt concern, but none should substitute for assessment of the relevant abilities and available support.

Clinical question	Useful conversational approach	Interpretation
Understanding	Ask the patient to explain the condition and proposed options	Can the relevant information be grasped?
Retention and use	Revisit the essential information during deliberation	Can it be retained sufficiently for this decision?
Personal implications and weighing	Ask how accepting or declining affects their own goals	Can options and consequences be considered meaningfully?
Communication	Offer speech, writing, aids or other appropriate methods	Can a choice be expressed by an accessible route?

Maximize participation before concluding inability

Use an appropriate interpreter, hearing or visual aids, plain language and a suitable environment. Treat reversible contributors when feasible and account for the effects of sedation, delirium or physiological deterioration. Allow time when delay is safe. A communication barrier should not be converted into a surrogate decision simply because doing so is faster.

Disagreement is not a diagnostic test

Assess the reasoning process rather than whether the patient selects the surgeon's preferred option. Serious consequences justify careful exploration and documentation, but not a rule that consent proves capacity while refusal proves incapacity. Ask whether misunderstanding, coercion or an acute impairment explains the response.

Document evidence and obtain help when needed

Record the specific decision, relevant information, support provided, the patient's responses, remaining uncertainty and the conclusion. Seek experienced or specialist support when the assessment is difficult; psychiatric referral is not automatically required for every capacity question. Apply the governing jurisdiction's legal test rather than treating this teaching framework as a universal statute.

Source Sabiston Chapter 16, e215 to e216. The functional assessment detail is a supplement from GMC Decision making and consent, paragraphs 81 to 84, and its Mental capacity guidance.

11 Informed refusal and continued care

A refusal requires understanding rather than capitulation

Clarify exactly what is being refused: the entire operation, a component such as transfusion, a particular recovery burden or treatment at the present time. Ask why. The reason may reveal a false belief, untreated pain, coercion, an access problem or a value that differs from the surgeon's own.

Explain the expected consequences of refusal, including serious harm or death when relevant, without exaggeration or threats. Discuss acceptable alternatives and what can still be offered. Confirm decision specific capacity and voluntariness; provide additional support or a second opinion if useful and feasible.

Finding	Management implication	Pitfall
Capable informed adult refuses	Respect the decision and agree on continued appropriate care	Override because the predicted outcome is poor
Misunderstanding drives refusal	Clarify and reassess the decision	Obtain a signature without correcting the error
Capacity is impaired or uncertain	Assess support, reversibility and the appropriate authority pathway	Use refusal alone as proof of incapacity
Patient accepts only part of treatment	Establish the precise limits and clinical feasibility	Assume permission for excluded components
Patient changes the decision	Review the current choice and its scope	Treat the earlier form as irrevocable

Refusal does not end the relationship

Document the discussion, the patient's reasoning, offered alternatives and agreed follow up or safety advice. Continue appropriate symptom care and support. If treatment conditions cannot be met safely, explain the limitation and seek suitable alternatives or referral while maintaining continuity and addressing urgent needs.

Separate ethical refusal from legal exceptions

The ethical starting point is respect for an informed voluntary refusal by an adult with relevant capacity, even when the consequences may be grave. Authority involving minors, applicable advance refusals, mental health legislation or other exceptional circumstances requires jurisdiction specific assessment. A general ethics summary cannot resolve every statutory exception.

Exam pearl The strength of the surgical recommendation and the patient's authority to decline are separate questions. A strong recommendation does not itself supply authorization.

Source Sabiston Chapter 16, e215 to e216. Supplements: ACS Statement on Principles, informed consent section; WMA International Code of Medical Ethics, paragraphs 13 and 15 to 18.

12 Emergency decisions and changing capacity

Define the emergency before using the exception

An emergency pathway addresses necessary treatment when delay threatens serious harm, the patient cannot participate and appropriate authorization cannot be obtained in time. Operational urgency, an empty operating slot or a missing routine signature does not create that situation.

Check available relevant preferences and directives without delaying essential care. The emergency pathway is not a mechanism for bypassing a known applicable refusal. When validity, applicability or authority is disputed, obtain urgent institutional advice while managing immediate clinical needs under the applicable framework.

Situation	Reasoning priority	Next step
Patient can decide despite urgency	Seek a focused meaningful decision	Explain the essential choice and consequences
Temporary impairment and safe delay	Support restoration of participation	Treat contributors and reassess
No capacity and unsafe delay	Identify necessary immediate treatment	Use the appropriate emergency pathway and document
No capacity but time is available	Establish a proper decision maker	Verify authority rather than presume family priority
Capacity returns	Restore the patient's participation	Review continuing intervention and authorization

Do not expand scope merely because the patient is anesthetized

Foreseeable contingencies should be discussed before elective surgery where possible. An unexpected finding during anesthesia requires consideration of prior scope, necessity, harm from waiting and available authority. A convenient additional procedure is not automatically justified as an emergency. Detailed scope and jurisdiction specific issues should be reviewed through the relevant institutional process.

What the record should show

Record the immediate threat, why the patient could not decide, relevant known preferences, attempts to identify available authority when feasible, the treatment considered necessary and the reason delay was unsafe. Revisit the situation as soon as participation or appropriate representation becomes possible.

Source Sabiston Chapter 16, e215 to e216. Supplements: AMA Opinions 2.1.1 and 5.2; WMA International Code, paragraphs 17 to 18; GMC consent guidance on scope. This is an ethical framework, not a universal emergency consent law.

13 Case one Refusal or unsupported communication

Extended clinical scenario

A 77 year old man is admitted for elective resection of a nonobstructing colon cancer. His daughter normally manages appointments and says he has mild memory problems. On the ward he repeatedly answers no when asked to sign the consent form, cannot name the operation and appears irritated. He has no hearing aids with him, the conversation is conducted rapidly in a language he understands imperfectly, and nobody has arranged an interpreter. He is hemodynamically stable and has received no sedative. The daughter asks to authorize surgery herself because he becomes confused in hospitals. The operating slot is available today, but a brief delay would not compromise cancer care. A nurse later speaks slowly while facing him; he explains that he fears a permanent stoma and believes nobody will discuss that possibility. He wants treatment if the alternatives and recovery burdens can be explained. An interpreter and appropriate hearing support can be arranged within hours.

Best next strategy

Pause the elective authorization process, provide communication support and reassess understanding and the particular decision. Discuss the possible stoma and alternatives directly with him. Establish whether he can decide rather than presuming either an informed refusal or incapacity from the first encounter.

Competing strategy	Why it is less appropriate
Ask the daughter to sign now	Authority cannot be inferred from convenience or appointment management
Treat the first no as a fully informed final refusal	Communication barriers and a material misunderstanding remain unresolved
Sedate to reduce resistance before consent	This does not create voluntary informed authorization
Require a normal cognitive screening score	A screening threshold is not equivalent to decision specific capacity

Decisive judgment Support can change the quality of the decision without predetermining its outcome. After clarification, the patient may still refuse; disagreement alone would not negate capacity.

Source Original case applying Sabiston Chapter 16 and the named capacity and communication supplements in sections 9 to 10.

14 Case two Refusal of a treatment component

Extended clinical scenario

A 59 year old woman is considering a major elective operation with a clinically important possibility of transfusion. She understands the diagnosis and requests surgery, but refuses donor red cells because of a longstanding personal conviction. She is alert, has no evidence of acute mental illness or delirium, and explains that she accepts the possibility of death rather than receive that treatment. Her husband asks the surgeon to obtain the signature now and transfuse later if necessary, believing emergency circumstances would cancel the refusal. The operation is not immediately required, and the patient is willing to discuss anemia treatment, blood conservation and referral. She has not yet specified which other products or techniques she would accept. The surgeon believes a safe acceptable plan might be possible, but cannot promise a blood free course or justify proceeding without clarifying the limits. The patient asks whether the surgeon will abandon her if she continues to refuse red cells.

Best next strategy

Clarify capacity, voluntariness and the precise treatment limits privately where appropriate. Discuss the specific operative risk, accepted alternatives and clinical feasibility with the relevant team. Document the informed decision and an actionable perioperative plan; if the conditions cannot be met, explain this and arrange appropriate alternatives or referral with continuity.

Competing strategy	Why it is less appropriate
Use the husband's permission to transfuse	It does not override her capable informed decision
Assume an emergency will erase the refusal	Known applicable preferences require explicit consideration
Promise that transfusion will never be needed	A guarantee conceals uncertainty and may misrepresent feasibility
End all care because she declines one component	Refusal does not justify abandonment of appropriate care

Decisive judgment Agreement to surgery does not imply agreement to every component. Respect for refusal and the surgeon's obligation to offer a clinically defensible plan must be addressed together. Applicability of refusal after capacity changes requires the relevant legal and institutional framework.

Source Original adult elective case applying Sabiston Chapter 16, ACS consent principles and WMA ethical guidance. It does not define jurisdiction specific transfusion law.

15 Consent and refusal final review

Question before proceeding	Evidence to seek
What is being authorized?	A specific operation, relevant contingencies and stated limits
Can this patient decide now?	Decision specific abilities after reasonable support
What matters to the patient?	Goals and burdens relevant to the choice
What information was discussed?	Benefits, important risks, alternatives and no treatment
Does the patient understand?	An explanation in the patient's own terms
Is the decision voluntary?	An opportunity to speak free of inappropriate pressure
What happens after refusal?	Continuity, alternatives, follow up and safety advice
What changes the decision pathway?	New facts, changed capacity, changed choice or true emergency

A concise oral examination answer

I would first establish urgency and the exact decision. I would support communication, assess capacity when indicated, explain the options in relation to the patient's goals and check understanding and voluntariness. I would clarify any refusal or treatment limit, recommend an appropriate plan and document the reasoning. If capacity is absent, I would use the appropriate authority or emergency pathway while respecting applicable known preferences and maintaining participation wherever possible.

References for this unit

Angelos P, Mellinger JD. Sabiston Textbook of Surgery. 22nd edition. Chapter 16, e215 to e216; supplied PDF pages 257 to 258. Detailed functional assessment, implementation and refusal examples above are original teaching syntheses with identified professional guidance supplements.

ACS. Statement of Principles Underlying Surgeon Responsibility Towards the Patient. Revised June 9, 2026. ACS. Statement on Principles, informed consent section. https://www.facs.org/about-acs/statements/

AMA Code of Medical Ethics. Opinions 2.1.1, Informed Consent; 2.1.3, Withholding Information from Patients; 5.2, Advance Directives. https://code-medical-ethics.ama-assn.org/

GMC. Decision making and consent. Communication, information preferences, scope and capacity sections, especially paragraphs 27 to 31, 65 to 68 and 81 to 84. https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent

WMA International Code of Medical Ethics. Revised 2022, paragraphs 13 and 15 to 18. https://www.wma.net/policies-post/wma-international-code-of-medical-ethics/

16 What is new and for whom

Ethical assessment begins by locating the novelty. A procedure may be unfamiliar to the profession, established elsewhere but new to the surgeon, or familiar to the surgeon but unsupported by the local team. These situations create different uncertainties and require different safeguards. The word innovative should not obscure which problem is actually present.

Situation	Main uncertainty	Relevant response
Novel operation or application	The profession has limited evidence about outcomes	Explain novelty, evidence limits and alternatives
Established operation new to the surgeon	Individual experience and procedural competence	Disclose relevant experience and establish appropriate support
Familiar operation in a new local setting	Team, equipment and rescue capability	Assess the actual system rather than the surgeon alone
Modification of an established approach	Whether evidence transfers to the change	Identify what changed and reassess its consequences

Newness is neither a benefit nor a disqualification

An innovation may offer an important improvement, but novelty alone does not establish superiority. Conversely, limited evidence does not make every new intervention impermissible. The decision requires a credible clinical rationale, appropriately prepared clinicians and a transparent account of uncertainty in relation to this patient's needs.

Separate collective evidence from personal experience

Published results from expert centers describe one aspect of the decision. They do not establish that the adopting surgeon or institution can reproduce those results. A surgeon's expertise in an adjacent technique may be relevant, but it should not be represented as identical experience with the proposed method.

Clinical pearl Ask three questions before offering the intervention: what is new to the profession, what is new to me, and what is new to this team?

Source Sabiston Chapter 16, e215 to e216; PDF pages 257 to 258. The classification is an original teaching synthesis. Adoption and setting considerations are supplemented by the named SAGES guidance.

17 Disclosing uncertainty without false reassurance

Make uncertainty specific

Sabiston emphasizes that the patient should know when an operation is innovative and when its actual risks remain uncertain. A general statement that all surgery has risks does not communicate a limited evidence base. Explain what is known, what is only anticipated and what remains unresolved, including relevant recovery or longer term outcomes.

Disclosure domain	Information that helps the decision	Misleading substitute
Clinical rationale	Why this option may help this patient	Newer technology is automatically better
Evidence	Nature and limits of available experience	A favorable report proves predictable benefit
Personal experience	The surgeon's relevant procedural experience	General seniority implies equivalent expertise
Alternative strategies	Established options and their burdens	The innovative method is the only real choice
Support and uncertainty	What assistance is planned and what it cannot guarantee	A mentor or consent form eliminates added risk

Use estimates in their proper context

If a numerical estimate comes from a small series, selected patients or an experienced center, explain the limitation when it matters. Do not invent a precise additional risk percentage for an individual learning curve. Acknowledge uncertainty while giving a clear recommendation and describing why the possible benefit may or may not justify it.

Give the patient a genuine choice

Describe established alternatives, relevant referral options and the consequences of waiting where applicable. Avoid implying that refusal of the novel approach means refusal of all care. Allow questions and time proportionate to urgency. Record the actual discussion rather than merely adding innovative to a generic form.

Exam pearl Honest uncertainty is compatible with clinical leadership. The surgeon can recommend an option while explaining the limits of the evidence and their own experience.

Source Sabiston Chapter 16, e215 to e216. Disclosure implementation is an original application; AMA Opinion 1.2.11 supports explaining differences from standard care, relevant experience and conflicts.

18 Learning curves and the limits of case numbers

An accepted procedure may still be new to the operator

Sabiston distinguishes uncertainty about an innovative procedure from the adopting surgeon's limited experience with an accepted one. Patients may reasonably find the latter relevant. Disclosure should describe the actual situation rather than imply that publication of a technique makes its performance routine for every surgeon.

There is no universal disclosure threshold

The chapter does not provide a single case number after which disclosure becomes unnecessary. The procedure, the clinician's development and whether the information remains relevant to a reasonable patient's decision all matter. Seniority, course attendance and a raw case count are not interchangeable measures of readiness.

Indicator	What it may show	What it does not establish alone
Observed or assisted cases	Exposure to the technique	Independent ability to perform it
Completed training course	Participation in an educational activity	Competence across real clinical scenarios
Number of cases	Amount of exposure	Quality, difficulty or completeness of performance
Operative time	One aspect of efficiency	Overall safety or clinical effectiveness
Clinical outcomes	Performance in the cases observed	Absence of delayed harm or case selection effects

Consent does not convert inadequate preparation into competence

A patient's willingness to accept a learning curve is not sufficient reason to offer a procedure that the surgeon is not appropriately prepared to perform. The duty to disclose and the duty to provide defensible care are complementary. When suitable support is unavailable, an established approach, a justified delay or referral may be preferable.

Describe assistance accurately

If a colleague will assist, explain the planned role and availability. Do not imply that an observer can necessarily take over or that remote advice supplies every form of rescue. The operational arrangement must match what is represented in the consent discussion.

Source Sabiston Chapter 16, e215 to e216. Training and support considerations are informed by SAGES Guidelines for the Introduction of New Technology and Techniques and are applied here as teaching analysis.

19 A safe adoption plan beyond consent

The following framework applies ethical obligations to the practical adoption decision. It is an original planning aid, not a universal credentialing rule. Institutional requirements, scope of practice and applicable regulatory obligations must be established in the relevant setting.

Decision	Evidence to establish	Reason to reconsider
Clinical selection	A patient specific rationale and reasonable alternatives	Convenience or publicity dominates selection
Preparation	Relevant knowledge and demonstrated procedural skills	Training exposure is mistaken for independent capability
Team readiness	Anesthesia, nursing, equipment and coordination	The surgeon is prepared but the system is not
Assistance	A clear arrangement for expertise and escalation	Promised support cannot actually be delivered
Rescue	A feasible response to failure or complication	No realistic route to an established alternative
Review	Follow up and examination of outcomes	Problems are concealed or not evaluated

Training should match the change

SAGES adoption guidance recommends procedure or device specific preparation and recognizes that a course alone may be insufficient. Depending on the change, preparation may include simulation, supervised experience and team training. The relevant endpoint is defensible performance and support, not merely attendance.

Do not use a difficult patient to satisfy a program milestone

Case selection should follow patient need and the actual ability to provide care. A technically demanding case may require experience beyond that of an early adoption program. The desire to complete a first case or avoid losing an equipment booking should not redefine an unsuitable case as an ideal candidate.

Define when to stop or change strategy

Agree on escalation and alternative approaches before the procedure where possible. A change to an established technique can be a responsible safety decision rather than a failure to innovate. Reassess after unexpected difficulty or adverse outcomes instead of pursuing a target number without reviewing what the cases reveal.

Source Original application of Sabiston principles. Training supplement: SAGES Guidelines for the Introduction of New Technology and Techniques. Oversight supplement: AMA Opinion 1.2.11 and SAGES Ethical Considerations Regarding Implementation of New Technologies and Techniques in Surgery.

20 Innovation research and competing interests

Do not classify an activity by its preferred label

Innovation and research can overlap, but not every change in clinical practice is automatically research. Equally, calling an intervention innovative care does not exempt an activity from relevant research review. Clarify the purpose, protocol and applicable oversight with the institution before recruitment or treatment where required.

When research requirements apply, ordinary surgical consent alone does not replace the relevant research information, review or authorization. Patients should understand what is intended for their clinical benefit and what is being done to answer a broader question. Do not promise that enrollment provides superior treatment.

Identify what may distort the recommendation

Influence	Question to ask	Ethical response
Financial relationship	Could a payment or ownership interest affect advice?	Disclose and manage the relevant conflict
Institutional investment	Is equipment utilization being treated as a patient benefit?	Base selection on clinical need and readiness
Academic priority	Is being first influencing case choice?	Separate career advantage from the treatment rationale
Patient enthusiasm	Has marketing created unrealistic expectations?	Provide balanced evidence and alternatives
Program targets	Is a case count overriding safety signals?	Review performance before further adoption

Disclosure is not the whole remedy

Telling a patient about a competing interest does not make every resulting arrangement acceptable. Independent review, altered roles or a different treatment recommendation may be needed. Similarly, documenting that risks are uncertain does not remove the responsibility to minimize avoidable risk.

Learning requires honest outcome review

Review complications, delayed effects and lack of benefit, not just technical completion or favorable early reports. Information from a small experience should be interpreted with attention to case selection and incomplete follow up. An unexplained adverse pattern can justify pausing adoption while it is investigated.

Source Sabiston Chapter 16 supplies the disclosure and professional responsibility foundation. Governance and conflict discussion is a teaching supplement informed by AMA Opinion 1.2.11 and SAGES ethical guidance; research classification requires the applicable institutional process.

21 Case one Established technique new surgeon

Extended clinical scenario

A 56 year old woman requires an elective operation for which established laparoscopic and robotic approaches are both medically reasonable. Her surgeon has extensive laparoscopic experience but has performed only two robotic cases with direct assistance. A short course has been completed, and the hospital has authorized a supported introduction program. The colleague expected to provide experienced intraoperative help becomes unavailable the day before surgery. The theatre team has used the platform only a few times, and no replacement expert is available locally. The patient believes robotic surgery is necessarily safer because hospital publicity describes it as advanced. She has not been told about the surgeon's limited experience or the change in support. A short delay or referral would not harm her disease treatment, and she would also consider the laparoscopic approach. The surgeon worries that postponement will waste the equipment booking and undermine confidence in the new service.

Best management strategy

Reassess readiness before proceeding. Explain the surgeon's relevant experience, the changed support and the available alternatives without presenting publicity as evidence of superiority. Agree on an established approach, appropriately supported rescheduling or referral according to patient preference and clinical feasibility.

Competing strategy	Why it is less appropriate
Proceed after adding a learning curve sentence	Disclosure does not supply missing support or competence
Use published expert outcomes as personal results	Collective evidence does not establish local performance
Rely on the patient's enthusiasm for technology	The enthusiasm rests on incomplete relevant information
Proceed to protect the program schedule	Equipment utilization does not outweigh patient focused readiness

Decisive judgment The operation is not necessarily novel to the profession, but the surgeon and team remain early in adoption. A change in promised support changes the clinical plan and the disclosure discussion.

Source Original case applying Sabiston Chapter 16, e215 to e216, with the training and adoption supplements identified in sections 18 to 19.

22 Case two Uncertain benefit and pressure to innovate

Extended clinical scenario

A 64 year old man with a complex recurrent condition has limited conventional treatment options. A surgeon proposes a substantially modified operation supported by a plausible rationale and a small published series with short follow up. The patient says that he is willing to accept risk if there is a realistic chance of symptom relief, but believes the procedure is already proven. The surgeon has a financial relationship with the device developer and hopes to publish the first local cases. A prospective data collection plan and additional follow up procedures are being drafted, but the relevant institutional review has not been clarified. The patient is stable enough for a brief review interval, and a specialist center can provide another opinion. A colleague argues that a detailed risk signature makes further review unnecessary because the patient has few alternatives. The surgeon has not yet explained the uncertain longer term outcomes or the competing interests.

Best management strategy

Pause the offer long enough to clarify evidence, personal experience, conflicts and the appropriate governance pathway. Explain uncertainty and genuine alternatives, including specialist review and symptom care. Determine whether a defensible supported intervention can be offered and whether the planned activity requires research review before obtaining the relevant authorization.

Competing strategy	Why it is less appropriate
Proceed because the patient accepts risk	Acceptance based on a false belief does not resolve disclosure or safety
Describe innovation as proven treatment	A small short term series cannot establish that claim
Avoid review by labeling every activity care	Classification depends on the activity and applicable framework
Reject solely because evidence is incomplete	Uncertainty calls for analysis rather than an automatic ban

Decisive judgment Limited alternatives can strengthen the reason to consider innovation, but do not erase uncertainty, competing interests or oversight obligations. Disclosure and responsible preparation must both be addressed.

Source Original case applying Sabiston Chapter 16 and the clearly identified innovation governance supplements.

23 Innovation and learning curve review

Question before offering treatment	What a defensible answer identifies
What is actually new?	Novelty to the field, operator or local system
Why this patient and this intervention?	A clinical objective rather than a program milestone
What is known and uncertain?	Evidence, anticipated harms and unresolved outcomes
What is my actual experience?	Relevant preparation without overstating transfer of expertise
Is support deliverable?	Team readiness, assistance and rescue capability
What choice does the patient have?	Reasonable alternatives and referral or delay implications
What oversight applies?	Applicable adoption, credentialing or research processes
What will trigger reassessment?	Unexpected difficulty, harm or lack of benefit

A concise oral examination answer

I would identify the type of novelty, assess the evidence and this patient's clinical goal, then establish the surgeon's and team's actual readiness. I would explain uncertainty, relevant experience, assistance, alternatives and competing interests. Consent would be paired with appropriate preparation and oversight. If the plan cannot be delivered safely, I would consider a supported delay, an established approach or referral, and specify outcome review and reasons to pause further adoption.

References for this unit

Angelos P, Mellinger JD. Sabiston Textbook of Surgery. 22nd edition. Chapter 16, Innovative Procedures and New Procedures for the Surgeon and the Learning Curve, e215 to e216; supplied PDF pages 257 to 258.

AMA Code of Medical Ethics. Opinion 1.2.11, Ethically Sound Innovation in Medical Practice. https://code-medical-ethics.ama-assn.org/ethics-opinions/ethically-sound-innovation-medical-practice

SAGES. Guidelines for the Introduction of New Technology and Techniques. https://www.sages.org/publications/guidelines/guidelines-introduction-new-technology-techniques/

SAGES. Ethical Considerations Regarding the Implementation of New Technologies and Techniques in Surgery. https://www.sages.org/publications/guidelines/ethical-considerations-regarding-implementation-new-technologies-techniques-surgery/

The comparisons, adoption framework and scenarios are original teaching applications. The named supplements extend the textbook discussion and should not be mistaken for a single universal credentialing or research rule.

24 Identifying the appropriate surrogate

Loss of capacity changes authority not the patient's importance

When a patient cannot make the relevant decision, first establish the nature and expected duration of the impairment. Support any participation that remains possible. If a decision can safely wait for recovery, that may preserve the patient's own choice. When waiting is unsafe, use the appropriate surrogate or emergency pathway rather than treating the inability to decide as unlimited professional discretion.

Question	Evidence to establish	Avoid assuming
Can the patient participate?	Decision specific abilities and available support	Every aspect of participation is lost
Is a representative designated?	The relevant document, scope and applicability	Any relative can override a designated person
If not who has authority?	Applicable law and institutional policy	A universal family hierarchy applies everywhere
What guides the decision?	Known wishes and values or a best interests assessment	The representative's personal preference is decisive
Is the situation urgent?	The consequences of delay	Administrative pressure creates an emergency

Verify authority rather than conduct a family vote

Sabiston describes a formally designated representative and, where none exists, family based arrangements that depend on the jurisdiction. A spouse, adult child or close friend may provide valuable knowledge without necessarily holding the same legal authority. Establish who is authorized for this decision and document unresolved uncertainty.

Representatives need guidance and respect

Explain the clinical options, anticipated outcomes and limits in understandable language. Invite accounts of what mattered to the patient. The surgeon should still provide a reasoned recommendation rather than transfer an unexplained technical choice to a distressed relative. A representative is acting for the patient, not receiving ownership of the patient's treatment.

Clinical pearl Separate three questions: who has authority, what standard guides that person, and which treatments are medically appropriate? Answering one does not settle the others.

Source Sabiston Chapter 16, e216; PDF page 258. Participation and implementation supplement: AMA Opinion 2.1.2. Authority and hierarchy must be verified under the applicable legal framework.

25 Substituted judgment and the patient's wishes

Ask what the patient would choose

Substituted judgment uses the patient's previously expressed preferences and reasonably inferable values to guide a decision when the patient cannot currently make it. The question is not what the representative would personally choose in the same illness. A clear applicable instruction is stronger evidence than a relative's unsupported belief about what most people would want.

Evidence	How it helps	Interpretive question
Specific prior instruction	Directly addresses a treatment or outcome	Does it apply to the present situation?
Documented clinical discussion	Connects preferences to a medical context	Were circumstances and uncertainty discussed?
Repeated conversations	Shows values across time	Are reports consistent and sufficiently specific?
Life priorities and prior choices	May support an inference about acceptable burdens	Is the inference grounded in this patient?
Representative's personal wish	Reveals family concerns that need support	Is it being mistaken for the patient's preference?

Do not treat all statements as interchangeable

A person who rejected permanent dependence may still have accepted brief intensive treatment with a reasonable prospect of recovery. Conversely, a general wish to live does not necessarily authorize every burdensome intervention. Explore the circumstances, meaning and reliability of statements rather than selecting whichever phrase supports the preferred plan.

Uncertainty should be visible in the recommendation

If the available evidence is incomplete, state what is known, what is inferred and what remains uncertain. Seek additional records or people who knew the patient when feasible. Do not invent a confident substituted judgment simply because a decision is difficult. Where wishes cannot reasonably be established, a best interests assessment may be required within the applicable framework.

Exam pearl The representative supplies knowledge of the person; the clinical team supplies knowledge of likely outcomes. A defensible decision connects both.

Source Sabiston Chapter 16, Best Interests and Substituted Judgment, e216. The evidence comparison is an original teaching application; AMA Opinion 2.1.2 provides a professional guidance supplement.

26 Best interests without substituting personal values

Use this standard when the patient's wishes are not available

Sabiston contrasts substituted judgment with a best interests approach for patients whose preferences cannot be established, including those who have never had the capacity to express them. The assessment considers the person's likely benefit and burden rather than the convenience of the team or the preferences of a third party.

Dimension	Relevant consideration	Reasoning error
Benefit	What improvement can the intervention plausibly deliver?	Technical completion is treated as benefit
Burden	Pain, complications and treatment intensity	Burden is omitted because survival is possible
Recovery	Likely function and ongoing care requirements	Uncertainty is replaced with a guarantee
Alternatives	Less burdensome ways to address the clinical goal	Surgery and abandonment are presented as the only choices
Lived experience	The patient's actual experience and relationships	Disability alone is treated as lack of value

Avoid categorical judgments about disability or age

Preexisting dependence can affect treatment burdens and recovery, but does not by itself establish that treatment is worthless. Examine the achievable outcome and the patient's circumstances without assuming that a life requiring assistance has no benefit. Similarly, a technically possible survival outcome does not settle whether a highly burdensome intervention is appropriate.

Distinguish the patient's interests from other real concerns

Families may face distress, caregiving pressures or financial difficulties. These concerns deserve support, but should not be silently substituted for the patient's interests. Resource allocation questions also require transparent processes rather than being hidden within an individual best interests label.

Children and developing participation

A child's inability to provide legally effective authorization does not remove the ethical value of age appropriate explanation and participation. Sabiston describes assent alongside the appropriate adult decision process. Legal age thresholds, exceptions and disputed parental decisions require the relevant jurisdiction's rules, not a single universal age cutoff.

Source Sabiston Chapter 16, Consent and Assent and Best Interests and Substituted Judgment, e216. Comparison and disability related reasoning are original applications of beneficence, nonmaleficence, respect and justice.

27 What is meant by futile treatment

State the goal before judging the intervention

Sabiston warns that futility is not a self explanatory or universally objective label. An intervention may be unlikely to achieve long term survival while having some potential to achieve a different short term goal. That difference requires analysis; it does not automatically justify the intervention. The burdens and chance of achieving the actual goal must still be considered.

Claim	What must be clarified	Implication
It cannot work	Which physiological effect is impossible?	Distinguish inability from a low probability
It will not help enough	Which meaningful outcome and whose values define enough?	A value judgment requires explicit reasoning
The prognosis is poor	What outcome, timeframe and uncertainty are described?	Poor prognosis alone does not settle every option
The family wants more time	Can the proposed treatment deliver that time with justified burdens?	Consider alternatives as well as intervention
There is nothing more to do	Which disease directed options are exhausted?	Symptom care and support remain active treatment

A terminology supplement from intensive care guidance

The ATS and partner societies distinguish strict futility, where an intended physiological goal cannot be achieved, from potentially inappropriate treatment, where some effect is possible but competing ethical considerations may argue against providing it. The distinction prevents a disputed value judgment from being presented as an uncontestable physiological fact.

Explain the recommendation rather than rely on a label

Describe the desired outcome, expected benefit, burden and available alternatives. A surgeon can recommend against an operation without claiming that all outcomes are impossible. Respect for autonomy does not require offering a procedure simply because it is requested, but disagreement should be managed through appropriate communication and review.

Clinical pearl Replace this is futile with a precise explanation: this intervention is unlikely to achieve the stated goal, for these reasons, and this is the care I recommend instead.

Source Sabiston Chapter 16, The Challenge of Futility, e216. Terminology supplement: ATS AACN ACCP ESICM SCCM policy statement 2015, doi:10.1164/rccm.201505-0924ST.

28 Disagreement review and time limited trials

Distinguish factual conflict from conflicting values

Different predictions about reversibility may require another clinical opinion. Different beliefs about acceptable dependence require discussion of the patient's values. Disagreement about who has authority requires a separate institutional or legal process. Several conflicts can coexist, and resolving only one may leave the decision unsettled.

Problem	Constructive next action	What to avoid
Family reports conflict	Clarify sources and verify decision authority	A majority vote replaces the patient's preferences
Representative departs from known wishes	Explore reasoning and seek appropriate ethics review	Either automatic compliance or unexplained dismissal
Clinical prognosis is contested	Seek a relevant independent assessment	Present one uncertain opinion as certainty
Requested care is judged inappropriate	Use communication and the applicable fair review process	Treat a label as permission for unilateral action
No representative is available	Use the appropriate unrepresented patient process	Assume every nonurgent choice is an emergency

A trial needs an endpoint and a review decision

When a potentially beneficial intervention has uncertain effectiveness, a time limited trial may help. Agree on the clinical goal, the measures of improvement or deterioration, a clinically meaningful review interval, participants in reassessment and what options follow. A trial should not simply postpone the same disagreement without defining what will be learned.

An operation is not generally reversible. A proposed trial of postoperative organ support does not erase the separate need to justify the operation itself. Continuing or stopping support must still follow the patient's goals, the relevant authority and the applicable decision process.

Continue appropriate care during disagreement

Provide symptom relief, clear updates and support while the conflict is addressed. Persistent disputes may require ethics consultation, independent review and the relevant institutional appeal or transfer process. Professional guidance does not by itself establish permission under every jurisdiction to withhold or withdraw disputed treatment.

Source Original synthesis of Sabiston e216. Trial supplement: AMA Opinion 5.3. Dispute review supplement: AMA Opinion 5.5 and the ATS partner society policy statement 2015. Legal implementation is setting specific.

29 Case one A representative and divided relatives

Extended clinical scenario

A 75 year old woman with a potentially reversible postoperative complication is ventilated and sedated. She cannot make the current decision about another operation. A document names her long term partner as her healthcare representative, but an adult daughter insists that blood relatives must decide and demands every possible intervention. A prior clinic note records that the patient would accept temporary intensive care if recovery to an interactive life was realistic, but would not want prolonged support without meaningful recovery. The partner asks how likely another operation is to achieve that goal. The daughter says that considering any limitation means abandoning her mother. The surgical and intensive care teams agree that recovery is uncertain but possible and can explain the major burdens. There is time for a prompt structured discussion, although prolonged delay may worsen the complication. The document's scope and applicability have not yet been verified, and no team member has clearly separated the authority question from the treatment recommendation.

Best management strategy

Verify the representative's authority under the applicable framework and involve other relatives as appropriate without substituting a family vote. Explain the clinical options and connect the prior conditional preference to the present prognosis. Clarify whether a recommended intervention offers a reasonable prospect of the outcome she valued, and document the rationale and review plan.

Competing strategy	Why it is less appropriate
Let the relatives vote	Numbers do not establish legal authority or the patient's values
Treat the partner's role as unrestricted personal choice	Authority remains directed toward the patient's wishes or interests
Interpret the old note as refusal of all intensive care	It explicitly allowed temporary treatment under specified conditions
Perform every requested intervention to avoid conflict	Conflict avoidance does not establish appropriate benefit

Decisive judgment Authority, evidence of the patient's wishes and clinical appropriateness are distinct. The surrogate discussion should connect them rather than use one to bypass the others.

Source Original case applying Sabiston Chapter 16, e216, and the surrogate guidance identified in this unit.

30 Case two More time and a burdensome operation

Extended clinical scenario

An 80 year old man is in intensive care after emergency abdominal surgery. He has progressive organ failure and now develops a complication for which another major operation is technically possible. The surgeons believe return to his previous function is extremely unlikely, but cannot establish that short term survival is impossible. He is sedated and has not expressed a specific preference about this situation. His authorized representative asks for surgery so a relative arriving in two days can see him alive. One clinician calls the operation futile and wants to end discussion; another believes any possibility of a heartbeat requires intervention. The intensive care team can explain the likely burdens and assess whether less invasive support might meet the short term goal. There is no agreed estimate of what the proposed operation would actually change. The family is distressed but willing to meet, and an independent senior clinician and ethics service can review the case promptly.

Best management strategy

Clarify the actual goal and whether surgery can plausibly achieve it, the burdens it introduces and whether other care could achieve the same aim. Because his own wishes are unknown, examine his best interests rather than treat the representative's request as sufficient justification. Seek timely clinical and ethics review if disagreement persists, while continuing appropriate symptom care and support.

Competing strategy	Why it is less appropriate
Decline solely by using the word futile	The label conceals the unresolved goal and prognosis questions
Operate because any short survival is possible	Possibility alone does not establish proportionate benefit
Treat family reunion as automatic authorization	The goal still requires evaluation against the patient's interests
Offer a trial of surgery as though it can be undone	The operation's irreversible burdens require their own justification

Decisive judgment A different goal may change the analysis without necessarily changing the recommendation. The task is neither automatic intervention nor automatic refusal, but a transparent assessment of benefit, burden, authority and alternatives.

Source Original case applying Sabiston's goal relative discussion of futility, e216. Review and trial considerations are identified professional guidance supplements.

31 Surrogate and treatment limits review

Decision point	Required distinction
Patient participation	Impaired capacity does not eliminate all possible involvement
Representative authority	Knowledge of the patient differs from formal authority
Substituted judgment	What the patient would choose differs from what the relative wants
Best interests	Patient benefit and burden differ from third party convenience
Futility claim	Physiological impossibility differs from low probability or disputed value
Time limited trial	A defined review differs from indefinite continuation
Treatment limitation	Limiting one intervention differs from ending all care
Dispute resolution	An ethical recommendation differs from jurisdiction specific authority

A concise oral examination answer

I would establish urgency and the patient's present participation, verify the appropriate representative and identify relevant prior wishes. I would use substituted judgment when those wishes can guide the choice, or an appropriate best interests assessment when they cannot. I would define the treatment goal, evaluate benefit and burden, recommend a plan and explain uncertainty. Persistent disagreement would prompt appropriate review, with clear documentation and continued symptom care. Any trial would have explicit goals and reassessment conditions.

References for this unit

Angelos P, Mellinger JD. Sabiston Textbook of Surgery. 22nd edition. Chapter 16, Consent and Assent; Decision-Making for Patients who Lack Autonomy; Best Interests and Substituted Judgment; The Challenge of Futility. e216; supplied PDF page 258.

AMA Code of Medical Ethics. Opinion 2.1.2, Decisions for Adult Patients Who Lack Capacity; Opinion 5.3, Withholding or Withdrawing Life-Sustaining Treatment; Opinion 5.5, Medically Ineffective Interventions. https://code-medical-ethics.ama-assn.org/

ATS AACN ACCP ESICM SCCM. Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units. Am J Respir Crit Care Med. 2015;191:1318–1330. doi:10.1164/rccm.201505-0924ST.

Tables, the practical framework and scenarios are original educational applications. Professional statements supplement the textbook and do not establish a universal surrogate hierarchy or legal dispute resolution rule.

32 Professionalism and the trust placed in surgeons

Professional status creates obligations

Surgical practice depends on trust in knowledge, skill, judgment and character. Patients permit invasive treatment and often surrender the ability to protect their interests during anesthesia. This vulnerability makes integrity, accountability and commitment to the patient central to practice rather than optional additions to technical competence.

Sabiston connects the individual professional with a wider moral community. A profession develops and maintains standards, prepares future members and accepts responsibility for how its privileges are used. Membership or certification alone does not establish that those obligations are being fulfilled in a particular encounter.

Obligation	Observable surgical expression	Failure that may be overlooked
Integrity	Represent findings, experience and outcomes honestly	A polished presentation conceals uncertainty
Accountability	Identify who will complete and review a care task	A handoff transfers information but no responsibility
Compassion	Recognize what illness and treatment cost the person	Efficiency is achieved by ignoring distress
Humility	Seek help and reconsider assumptions when needed	Confidence discourages questions
Collaboration	Respect information from all relevant team members	Hierarchy substitutes for assessment
Lifelong learning	Use feedback and outcomes to improve practice	Past experience becomes immunity from review

Professionalism is not personal style alone

Warmth and courtesy matter, but a pleasant manner cannot compensate for concealment, unreliable follow up or unsafe practice. Conversely, direct communication in an emergency need not be unprofessional if it remains respectful, proportionate and focused on care. Evaluate the action, its context and its effects rather than equating professionalism with a preferred personality.

Clinical pearl Ask whether the patient and team could reasonably rely on this surgeon when the work becomes inconvenient, uncertain or difficult.

Source Sabiston Chapter 16, Foundations of Professionalism in Surgery, e216 to e217; PDF pages 258 to 259. Table is an original application of the chapter's professional qualities.

33 Three complementary professionalism frameworks

Sabiston discusses three approaches: virtue based professionalism, behavior based professionalism and professional identity formation. They illuminate different parts of the same developmental task. The following comparison reorganizes their implications for surgical teaching rather than reproducing the textbook table.

Framework	Central question	Teaching contribution
Virtue based	What values and habits guide this surgeon?	Reflection on motives, character and moral reasoning
Behavior based	What does the surgeon actually do?	Clear expectations, observation and specific feedback
Identity formation	Who is this surgeon becoming in this community?	Mentorship, participation and examination of role models

Why one approach is insufficient

A resident may recite values but fail to communicate an abnormal result. A checklist can detect the missed action, but may not explain whether the cause was misunderstanding, workflow, fear or disregard. A culture that rewards concealment can undermine both good intentions and a formal reporting requirement.

Single approach used in isolation	What it can miss	Complementary response
Values without observation	A gap between intention and actual conduct	Examine specific actions and their effects
Behaviors without meaning	Compliance only when being watched	Explore responsibility and professional commitment
Belonging without critique	Uncritical imitation of harmful local norms	Compare community practices with defensible standards

Combine the approaches in one teaching encounter

After a difficult handoff, establish the observable problem, ask how the resident understood their responsibility and examine the service norms that influenced the action. Agree on a concrete improvement and review it later. This connects behavior, motivation and environment without assuming that a single lapse reveals an unchangeable character.

Exam pearl A professionalism checklist is useful evidence, not a complete theory of professional development. Reflection and belonging are also insufficient if unsafe conduct remains unaddressed.

Source Sabiston e217 to e218; PDF pages 259 to 260. Framework reference cited by the chapter: Irby DM, Hamstra SJ. Acad Med. 2016;91:1606–1611. doi:10.1097/ACM.0000000000001190.

34 How professional identity develops

Identity is formed through participation

Professional identity formation concerns the integration of values, responsibilities and ways of acting into the person's understanding of being a surgeon. It develops through repeated clinical encounters, observation, feedback and relationships. It is not completed by a single lecture, graduation or appointment to a senior role.

Experience	Possible constructive learning	Possible distorted learning
A supervisor asks for assistance	Knowing limits is responsible practice	Help seeking is weakness if the request is mocked
A complication is reviewed	Honest analysis supports improvement	Protecting reputation matters more than accuracy
A patient refuses treatment	Respectful disagreement preserves care	Difficult patients deserve less attention
A nurse raises concern	Relevant information can come from any role	Only the most senior voice should be heard
Responsibility changes hands	Clear ownership protects continuity	Another service will eventually solve the problem

Make expert reasoning visible

Learners can observe a decision without understanding the motives or uncertainty behind it. A supervisor should explain why help was requested, why an attractive procedure was declined or how the patient's goals altered the recommendation. Debriefing makes professional judgment available for examination rather than leaving trainees to infer that confidence or speed was the only value.

Belonging should allow thoughtful disagreement

A trainee can learn from a community without accepting every established habit. Encourage questions that connect practice with patient welfare and professional standards. Inclusion should not depend on copying a particular personality, concealing a limitation or accepting disrespect. Diverse perspectives can reveal assumptions that established members no longer notice.

Clinical pearl Ask a learner not only what the supervisor did, but what they learned about the kind of surgeon they are expected to become.

Source Sabiston e217 to e220; PDF pages 259 to 262. Clinical illustrations are original teaching applications of identity formation and professional community concepts.

35 Recognizing the hidden curriculum

Distinguish declared teaching from enacted norms

The formal curriculum states what should be learned. Informal teaching occurs through everyday interaction. The hidden curriculum consists of messages conveyed through routines, incentives, hierarchy and responses to behavior, even when nobody explicitly teaches them. These categories can overlap; the useful question is what learners infer from the environment.

Formal message	Observed practice	Possible hidden lesson
Ask for help when uncertain	A resident is ridiculed for requesting assistance	Conceal uncertainty to preserve status
Listen to the whole team	Safety concerns from nursing are dismissed	Authority outweighs relevant evidence
Document accurately	A template is signed without the underlying work	Recorded compliance matters more than actual care
Respect the patient's decision	Refusal is described as disobedience	Agreement is required to receive respect
Report concerns	Those who raise problems lose opportunities	Silence is necessary for advancement
Learn from complications	Discussion focuses on blame or public humiliation	Avoid exposing mistakes rather than improve care

The hidden curriculum can also reinforce good practice

A senior surgeon who acknowledges a limitation, thanks a colleague for a warning and completes an inconvenient follow up demonstrates that the stated standards apply under pressure. Promotion, feedback and allocation of responsibility can reinforce those actions rather than reward output alone.

Look at what the institution actually rewards

Evaluate how a service responds to competing demands. If throughput is praised while omitted communication is ignored, the practical priority may be clear despite formal teaching. A culture review therefore needs specific examples and consequences, not merely another statement that professionalism matters.

Exam pearl A discrepancy between teaching and behavior is a reason to examine both individual responsibility and the environment. Context can explain a lapse without excusing it.

Source Sabiston e217 to e220. The chapter discusses the hidden curriculum and role modeling; this comparison and the formal informal hidden distinction are educational syntheses applied to surgery.

36 Teaching accountability without humiliation

Address immediate safety before the teaching discussion

If a behavior creates a current risk, secure the patient's care and establish responsibility first. Feedback, reporting and reflection follow without substituting for the required clinical action. The educational response should match the observed behavior and context rather than rely on a vague character label.

Task	Constructive approach	Unhelpful substitute
Describe the event	Use specific observations and consequences	You are unprofessional without examples
Understand the context	Ask about workload, knowledge, hierarchy and decisions	Assume either bad character or total system blame
State the standard	Explain the expected action and why it matters	Assume the learner knows an unstated rule
Agree on change	Specify support, behavior and follow up	Demand a promise without a practical plan
Review progress	Observe whether practice improves	Treat one apology or one score as definitive

Psychological safety and standards belong together

A team should be able to raise uncertainty or concern without humiliation or retaliation. This does not remove accountability for unsafe conduct. Respectful correction allows a precise discussion of performance; repeated or serious concerns may require formal institutional review with appropriate fairness and support.

Do not confuse self sacrifice with reliable care

Recognition of personal limits, fatigue and the need for assistance can protect patients. The professional task is to arrange safe responsibility rather than perform unsupported to demonstrate toughness. Equally, a request for help should lead to an actual handoff or assistance plan, not an unexplained disappearance from duty.

Keep reflective work connected to practice

Ask what happened, what values were in tension, how the environment influenced the action and what should change next time. Reflection is useful when it leads to observable improvement. Compulsory statements of virtue cannot by themselves establish competence, motivation or durable change.

Source Original teaching framework based on Sabiston's behavioral, virtue and identity approaches, e217 to e220. ACS Statement on Principles supplements the discussion of respect, learning and arrangements when performance is impaired. Formal procedures remain institution specific.

37 Case one Speaking up in a respected team

Extended clinical scenario

A second year resident is assisting a technically accomplished surgeon during a demanding elective operation. A circulating nurse points out that the displayed imaging may not correspond to the patient. The surgeon dismisses the concern without checking and tells the resident that good trainees protect the flow of the operating list. The resident notices a discrepancy in the identifiers but fears losing operative opportunities if he challenges the supervisor. The department formally teaches team communication and patient identification, yet senior residents say that questioning this surgeon is career limiting. The patient is stable, the concern can be checked immediately and no irreversible step has begun. The resident has seen the same surgeon seek expert technical advice respectfully on other occasions, which makes the inconsistency confusing. A senior anesthetist is present and can help coordinate verification. The resident must choose how to protect the patient while also responding to a powerful example of what the local team appears to reward.

Best management strategy

Raise the specific identifier concern promptly and request verification before an irreversible step. Use available team support and escalation if the concern is not addressed. After immediate safety is secured, document and report through the appropriate process and seek a supported debrief about the hierarchy and learning environment.

Competing strategy	Why it is less appropriate
Wait until the postoperative debrief	It leaves a current preventable risk unresolved
Assume technical reputation settles the concern	Expertise does not establish that the identifiers match
Challenge the surgeon's character instead of stating the discrepancy	A factual safety check is the immediate priority
Remain silent to preserve access to training	Career pressure does not justify bypassing verification

Decisive judgment The formal standard and the hidden lesson conflict. The response must protect present care and later address the environment that discourages speaking up.

Source Original case applying Sabiston's teamwork, role modeling and hidden curriculum concepts. The response is a teaching framework rather than a universal reporting procedure.

38 Case two Perfect documentation unreliable practice

Extended clinical scenario

A final year resident receives excellent scores for completing discharge paperwork quickly. Over several weeks, a faculty mentor notices that follow up plans are copied accurately into records but important pending results are not assigned to a responsible clinician. One patient experiences a delayed review after each service assumes the other owns the result. The resident apologizes and says that the department rewards rapid discharge and that asking for clarification is considered inefficient. A different supervisor describes the resident as lacking integrity and requests immediate exclusion from operative training. There is no evidence that results were deliberately falsified, but the patient safety consequences are real and the pattern is recurring. The resident can explain the expected standard in a classroom discussion and wants to improve. The program has not examined the workflow or how senior staff model ownership. The mentor must respond without reducing the problem either to an inherently bad person or to a system issue that removes individual accountability.

Best management strategy

Secure review of outstanding patient results and clarify current ownership. Give specific feedback about the recurring gap, explore the decisions and workflow, state the required behavior and arrange supported observation of improvement. Review the incentives and supervisory examples that reward speed while leaving responsibility unclear. Escalate persistent or serious concerns through fair institutional processes.

Competing strategy	Why it is less appropriate
Accept the apology as sufficient remediation	The recurring care gap needs an observable improvement plan
Judge permanent character from the label alone	Observed behavior and context require careful assessment
Blame workload and remove personal responsibility	The resident still has duties to communicate and clarify ownership
Repeat the lecture without reviewing practice	The learner already knows the stated standard

Decisive judgment A complete response combines behavioral expectations, reflection on responsibility and examination of community incentives. Immediate patient protection precedes the developmental assessment.

Source Original case applying the three professionalism frameworks described in Sabiston e217 to e220. Institutional review standards should be applied locally.

39 Professional formation review

Concept	Question that tests understanding
Professional trust	What can the patient and team reasonably rely on?
Virtue based approach	Which motives and habits shape the action?
Behavior based approach	What was observed and what should change?
Identity formation	What kind of surgeon is the community teaching this person to become?
Role modeling	Is the reasoning behind the example made explicit?
Hidden curriculum	What do rewards, silence and hierarchy actually teach?
Accountability	Who owns the next action and how will change be checked?
Culture and fairness	Can concerns be raised and assessed without humiliation or arbitrary judgment?

A concise oral examination answer

I would protect any patient currently at risk, describe the observed behavior and establish the professional obligation involved. I would examine the learner's understanding, motives and context without assuming that a label explains the event. I would combine a specific behavioral plan with reflection, mentorship and review of the environment. Follow up should assess actual practice, while serious or persistent concerns use an appropriate fair process.

References for this unit

Angelos P, Mellinger JD. Ethics and Professionalism in Surgery. Sabiston Textbook of Surgery. 22nd edition. Chapter 16, Foundations of Professionalism; Professionalism Frameworks and Teaching Professionalism; Contemporary Challenges; Professional Identity Formation and the Future of the Profession. e216 to e220; supplied PDF pages 258 to 262.

Irby DM, Hamstra SJ. Parting the Clouds: Three Professionalism Frameworks in Medical Education. Acad Med. 2016;91:1606–1611. doi:10.1097/ACM.0000000000001190. This is the framework reference cited in Sabiston.

American College of Surgeons. Statement on Principles. Professional conduct, teaching responsibilities and surgeon impairment sections. https://www.facs.org/about-acs/statements/statements-on-principles/

Tables, teaching steps and scenarios are original educational applications. They are intended to support reasoning and faculty discussion, not to define a validated professionalism score or a universal disciplinary process.

40 Contemporary pressures and professional disagreement

Shared obligations in a pluralistic environment

Sabiston describes challenges when patients, clinicians and institutions bring different values to surgical care. Disagreement may concern autonomy, professional conscience, fairness, access or the meaning of benefit. These tensions should be made explicit rather than concealed beneath a claim that every difference is either misconduct or merely personal opinion.

Pressure	Professional question	Constructive response
Diverse patient values	Can the recommendation respect goals without abandoning clinical judgment?	Explain the options and the basis of disagreement
Conscience or moral distress	Which duty, belief or constraint is in tension?	Seek timely discussion and an appropriate care pathway
Productivity expectations	Are speed or volume displacing patient welfare?	Identify the concrete risk and review incentives
Scarce resources	Are comparable needs treated fairly?	Use transparent relevant allocation processes
Hierarchy and reputation	Can concerns be heard regardless of status?	Provide credible review and protection from retaliation
Changing professional norms	Are standards applied fairly across different people?	Examine assumptions and distinguish conduct from identity

Disagreement does not remove obligations to the patient

A reasoned professional objection should identify the concern, preserve respectful communication and address continuity and urgent needs. It is not equivalent to humiliating a patient, withholding relevant information or leaving care unowned. The practical resolution of conscience disputes and any transfer or referral duties depend on the applicable professional, legal and institutional framework.

Present contested perspectives as perspectives

The chapter explores the relationship between personal convictions and collective professional expectations. Its wider cultural interpretations should not be treated as empirical proof that any particular worldview produces good or bad surgeons. Assess the clinical obligations, behavior and effects in the case at hand.

Exam pearl A professionalism assessment should permit principled criticism while requiring respectful, accountable conduct. Agreement with the most powerful person is not the definition of professionalism.

Source Sabiston Chapter 16, Contemporary Challenges in Cultivating Professionalism, e218 to e219; PDF pages 260 to 261. Table and clinical implications are original teaching applications.

41 Recognizing behavior that undermines care

Describe conduct and effects before assigning a label

Disruptive conduct can interfere with collaboration or care even when technical skill is strong. Examples include intimidation that suppresses safety information, demeaning comments, harassment, discriminatory treatment and recurring refusal to engage with necessary communication. A poor outcome alone, however, does not establish misconduct.

Observation	Concern to investigate	What it does not establish by itself
A sharp disagreement about treatment	Whether communication obstructed appropriate care	That criticism in good faith is disruptive
A report of humiliation	What was said, context, witnesses and effects	That a report can be dismissed as sensitivity
Repeated communication failures	A pattern, its contributors and patient consequences	That lack of actual injury proves safety
Discriminatory or harassing comments	Harm to individuals and the working environment	That technical reputation excuses the conduct
New change in performance	Possible health, workload or functional contributors	A specific medical diagnosis
Delayed response to concern	Whether hierarchy or fear inhibited escalation	That silence means the team agreed

Distinguish criticism from intimidation

AMA guidance explicitly distinguishes disruptive behavior from criticism offered in good faith to improve patient care. Examine the manner, content, pattern and effects. Reporting systems should not become tools for punishing a clinician who questions an unsafe practice or voices a minority professional view.

Patient safety and staff dignity both matter

Do not wait for a preventable injury before addressing a credible pattern. People harmed by bullying or harassment deserve support in their own right. The effects on speaking up, learning and teamwork also matter. Institutional policy should define the relevant behaviors and reporting routes clearly.

Clinical pearl Replace difficult personality with an account of what happened, what standard is relevant and what impact requires action.

Source Sabiston e218; PDF page 260. Supplements: AMA Opinion 9.4.4, Physicians with Disruptive Behavior; ACS Statement on Harassment, Bullying, and Discrimination.

42 Fair review and immediate protection

Safety action and a final finding are different

A credible current threat may require prompt protective action under institutional procedures while facts are assessed. Such action should not be represented as proof of guilt or a permanent judgment of character. Conversely, a review process must not be used to postpone necessary protection from an immediate risk.

Stage	Purpose	Safeguard
Initial response	Protect current care and affected people	Use proportionate action and identify responsible leadership
Record the concern	Preserve specific factual information	Separate observation, inference and hearsay
Review and verification	Establish what occurred and whether a pattern exists	Use appropriately independent reviewers
Response from the clinician	Understand their account and relevant context	Give a meaningful opportunity to respond
Decision and intervention	Match the action to findings and risk	Apply consistent standards and relevant procedures
Follow up	Assess improvement, recurrence and ongoing safety	Assign review ownership and protect reporting channels

Manage conflicts and confidentiality

A reviewer's supervisory, financial or personal relationship may affect independence. Disclose and manage relevant conflicts through the institutional process. Share information through appropriate channels and protect confidentiality while recognizing that absolute secrecy cannot always be promised. Applicable reporting duties and procedural rights must be established locally.

Protect reporting without assuming every allegation is proven

Support people who raise concerns and actively address retaliation. At the same time, assess reports fairly and do not circulate accusations as established fact. Neither seniority nor junior status should determine credibility automatically. Evidence and context require examination.

Serious events need not pass through every minor coaching step

A proportionate framework may use early feedback for some concerns and immediate formal escalation for severe or persistent conduct. A single serious incident can warrant action. The appropriate response depends on findings, current risk and policy rather than a mandatory sequence of repeated informal warnings.

Source Original review framework informed by Sabiston and AMA Opinion 9.4.4. This section does not define a universal disciplinary process or employment law standard.

43 Assessing contributors without excusing harm

Different mechanisms require different interventions

A professional lapse can arise from a knowledge or communication deficit, faulty judgment, health related impairment, environmental pressures or several factors together. Do not infer a psychiatric diagnosis from an angry interaction, or assume that stress explains deliberate deception. Assessment should be appropriate to the concern and conducted by suitably qualified people.

Possible contributor	Question to examine	Potential response
Unclear skill or expectation	Does the clinician know and demonstrate the required behavior?	Clarify standards and provide targeted practice
Judgment or insight gap	Does the clinician recognize the impact and alternatives?	Structured feedback and guided reflection
Health or functional concern	Is there a current limitation affecting safe performance?	Confidential appropriate assessment and safe coverage
Workload or workflow	Does the environment make the expected action unreliable?	Redesign tasks, staffing or handoffs as indicated
Reinforced conduct	Does intimidation or concealment bring practical rewards?	Change incentives and enforce consistent standards
Persistent serious misconduct	Does risk continue despite appropriate intervention?	Use formal safety and accountability processes

Care for the clinician and protect the patient

Illness and impairment should not be treated as interchangeable labels. A health condition may be well managed without unsafe performance, while acute functional impairment may require another clinician to assume duties. Arrange actual coverage when necessary; simply advising rest without assigning care leaves the patient exposed.

An explanation is not an exemption

Workload and distress can help explain conduct and guide support, but do not make harm acceptable. Equally, an exclusively punitive response may miss a remediable deficit or a system that will reproduce the problem in another person. Review individual choices and the environment together.

Source Sabiston e218 to e220; PDF pages 260 to 262. Remediation supplement: Williams BW, Williams MV. Ann Thorac Surg. 2020;109:317–324. ACS Statement on Principles supplements the discussion of impaired performance and coverage.

44 Building a measurable remediation plan

Define the behavior that must replace the lapse

An effective plan specifies what needs to change, how the change will be supported and how it will be observed in real work. A promise, an apology or course attendance may contribute but does not demonstrate durable improvement. The following is an original educational planning framework, not a validated scoring system.

Plan component	Example of an actionable requirement	Inadequate substitute
Target behavior	Communicate urgent concerns without personal insults	Be nicer
Patient protection	Use specified supervision or coverage while risk is assessed	Continue unchanged until the course ends
Skills and support	Practice difficult conversations with observation and feedback	Attend an unrelated lecture
Environmental change	Remove the incentive that rewards bypassing the safety step	Ask the individual to compensate for every system failure
Evidence of change	Review observed encounters and relevant team feedback	Accept a statement of good intentions
Review arrangements	Name reviewers, dates and criteria for progress	Assume somebody will follow up
Failure or recurrence	Specify escalation through the relevant process	Restart informal advice indefinitely

Observe improvement in the setting that matters

A clinician may perform well in a simulated discussion yet revert under time pressure. Review behavior during relevant clinical work, using appropriate sources and fair interpretation. Account for exposure and opportunity: fewer complaints after someone stops working with a team do not automatically demonstrate improved interaction.

Treat confidence in recovery as a conclusion to test

Williams and Williams emphasize addressing contributors, teaching missing skills and supporting their implementation until a sustainable alternative behavior is established. Improvement should therefore be more than temporary compliance during close observation. Maintenance, recurrence risk and the need for further support require explicit review.

Exam pearl Define success before intervention begins. If no one can describe what evidence would show improvement, the plan is not yet adequate.

Source Original plan informed by Sabiston e219 to e220 and Williams and Williams 2020. Clinical restrictions, return to duties and formal consequences require the appropriate institutional and regulatory decisions.

45 Case one High performance repeated intimidation

Extended clinical scenario

A department receives several reports that a high volume surgeon humiliates nurses and threatens residents who question an operative decision. The surgeon has good reported technical outcomes and generates substantial activity for the hospital. Two reports describe delayed escalation because staff feared the response, although no permanent patient injury has been confirmed. One resident also reports a heated but factual disagreement about a treatment plan, making it important not to equate every criticism with intimidation. The surgeon says the complaints reflect resistance to high standards and has not been given a detailed opportunity to respond. A manager proposes dismissing all reports because replacing the surgeon would be difficult; another proposes permanent suspension based only on the number of complaints. Some staff fear retaliation, and the usual reviewer has a financial connection to the surgeon. The next operating list is tomorrow, so leadership must assess current safety while arranging a fair review.

Best management strategy

Assess immediate risk and provide proportionate protection through the appropriate leadership process. Preserve specific reports, protect those raising concerns, manage the reviewer conflict and arrange fair verification with an opportunity for the surgeon to respond. Distinguish good faith clinical criticism from intimidating conduct; match intervention and monitoring to the findings rather than revenue or reputation.

Competing strategy	Why it is less appropriate
Ignore reports because outcomes are good	Technical outcomes do not exclude harm to communication or staff
Treat every disagreement as misconduct	This can suppress legitimate criticism and distort the evidence
Make a permanent finding from complaint counts alone	Volume of reports does not replace fair assessment
Use the financially connected reviewer without safeguards	The process needs credible independence

Decisive judgment Current protection and procedural fairness are simultaneous obligations. Neither commercial value nor an allegation alone supplies the final conclusion.

Source Original case applying Sabiston's contemporary challenges discussion, with AMA disruptive behavior guidance and ACS harassment guidance as supplements.

46 Case two New performance change and unsafe coverage

Extended clinical scenario

A previously reliable surgeon begins missing urgent calls, making unusual handoff errors and responding angrily when colleagues ask for clarification. The change has developed over several weeks. Staff know that the surgeon has recently had health problems and a difficult personal situation, but nobody has an appropriate clinical assessment or evidence of substance use. After a prolonged night on call, the surgeon arrives for an elective operating list visibly exhausted and acknowledges difficulty concentrating. A colleague suggests giving a warning letter and allowing the list to proceed because cancellations would affect waiting times. Another wants the department to announce that the surgeon is mentally ill. A qualified colleague is available to take over, although reassignment requires coordination with anesthesia and the patients. Leadership can arrange confidential professional assessment and review the workload. The surgeon asks for help but fears that accepting it will permanently end their career.

Best management strategy

Address the present functional concern and arrange safe transfer or postponement of duties through the appropriate process. Coordinate actual patient handoffs, seek confidential qualified assessment and offer support without inventing a diagnosis. Review workload and the pattern of errors, then develop any return or remediation plan with observable requirements and responsible oversight.

Competing strategy	Why it is less appropriate
Proceed after a warning because access is important	A warning does not restore safe performance today
Publicly assign a psychiatric diagnosis	The evidence does not establish it and privacy matters
Send the surgeon home without transferring care	Removing the clinician does not complete the handoff
Promise immediate unrestricted return after rest	Readiness depends on assessment and the relevant duties

Decisive judgment The present action is driven by functional safety, not an assumed diagnosis. Compassionate support and patient protection can be pursued together, while long term decisions follow appropriate assessment.

Source Original case applying Sabiston and ACS principles on professional responsibility. Health assessment and return to practice processes are setting specific.

47 Contemporary professionalism review

Judgment task	Key distinction
Recognize a concern	Specific observed conduct versus a personality label
Allow disagreement	Good faith criticism versus behavior that obstructs care
Protect people	Immediate proportionate safeguards versus a premature final finding
Assess reports	Verified information versus assumption or malicious accusation
Assess contributors	Context and health support versus excuse or unsupported diagnosis
Remediate	Demonstrated replacement behavior versus an apology or certificate
Evaluate the environment	Institutional incentives versus individual responsibility alone
Review progress	Sustained improvement versus temporary compliance or missing exposure

A concise oral examination answer

I would identify any current risk and arrange proportionate protection and actual continuity of care. I would document specific conduct, support reporting, manage conflicts and use a fair review with an opportunity to respond. I would distinguish professional disagreement from disruptive conduct and assess contributors without excusing harm or assigning an unsupported diagnosis. The plan would combine accountability, appropriate support, measurable behaviors, named reviewers and escalation criteria, with follow up in real clinical work.

References for this unit

Angelos P, Mellinger JD. Sabiston Textbook of Surgery. 22nd edition. Chapter 16, Contemporary Challenges in Cultivating Professionalism and Professional Identity Formation and the Future of the Profession. e218 to e220; supplied PDF pages 260 to 262.

Williams BW, Williams MV. Understanding and Remediating Lapses in Professionalism: Lessons From the Island of Last Resort. Ann Thorac Surg. 2020;109:317–324. PMID:31479640. This is a remediation reference cited by Sabiston; the discussion here is limited to its published framework and abstract.

AMA Code of Medical Ethics. Opinion 9.4.4, Physicians with Disruptive Behavior. https://code-medical-ethics.ama-assn.org/ethics-opinions/physicians-disruptive-behavior

ACS. Statement on Harassment, Bullying, and Discrimination. https://www.facs.org/about-acs/statements/harassment-bullying-and-discrimination/ ACS. Statement on Principles. https://www.facs.org/about-acs/statements/statements-on-principles/

Assessment tables, practical steps and cases are original teaching applications. They do not establish a universal disciplinary sequence, legal reporting duty or return to practice standard.

48 Comprehensive ethical judgment algorithm

Start by defining the decision rather than assigning an ethical label. A defensible plan connects clinical facts, the patient's goals, appropriate authority and professional obligations. This algorithm integrates the chapter as an original teaching framework; it is not a validated score or a universal legal process.

Step	Question to resolve	Action
1 Protect immediate safety	What harm would delay cause?	Stabilize and establish whether there is time for deliberation
2 Define the decision	Which specific action is proposed or disputed?	Separate the operation, its components and continuing support
3 Establish facts	What is known, uncertain or assumed?	Clarify prognosis, reversibility and relevant evidence
4 Support participation	Can the patient make this decision now?	Address barriers and assess capacity when indicated
5 Establish authority	If the patient cannot decide, who may act?	Verify relevant directives and the applicable surrogate pathway
6 Define the goal	What outcome would justify treatment for this patient?	Use known wishes or an appropriate best interests assessment
7 Compare options	Which choices offer proportionate benefit and burden?	Include reasonable alternatives and appropriate nonintervention
8 Check professional limits	Can the plan be delivered competently and fairly?	Review experience, resources and competing interests
9 Recommend and resolve	What plan is justified and what disagreement remains?	Explain reasoning and obtain appropriate review when needed
10 Implement and revisit	Who owns the next action and what could change the decision?	Document, hand over and reassess

Urgency changes the available process

A true emergency may require focused assessment and immediate action through the applicable pathway. It does not make known preferences irrelevant or turn every additional intervention into authorized treatment. When delay is safe, use that time to improve understanding, establish authority and resolve uncertainty.

Exam pearl Name the pivotal unresolved question. More information, a family meeting and ethics review serve different purposes; choose the next action that addresses the actual uncertainty.

Source Original synthesis of Sabiston Chapter 16 and the professional guidance explicitly identified in the preceding units. Legal authority and emergency implementation remain jurisdiction specific.

49 Participation authority and authorization review

Situation	Primary pathway	Critical boundary
Capable informed patient accepts	Confirm voluntary authorization and scope	A signature is not unlimited permission
Patient refuses	Clarify understanding, voluntariness and exact refusal	Disagreement does not prove incapacity
Communication is difficult	Provide accessible information and support	A barrier is not itself loss of capacity
Patient requests less detail	Clarify genuine preferences and basic understanding	Family wishes do not establish the patient's preference
Capacity is impaired but may return	Consider safe delay and supported reassessment	Do not impose an unnecessary irreversible decision
Capacity absent and wishes known	Verify authority and apply relevant prior wishes	The representative's preference is not the standard
Wishes cannot reasonably be established	Use the applicable best interests process	Do not invent a confident substituted judgment
Urgent threat with no timely authorization	Use the appropriate emergency pathway	Convenience alone does not establish an emergency

Three separate checks

Capacity concerns the patient's ability to make the particular decision at the relevant time. Authority concerns who may act if the patient cannot. Authorization concerns what treatment has actually been accepted. A correct answer to one does not resolve the other two.

A known preference still needs interpretation

Check whether the statement or directive applies to the current situation. Temporary support with a reasonable recovery prospect can differ from prolonged support without that prospect. Avoid either ignoring a relevant instruction or extending a general statement beyond what it reasonably addresses.

Assent and developing participation

For children, seek developmentally appropriate involvement alongside the legally appropriate authorization process. A disagreement between a child, family and clinicians may require further review. The ethical value of participation should not be confused with a universal legal age threshold.

Source Review of sections 8 to 15 and 24 to 26. Sabiston e215 to e216; named AMA, GMC, ACS and WMA supplements retain the contexts described in those units.

50 Goals benefit burden and treatment limits

Concept	What it means for judgment	Common error
Beneficence	Pursue a meaningful achievable good	Treat technical completion as adequate benefit
Nonmaleficence	Avoid unjustified or disproportionate harm	Assume every risk makes surgery unacceptable
Respect for autonomy	Support informed choices within appropriate care	Treat a request as a claim to any intervention
Justice	Apply relevant fair processes to comparable claims	Allow influence or convenience to determine access
Substituted judgment	Use the patient's reasonably established preferences	Ask what the family personally wants
Best interests	Assess benefit and burden when wishes are unavailable	Replace the patient's interests with third party needs
Strict physiological futility	The specified physiological effect cannot be achieved	Use the term for any unfavorable prognosis
Potentially inappropriate treatment	Some effect is possible but its justification is disputed	Present a value judgment as unquestionable fact

Match the intervention to the actual goal

Separate survival to discharge, a brief period of additional life, symptom relief and return to independent function. A treatment can have different probabilities of achieving each. A change in goal may change the analysis without necessarily making the same burdensome intervention appropriate.

Time limited support requires a defined review

Specify the aim, measures, timeframe, reviewers and possible next decisions. Do not use a trial simply to postpone disagreement. An operation's irreversible effects still need justification even if postoperative organ support will be reviewed later.

A recommendation against intervention must include care

Explain what the proposed treatment is unlikely to achieve and why. Offer appropriate symptom management, support and alternatives. Continuing care, maintaining trust and using fair review for persistent disputes remain responsibilities when a specific operation is not recommended.

Source Review of sections 1 to 6 and 24 to 31. The strict futility terminology is an identified ATS partner society supplement, rather than a claim that Sabiston supplies a universal objective futility definition.

51 Innovation and professional limits review

Question	Evidence needed	Why consent alone is insufficient
What is novel?	Novelty to the profession, surgeon or local system	Different uncertainties need different safeguards
Why this patient?	A clinical goal and comparison with alternatives	Enthusiasm does not establish likely benefit
What evidence applies?	Relevant outcomes, limitations and follow up	Expert center results are not guaranteed local results
What experience is present?	Actual preparation and demonstrated performance	A course or raw count does not establish competence
What support is deliverable?	Team readiness, assistance and rescue	Promised help must exist in practice
Which interests may distort advice?	Relevant financial, academic or institutional influences	Disclosure does not remove every conflict
Which oversight applies?	Local adoption, credentialing and research requirements	Calling something care does not decide classification
When will the program pause?	Review of difficulty, harm and lack of benefit	A milestone does not justify ignoring safety signals

Two thresholds must be addressed

The patient needs a meaningful choice based on relevant information. The surgeon also needs a clinically defensible plan that can be delivered with appropriate skill and support. A patient may accept disclosed uncertainty without making an inadequately supported intervention acceptable.

Use alternatives rather than a false binary

The choice may include an established operation, supported rescheduling, expert assistance, referral or nonoperative care. Explain the clinical consequences of delay. Do not describe refusal of the new method as refusal of all treatment when reasonable alternatives remain.

Disclosure remains relevant as circumstances change

Loss of an experienced assistant, a change in procedure or new evidence of harm can alter both readiness and what the patient needs to know. Revisit the plan before proceeding rather than rely on an earlier discussion that described different conditions.

Source Review of sections 16 to 23. Sabiston e215 to e216; the named AMA and SAGES supplements support the additional adoption and governance considerations.

52 Professional conduct assessment and response review

Finding	First judgment task	Next response
Current patient safety threat	What protection is needed now?	Arrange proportionate safeguards and actual continuity
A report of misconduct	What occurred and how reliable is the information?	Preserve specifics and use a fair review
Clinical disagreement	Is it good faith criticism or obstructive conduct?	Address evidence without silencing legitimate concern
Possible impairment	What functional limitation is present?	Use appropriate assessment and safe coverage
Recurring lapse	Which contributors and replacement skills matter?	Create a measurable supported improvement plan
Workplace intimidation	Are people being harmed or prevented from speaking?	Protect reporting and address the environment
Claimed improvement	What changed in relevant real work?	Review observations and recurrence, not certificates alone
Persistent serious risk	Is the current plan adequate?	Use the relevant formal escalation process

Use the three frameworks together

Behavior based assessment asks what happened and what should change. Virtue based reflection examines motives and habits. Identity formation examines what the community teaches through examples, incentives and belonging. None excuses unsafe practice; together they can explain why a standard is or is not reliably enacted.

Separate explanation accountability and diagnosis

Workload can contribute without absolving responsibility. A health condition need not imply unsafe performance, while functional concern may require protection before a diagnosis is established. An allegation requires fair assessment; a protective measure need not be presented as a final finding.

A useful remediation plan can be audited

Identify the target behavior, support, any temporary safety arrangements, responsible reviewers, evidence of progress, review dates and escalation criteria. Check how the environment reinforces or frustrates change. An apology or reduced complaint count without comparable exposure is not sufficient proof of durable improvement.

Source Review of sections 32 to 47. Sabiston e217 to e220; the identified ACS and AMA professional conduct guidance and Williams and Williams remediation framework supply the named supplements.

53 Integrated case and final decision record

Extended clinical scenario

A 72 year old woman develops a serious but potentially treatable complication after surgery. She is currently sedated and cannot decide about another intervention. A prior documented discussion says she would accept temporary support if there were a reasonable prospect of returning to an interactive life, but not prolonged treatment without that prospect. Her designated representative asks for a clear recommendation. The surgeon proposes a new technique based on a small series and acknowledges limited personal experience. The colleague expected to assist is unavailable. An established approach could be provided by another team, although it carries substantial burdens. A resident raises the missing support issue and is told not to undermine confidence. The patient's family is divided between demanding every option and rejecting all further treatment. The clinical team believes several hours of coordinated review are available, but prolonged delay could reduce the chance of recovery. No one has clarified which intervention best serves the patient's stated goal or assigned responsibility for resolving the competing issues.

Reasoned next step

Coordinate a timely review that addresses prognosis, applicable representation, the patient's conditional wishes and clinically deliverable options. The unsupported novel technique is not justified by family demand or a generic signature. Evaluate the established alternative without assuming either automatic intervention or refusal. Protect the resident's ability to raise the safety issue and document the agreed action and review conditions.

Record element	What should be explicit
Decision and urgency	The proposed action and consequences of waiting
Facts and uncertainty	Prognosis, evidence limits and unresolved assumptions
Participation and authority	Capacity, relevant instructions and verified representative
Goal and comparison	Desired outcome, benefits, burdens and alternatives
Deliverability	Experience, support, resources and relevant conflicts
Recommendation and ownership	Reasoning, disagreement, review and responsible clinicians

Source Original integrated case and decision record based on the chapter units. Primary reference: Angelos P, Mellinger JD. Sabiston, 22nd edition, Chapter 16, e214 to e221; PDF pages 256 to 263. Named professional supplements are listed in the preceding units.

Advanced ethical judgment question bank

One hundred extended single best answer cases

Read the whole case and select the most appropriate strategy for the stated clinical circumstances, urgency and information. The questions emphasize which issue must be resolved next, whose preferences guide care and which proposed action remains unjustified despite apparently reassuring facts.

Each case has four options, an explained answer and separate analysis of every competing option. Cover the answer while attempting the question. The answer key follows Question 100. Case details are educational scenarios rather than reports of actual patients.

Professional guidance supplements are identified in the chapter and source notes. These cases test ethical reasoning, not recall of an unspecified jurisdiction's law. When authority, research classification or a formal process is uncertain, the appropriate framework must be established rather than assumed.

001 to 010 Ethical principles goals and proportionality

011 to 020 Informed consent disclosure and scope

021 to 030 Capacity voluntariness and supported decisions

031 to 040 Surrogates assent and patient centered standards

041 to 050 Treatment limits uncertainty and conflict resolution

051 to 060 Innovation evidence and learning curves

061 to 070 Professional duties integrity and competing pressures

071 to 080 Identity formation and the hidden curriculum

081 to 090 Disruptive conduct fair review and functional safety

091 to 100 Remediation measurement and integrated judgment

The cases are designed for advanced study and discussion. Their examination difficulty and scoring have not been psychometrically validated.

Question 001

Ethical principles goals and proportionality

A 74 year old woman has a resectable colon cancer and no immediate obstruction. Her surgeon estimates a meaningful chance of disease control, but postoperative rehabilitation is likely because she has lost strength and needs help shopping. She explains that returning to her own home matters more than maximizing survival. Her daughter requests surgery immediately and argues that cure should take priority over preferences expressed while frightened. The patient can explain the diagnosis, alternatives and consequences and has not received sedatives. The team has discussed operative mortality but has not explored the probability or duration of dependence. A two week planning interval is oncologically acceptable. Rehabilitation and home support assessments are available, although neither can guarantee independence. The daughter asks the surgeon to give a firm recommendation today so that the family can stop arguing.

The patient asks for a recommendation that includes the possibility of rehabilitation rather than only the probability of surviving the operation. The daughter is willing to listen if the surgeon explains why technical success and recovery to independence are different outcomes.

Which approach best supports a defensible recommendation?

A. Ask the daughter to choose after reviewing the mortality estimate

B. Recommend observation because rehabilitation conflicts with her stated goal

C. Recommend resection using cancer control as the principal benefit

D. Clarify recovery outcomes and her priorities before recommending among appropriate options

Correct answer D. The unresolved issue is whether expected recovery fits the capable patient's priorities, not simply whether resection is technically beneficial.

Why A is less appropriate. Family preference cannot replace this capable patient's decision.

Why B is less appropriate. Likely rehabilitation does not prove her goal impossible.

Why C is less appropriate. Cancer control is not her only material outcome.

Source framework: Sabiston Chapter 16, e214 to e216; chapter sections 1 to 6 and 48 to 50.

Question 002

Ethical principles goals and proportionality

A 63 year old man with incurable malignancy has recurrent obstruction. A bypass could provide durable symptom relief but entails substantial recovery, while an endoscopic option offers faster relief with a greater chance of reintervention. He understands that neither treats all the cancer. His priority is attending a family event in three weeks, and he would accept later repeat treatment to maximize time at home now. The surgeon favors bypass based on durability and has successfully used it in similar patients. The patient is not in immediate danger, and both options are medically reasonable. His relatives ask the surgeon to select the procedure with the longest technical success because they find repeat procedures distressing. The patient can participate and asks which burden is most relevant to his short term objective. The endoscopic team can assess him today.

The endoscopist can explain the chance and consequences of later failure. The patient does not regard every repeat procedure as unacceptable. The surgeon can therefore compare strategies without assuming that the longest lasting anatomical solution necessarily provides the best result within the patient's chosen timeframe.

What is the best recommendation process?

A. Recommend bypass because durability is the most objective outcome

B. Compare time to benefit and recovery burden against his stated objective

C. Let family preference determine which repeat treatment burden is acceptable

D. Recommend the endoscopic option without discussing its failure risk

Correct answer B. Medically appropriate alternatives should be compared using the patient's relevant time horizon and values while retaining honest uncertainty.

Why A is less appropriate. Durability does not alone define benefit here.

Why C is less appropriate. The capable patient's burden assessment remains central.

Why D is less appropriate. A preferred option still requires balanced disclosure.

Source framework: Sabiston Chapter 16, e214 to e216; chapter sections 1 to 6 and 48 to 50.

Question 003

Ethical principles goals and proportionality

A 70 year old patient requests an extensive operation that two specialists believe cannot reasonably achieve the desired goal of restoring independent swallowing. The request follows an online account describing a superficially similar condition with a different anatomical problem. The patient has capacity, understands the general operative risks and says accepting those risks should make the operation available. A less invasive symptom plan could address discomfort but would not restore normal function. The surgeon is uneasy about declining because the patient has already traveled a long distance and paid for accommodation. There is no emergency. Another opinion can be arranged without abandoning current symptom care. The patient says that refusal would demonstrate disregard for autonomy, while the surgeon wants to preserve trust without offering an unjustified intervention. The family asks for a concrete explanation rather than a label of futility.

The patient is not requesting abandonment of symptom treatment and would accept another opinion. The surgeon can show which anatomical differences make the online example inapplicable. Further testing has no defined consequence unless a new clinical uncertainty is identified during that review.

Which response is best?

A. Explain goal specific limits, offer appropriate care and facilitate further review

B. Offer the operation after documenting the patient's willingness to accept harm

C. Order more tests without identifying a remaining clinical uncertainty

D. Decline all further involvement because the request is inappropriate

Correct answer A. Autonomy does not compel an intervention lacking a reasonable beneficial objective; explanation, alternatives and continued care preserve respect.

Why B is less appropriate. Risk acceptance does not supply a therapeutic rationale.

Why C is less appropriate. Nonactionable testing postpones rather than resolves the disagreement.

Why D is less appropriate. A declined procedure does not justify abandonment.

Source framework: Sabiston Chapter 16, e214 to e216; chapter sections 1 to 6 and 48 to 50.

Question 004

Ethical principles goals and proportionality

A 66 year old woman has two medically acceptable operations with different cosmetic and recovery consequences. Evidence does not establish a clear survival advantage between the options in her circumstances. She prefers the more extensive procedure after discussing the burdens and says the preference reflects longstanding values rather than a belief that larger surgery guarantees cure. The surgeon would personally choose the smaller operation and worries that accepting her preference violates the duty to minimize harm. Her partner prefers the smaller procedure as well. She accurately explains the alternatives and remains consistent after an interval for reflection. No new clinical fact makes either option inappropriate. The team asks whether the surgeon should continue counseling until she adopts the less extensive choice. A second opinion is available if she wants it, but she is not requesting another assessment.

She says the partner may participate but should not decide for her. Her preference remains stable after a further explanation of recovery burdens. There is no disputed fact that could be resolved merely by repeating the survival evidence.

Which action is most appropriate?

A. Use the partner's agreement to select the smaller procedure

B. Continue counseling until she chooses the operation with fewer immediate burdens

C. Classify her preference as impaired reasoning because it differs from the recommendation

D. Respect her informed preference among the medically acceptable options

Correct answer D. When both options are appropriate, the informed patient's weighting of acceptable benefits and burdens should guide the choice.

Why A is less appropriate. The partner does not replace her authority.

Why B is less appropriate. Counseling should not become pressure for conformity.

Why C is less appropriate. Disagreement alone does not demonstrate impaired capacity.

Source framework: Sabiston Chapter 16, e214 to e216; chapter sections 1 to 6 and 48 to 50.

Question 005

Ethical principles goals and proportionality

A 59 year old man is offered surgery for severe symptoms. He accepts the surgeon's estimate of complication risk but believes the expected functional gain would be too small to justify prolonged recovery. The surgeon believes even a modest gain would be worthwhile. Both agree about the clinical evidence and recognize uncertainty. A trainee requests another imaging study to settle the disagreement, although no possible result would change the expected options or prognosis. The patient has no communication barrier and has explained his priorities consistently. There is time for further discussion without harm. His family thinks a new test would be reassuring and asks the surgeon to avoid discussing values because that sounds subjective. The surgeon wants to recommend responsibly without either imposing personal preferences or abandoning the patient to choose alone.

The patient is willing to explain why the modest expected gain is not worthwhile to him. His relatives can support that conversation but have not been authorized to replace his decision.

What should the next conversation address?

A. The family's preferred balance because the patient is declining benefit

B. A consent signature confirming acceptance of the published risk estimate

C. Additional imaging as the first route to objective agreement

D. The different valuations of benefit and burden, with a reasoned recommendation

Correct answer D. The facts are shared; the unresolved issue is what constitutes worthwhile benefit for this person.

Why A is less appropriate. Family values do not replace the capable patient's values.

Why B is less appropriate. Understanding probabilities is not agreement to treatment.

Why C is less appropriate. The test has no defined management consequence.

Source framework: Sabiston Chapter 16, e214 to e216; chapter sections 1 to 6 and 48 to 50.

Question 006

Ethical principles goals and proportionality

A hospital has one specialized operating slot before a clinically important deadline and two patients with comparable need. One is a prominent donor whose relatives contact leadership; the other has limited social influence but the same urgency and expected benefit. Both are currently stable enough for the established allocation process to be applied. A manager asks the surgeon to describe the donor as more urgent to avoid controversy and offers to find a later appointment for the other patient. The surgeon understands that both patients deserve advocacy and that the resource genuinely cannot serve both simultaneously. No new clinical evidence differentiates their priority. An institutional review route is available immediately. The team needs a decision that can be explained consistently to affected patients without disclosing another person's private information.

Neither patient has a clinical characteristic that the established priority system treats as differentiating urgency. The review can occur before the slot is assigned, so there is no need to distort the diagnosis to make a timely decision.

Which strategy best addresses justice and professional integrity?

A. Let the surgeon choose privately to avoid distressing either family

B. Record greater urgency for the donor while providing another slot later

C. Apply the relevant transparent allocation process without altering clinical facts

D. Prioritize the donor because additional funding may benefit future patients

Correct answer C. Justice requires relevant consistent criteria; truthful documentation and transparent process should not be displaced by influence.

Why A is less appropriate. Private discretion alone weakens consistency and accountability.

Why B is less appropriate. A later slot does not make invented urgency truthful.

Why D is less appropriate. Speculative institutional benefit does not justify falsifying priority.

Source framework: Sabiston Chapter 16, e214 to e216; chapter sections 1 to 6 and 48 to 50.

Question 007

Ethical principles goals and proportionality

A 78 year old man with chronic disability is offered surgery for a painful condition. He needs assistance with transfers but describes his life as satisfying and values time with friends. The operation may relieve pain without improving his preexisting dependence. A clinician recommends against treatment because survival with assistance would not be meaningful, while another argues that any possible survival benefit requires surgery. The patient understands the risks and asks whether his own experience matters. Less invasive symptom measures have provided limited relief, and both operative and nonoperative strategies remain clinically defensible. There is no emergency or cognitive impairment. The surgeon must frame a recommendation without either discounting disability or ignoring real recovery burdens. The patient's caregiver can explain practical support needs but does not claim decision authority.

The caregiver can describe practical rehabilitation resources, while the patient can explain what pain relief would allow him to do. The decision therefore involves attainable goals and treatment burdens rather than an external judgment that dependence makes every benefit meaningless.

Which approach is best?

A. Evaluate achievable relief and burdens using his goals and lived experience

B. Use baseline dependence as the main reason to withhold the operation

C. Recommend surgery because the possibility of survival outweighs all burdens

D. Ask the caregiver to define the value of his expected quality of life

Correct answer A. Disability informs burdens but does not itself determine worth; the capable patient's experience matters in comparing appropriate options.

Why B is less appropriate. Dependence alone does not establish absence of benefit.

Why C is less appropriate. Possible survival does not settle proportionality.

Why D is less appropriate. Support knowledge is valuable but does not replace his values.

Source framework: Sabiston Chapter 16, e214 to e216; chapter sections 1 to 6 and 48 to 50.

Question 008

Ethical principles goals and proportionality

A surgeon offers an elective operation with uncertain recovery. The patient asks for a direct recommendation because reading several probability estimates has become overwhelming. The surgeon responds that autonomy requires the patient to choose without influence and declines to explain which option seems preferable. The patient understands the diagnosis and can participate but wants clinical guidance in relation to a stated goal of maintaining mobility. Two treatments are reasonable, with different burdens, and the surgeon has no financial conflict. A relative offers to make the decision instead. There is adequate time for supported discussion. The team worries that a clear recommendation could be paternalistic, although withholding expertise has left the patient less able to compare options. The patient specifically asks for reasons rather than a guarantee or an instruction that cannot be questioned.

The patient wants the reasoning to be open to questions and knows that the final choice may differ from the recommendation. No one has identified a reason why clinical expertise must be withheld rather than explained.

What is the best response?

A. Choose the operation privately and describe it as the only appropriate option

B. Transfer the choice to the relative because the patient requests guidance

C. Offer a reasoned recommendation linked to the patient's goals while preserving choice

D. Continue withholding a recommendation to prevent any influence

Correct answer C. Shared decision making includes clinical advice; explaining reasons and alternatives supports rather than displaces autonomous choice.

Why A is less appropriate. Concealing alternatives would undermine meaningful choice.

Why B is less appropriate. Requesting advice is not loss of decision authority.

Why D is less appropriate. Abandoning guidance does not improve informed participation.

Source framework: Sabiston Chapter 16, e214 to e216; chapter sections 1 to 6 and 48 to 50.

Question 009

Ethical principles goals and proportionality

An 82 year old woman has a potentially reversible acute complication after surgery. Her prognosis is uncertain, and the team is considering another intervention. A consultant calls the procedure futile because meaningful recovery is unlikely, but another notes that short term stabilization remains possible. Her representative asks whether stabilization would allow time to establish her previously expressed wishes and assess reversibility. The consultants have not agreed on what outcome they mean by success. Neither claims that the immediate physiological effect is impossible. There is time for prompt independent review while current support continues. A trainee suggests resolving the issue by counting how many physicians favor intervention. The family wants a clear recommendation and does not insist that every technically possible treatment be given.

The independent clinician can distinguish the likely physiological response from the more uncertain longer term outcomes. The representative is asking how these distinctions relate to the patient's values, rather than simply requesting the most invasive option available.

What is the most useful next step?

A. Define the treatment goal and clarify prognosis, burdens and uncertainty

B. Provide the intervention because any physiological effect remains possible

C. Accept the futility label because long term recovery is unlikely

D. Use the majority clinical vote as the complete ethical decision

Correct answer A. Without a specified goal, the disagreement mixes probabilities and values; neither a label nor possibility alone determines appropriate treatment.

Why B is less appropriate. Some effect does not establish proportionate benefit.

Why C is less appropriate. Low probability differs from physiological impossibility.

Why D is less appropriate. A vote does not replace patient centered reasoning.

Source framework: Sabiston Chapter 16, e214 to e216; chapter sections 1 to 6 and 48 to 50.

Question 010

Ethical principles goals and proportionality

A 65 year old man develops a complication that could be treated by either immediate surgery or brief observation with close reassessment. Both strategies are accepted in appropriately selected patients. The surgeon favors observation based on current stability, while the patient prefers intervention because he fears sudden deterioration after a prior traumatic admission. He understands that surgery itself adds risk. The disagreement is respectful and there is no evidence of impaired capacity. The team has not explored whether a monitored observation plan and explicit escalation criteria would address his fear. A resident proposes classifying him as noncompliant if he will not accept the initial recommendation. A senior colleague is available to review the clinical options. The surgeon wants to avoid both an unnecessary operation and dismissing a legitimate concern merely because it is emotionally informed.

The patient says a clear plan for deterioration would make observation easier to consider. He has not misunderstood that immediate surgery also carries burdens. The senior colleague can help compare clinically appropriate options without treating emotion alone as a loss of authority.

Which action is best?

A. Repeat the recommendation without explaining the observation safeguards

B. Explore the concern and compare defensible strategies with explicit reassessment criteria

C. Label the preference noncompliance and end the discussion

D. Operate immediately solely to remove the patient's anxiety

Correct answer B. Fear may identify a communication need; defensible options and monitoring should be discussed rather than equating emotion with irrationality.

Why A is less appropriate. Unexplained repetition does not address the unresolved concern.

Why C is less appropriate. Disagreement is not itself misconduct or incapacity.

Why D is less appropriate. Anxiety alone does not establish an operative indication.

Source framework: Sabiston Chapter 16, e214 to e216; chapter sections 1 to 6 and 48 to 50.

Question 011

Informed consent disclosure and scope

A 61 year old woman has signed a generic consent form for elective hernia reconstruction. Updated imaging suggests that extensive adhesiolysis may require bowel resection and a prolonged admission. She tells the admitting nurse that the operation cannot involve her bowel because the form only says hernia repair. The surgeon previously mentioned adhesions but did not explore this possibility or its consequences. She is alert, understands her condition and has received no premedication. Her husband says she becomes anxious and asks the team to add bowel resection to the form without another discussion. There is no incarceration or other immediate threat. A later date is available without clinical harm, although today's operating slot would be lost. The patient wants treatment but asks to understand how much the plan has changed. The team needs to decide what must occur before induction.

The patient can explain why bowel resection or a stoma would affect her choice. She is not refusing every possible contingency, but wants to know what may be necessary before authorizing it. The team can provide that discussion before any sedating medication.

Which action is best?

A. Amend the form and rely on the earlier signature

B. Induce anesthesia while arranging the expanded discussion

C. Revisit the changed scope and obtain meaningful current authorization

D. Ask the husband to authorize foreseeable bowel treatment

Correct answer C. Material scope remains misunderstood; discussion must precede elective treatment.

Why A is less appropriate. An amendment does not establish understanding.

Why B is less appropriate. Induction removes an available opportunity for participation.

Why D is less appropriate. She retains her own authority.

Source framework: Sabiston e215; chapter sections 8 to 9 and 11 to 12. AMA 2.1.1 and 2.1.3; GMC consent guidance; ACS principles as relevant.

Question 012

Informed consent disclosure and scope

A 49 year old man is considering surgery with a small but serious risk of impaired hand function. He earns his living through precise manual work and says even minor loss of dexterity would change his employment. The standard leaflet emphasizes survival and common complications but does not mention occupational consequences. The surgeon considers the risk too rare to discuss routinely. The patient has asked detailed questions and can understand numerical estimates when explained clearly. A less effective nonoperative option exists. His partner thinks the surgeon should minimize discussion because fear may lead him to decline a beneficial procedure. There is time for another consultation. The surgeon must decide which information is material to this particular patient's choice, without reciting every conceivable complication or exaggerating an unlikely outcome. The clinical recommendation would remain surgery, but the patient's weighting might differ.

The patient has not demanded zero risk and would accept uncertainty if the likely consequences are explained. His question concerns whether a small functional loss might still be devastating in his own life. The surgeon can retain a recommendation while allowing a different informed weighting.

What should be done?

A. Use the standard leaflet as sufficient disclosure

B. Describe the risk only if its numerical probability increases

C. Discuss the serious functional risk and its personal significance

D. Omit the risk because disclosure might cause refusal

Correct answer C. His occupation makes this consequence particularly relevant to informed choice.

Why A is less appropriate. Generic information may miss material priorities.

Why B is less appropriate. Significance is not probability alone.

Why D is less appropriate. Possible refusal does not justify concealment.

Source framework: Sabiston e215; chapter sections 8 to 9 and 11 to 12. AMA 2.1.1 and 2.1.3; GMC consent guidance; ACS principles as relevant.

Question 013

Informed consent disclosure and scope

A 72 year old patient asks the surgeon to explain the main recommendation but not every technical detail. He says detailed descriptions of instruments and operative steps worsen his anxiety. He can explain the diagnosis, that surgery is invasive, the main serious risks and the nonoperative alternative. The surgeon has offered further information and checked that this preference is genuine. His daughter asks that the diagnosis also be hidden, although the patient has not requested that. The operation is elective, and the team can pace discussion over another visit. A trainee believes valid consent requires forcing the patient to hear every detail; another believes his request permits no further communication. He wants to decide himself and asks whether wanting less detail means he has given up that right.

The patient has not rejected information about serious harm. He distinguishes the essential choice from technical detail he does not want. The daughter is trying to reduce anxiety, but her broader withholding request has not been confirmed as his own communication preference.

Which approach best respects his preference while preserving meaningful consent?

A. Tailor detail to his wishes while confirming essential understanding

B. Treat his request as blanket authorization for future changes

C. Accept the daughter's request to conceal the diagnosis

D. Require all technical information before accepting his choice

Correct answer A. Voluntary information preferences differ from concealment or unlimited permission.

Why B is less appropriate. Scope must still be understood.

Why C is less appropriate. The daughter's preference is not his.

Why D is less appropriate. Exhaustive technical recitation is not required.

Source framework: Sabiston e215; chapter sections 8 to 9 and 11 to 12. AMA 2.1.1 and 2.1.3; GMC consent guidance; ACS principles as relevant.

Question 014

Informed consent disclosure and scope

A 58 year old woman is diagnosed with a potentially treatable cancer. Her family asks the surgeon to describe it as a benign growth because she has previously become distressed during medical discussions. She is currently alert, has no acute psychiatric symptoms and directly asks whether the growth is cancer. Nobody has asked how she wants information shared. The family says disclosure might make her refuse surgery and believes protecting hope is more important than accuracy. The operation is not urgent enough to prevent a thoughtful conversation. The surgeon can offer support and paced explanation without promising cure. The patient has not authorized the family to receive information instead of her. The team must distinguish sensitive communication from paternalistic withholding while maintaining a workable relationship with relatives who are trying to help.

A nurse can remain during the conversation, and psychological support is available if distress occurs. The patient has previously asked direct questions and valued honest answers. No clinician has identified the exceptional circumstances that would justify delaying essential information under the applicable professional framework.

Which response is best?

A. Establish her preferences and answer honestly with appropriate support

B. Give only the signed consent form to communicate the diagnosis

C. Follow the family's protective request until after surgery

D. Avoid answering until every treatment option is finalized

Correct answer A. Distress calls for support, not unauthorized concealment from a capable patient.

Why B is less appropriate. A form does not replace communication.

Why C is less appropriate. Fear of refusal is insufficient justification.

Why D is less appropriate. She has asked a relevant current question.

Source framework: Sabiston e215; chapter sections 8 to 9 and 11 to 12. AMA 2.1.1 and 2.1.3; GMC consent guidance; ACS principles as relevant.

Question 015

Informed consent disclosure and scope

A 67 year old man initially agrees to elective surgery after a detailed consultation. On the morning of the operation, before sedation, he says he no longer wishes to proceed because the possible recovery burden conflicts with his priorities. He accurately describes the risks of waiting and understands that symptoms may worsen. There is no emergency. His spouse urges the team to proceed because travel and preparation have been difficult. The surgeon believes the operation remains beneficial and points to the earlier signed form. The patient has not asked to end all care and wants to discuss symptom management and another opinion. He is not being threatened and can explain his reasoning consistently. The ward asks whether the old form permits anesthesia despite today's statement.

He agrees to a focused check of understanding but does not want persuasion disguised as repeated capacity testing. The surgeon can explain future warning symptoms and arrange continued review without presenting the refusal as a decision to abandon every treatment relationship.

What is the best next step?

A. Ask the spouse to confirm the original choice

B. Repeat counseling until the patient reverses the refusal

C. Proceed using the earlier signed authorization

D. Clarify and respect the current decision while arranging appropriate continued care

Correct answer D. Authorization is current and revisable; an informed refusal does not end care.

Why A is less appropriate. The spouse cannot override his choice.

Why B is less appropriate. Counseling should not become coercion.

Why C is less appropriate. Earlier consent is not irrevocable.

Source framework: Sabiston e215; chapter sections 8 to 9 and 11 to 12. AMA 2.1.1 and 2.1.3; GMC consent guidance; ACS principles as relevant.

Question 016

Informed consent disclosure and scope

A 46 year old woman agrees to cancer surgery only if a particular irreversible additional procedure is avoided unless discussed with her first. The surgeon believes that additional treatment might become advisable if unexpected findings appear, but currently it is not necessary. Her condition is stable enough to clarify the plan before surgery. She understands that staging or a later procedure might then be required. The team has not decided whether her conditions permit a clinically defensible operation. A trainee suggests using broad consent wording so the surgeon can do whatever seems best during anesthesia. Another suggests refusing all involvement without explaining alternatives. The patient is willing to discuss the consequences and consider referral, but will not give unlimited permission.

The patient understands that these limits may change what can reasonably be offered. The surgeon can seek another opinion about feasibility and discuss a staged approach. None of those options requires pretending that a generic form cancels a clearly expressed condition.

Which response best addresses scope and professional responsibility?

A. Use broad wording to override the stated limitation

B. Clarify limits and feasibility and agree on a defensible plan or alternatives

C. End the relationship because conditional consent is inconvenient

D. Accept the condition without assessing whether it can be honored

Correct answer B. Specific limits and clinical feasibility must both be addressed before proceeding.

Why A is less appropriate. Generic wording does not erase explicit limits.

Why C is less appropriate. Appropriate alternatives and continuity remain obligations.

Why D is less appropriate. An undeliverable promise misleads the patient.

Source framework: Sabiston e215; chapter sections 8 to 9 and 11 to 12. AMA 2.1.1 and 2.1.3; GMC consent guidance; ACS principles as relevant.

Question 017

Informed consent disclosure and scope

A resident is asked to collect a signature for a complex operation that the attending surgeon has not discussed with the patient. The resident can explain general ward preparation but cannot answer questions about alternatives, likely functional loss or why this procedure is preferred. The patient wants those questions answered before agreeing. The attending is occupied elsewhere, and the list coordinator argues that documentation must be completed now to avoid delay. The procedure is elective, the patient has capacity and a short scheduling change is clinically acceptable. A leaflet is available, but the patient has already read it and still does not understand the recommendation. The team must distinguish support with the consent process from replacing the surgeon's substantive management discussion.

The resident is willing to help organize the discussion and document unresolved questions. The patient is not asking for information irrelevant to the choice. The responsible clinician can attend later, and no emergency makes signature collection the only possible path to treatment today.

Which action is most appropriate?

A. Collect the signature and ask the attending to explain after induction

B. Read the leaflet aloud and record the unanswered questions for discharge

C. Ask a relative to sign because the patient remains uncertain

D. Arrange the responsible surgical discussion before obtaining operative authorization

Correct answer D. Administrative signature collection cannot substitute for the necessary surgical conversation.

Why A is less appropriate. Explanation after induction comes too late.

Why B is less appropriate. The key management questions remain unanswered.

Why C is less appropriate. Uncertainty does not transfer patient authority.

Source framework: Sabiston e215; chapter sections 8 to 9 and 11 to 12. AMA 2.1.1 and 2.1.3; GMC consent guidance; ACS principles as relevant.

Question 018

Informed consent disclosure and scope

A 62 year old man understands the surgeon's words during consent but interprets a stated 90 percent technical success rate as a guarantee that he will return to work within one week. The operation's reported endpoint is symptom control at six months, and functional recovery varies substantially. The surgeon notices the misunderstanding when the patient repeats his plans. He has already signed the form and arranged travel, but is willing to reconsider if the actual recovery differs. There is no immediate threat requiring treatment today. A colleague suggests avoiding correction because it may undermine confidence and the success rate was quoted accurately. The patient's central concern is time away from work rather than the technical endpoint.

The patient says that a longer recovery could change the timing or even his choice. He is not questioning the accuracy of the study's actual endpoint. The surgeon can explain the distinction before either party treats a technically correct statistic as a shared understanding of personal benefit.

What is the best next step?

A. Correct the endpoint misunderstanding and revisit the decision

B. Ask the family to reassure him without changing the discussion

C. Proceed because the quoted number itself was accurate

D. Replace the estimate with a more optimistic recovery statement

Correct answer A. Accurate numbers can still produce materially false understanding requiring correction.

Why B is less appropriate. The surgeon must address the misunderstanding directly.

Why C is less appropriate. Literal accuracy does not establish comprehension.

Why D is less appropriate. A new unsupported assurance compounds the error.

Source framework: Sabiston e215; chapter sections 8 to 9 and 11 to 12. AMA 2.1.1 and 2.1.3; GMC consent guidance; ACS principles as relevant.

Question 019

Informed consent disclosure and scope

A 70 year old woman with limited proficiency in the language used by the team is considering elective surgery. Her adult son translates but repeatedly answers before she can speak and omits discussion of a possible stoma. She appears uncertain and asks him questions that he does not relay. He says professional interpretation is unnecessary because he knows what is best for her. The patient has no known cognitive impairment. An interpreter is available later today without harmful treatment delay. The surgeon must determine whether agreement reflects her informed choice and whether the omitted outcome is acceptable to her. The son has been supportive during previous care, so the team does not want to assume bad intent.

The patient asks to speak through someone who will translate all relevant options. Her son can still support her with permission. The delay concerns communication resources rather than clinical deterioration, and there is no reason to infer that language support would reveal incapacity rather than a capable preference.

Which strategy is best?

A. Treat language difficulty as incapacity and use surrogate consent

B. Use appropriate interpretation and seek her own understanding and preference

C. Accept the son's translation because he knows her well

D. Proceed if the son signs a statement accepting responsibility

Correct answer B. Accessible direct communication can clarify understanding without presuming incapacity or malicious intent.

Why A is less appropriate. Language barriers are not themselves incapacity.

Why C is less appropriate. Familiarity does not resolve the observed omission.

Why D is less appropriate. Responsibility cannot be transferred by that signature.

Source framework: Sabiston e215; chapter sections 8 to 9 and 11 to 12. AMA 2.1.1 and 2.1.3; GMC consent guidance; ACS principles as relevant.

Question 020

Informed consent disclosure and scope

A patient is anesthetized for a limited elective operation when an incidental lesion is found. It is not causing immediate harm, and deferral for further characterization would not endanger the patient. Removing it now would add meaningful risk and was not covered in the consent discussion. The surgeon believes the patient might prefer avoiding another anesthetic, while an assistant notes that the lesion could be benign and the patient may value preserving the affected structure. No applicable prior authorization addresses this situation. The family is waiting outside but their authority to expand consent has not been established. The original operation can be completed safely. The team wants to avoid both unnecessary treatment and a missed opportunity without invoking an emergency that does not exist.

The incidental finding can be documented and investigated after recovery. No evidence suggests that leaving it briefly would cause irreversible harm. The surgeon's belief that avoiding a second anesthetic is attractive remains an inference about preference, not established permission for the additional burden.

What is the best action?

A. Complete authorized care and arrange discussion of the incidental finding afterward

B. Assume any waiting relative can authorize added surgery

C. Describe the finding as an emergency to permit extension

D. Remove the lesion because another anesthetic would be inconvenient

Correct answer A. A nonurgent material extension requires appropriate authorization, not inferred convenience.

Why B is less appropriate. Authority must not be assumed.

Why C is less appropriate. The supplied facts do not establish emergency need.

Why D is less appropriate. Convenience does not establish consent or necessity.

Source framework: Sabiston e215; chapter sections 8 to 9 and 11 to 12. AMA 2.1.1 and 2.1.3; GMC consent guidance; ACS principles as relevant.

Question 021

Capacity voluntariness and supported decisions

A 79 year old man refuses an operation during a hurried ward interview. He has mild memory impairment, lacks his hearing aids and repeatedly asks what the surgeon said. His daughter requests surrogate consent because refusal seems out of character. The condition is serious but a few hours of assessment would not change the outcome. He has received no sedative, and his usual functioning includes managing finances and explaining complex choices. In a quieter room he says he fears losing independence and wants the alternatives explained. A hearing device and communication support can be arranged. The team has not assessed the particular decision beyond noting his age and repeated questions. A resident proposes treating the first refusal as either final informed refusal or proof of incapacity.

His daughter confirms that misunderstanding occurs when he cannot hear and that he normally asks detailed questions. She can provide useful background without automatically taking over. The team can clarify the stoma concern and reassess whether his final choice reflects informed values rather than inaccessible communication.

What is the best next step?

A. Support communication and assess his decision specific abilities

B. Treat the initial refusal as fully informed and final

C. Require a normal cognitive screening score before any discussion

D. Accept the daughter's signature based on memory impairment

Correct answer A. Unresolved communication barriers prevent a sound conclusion about either capacity or informed refusal.

Why B is less appropriate. Understanding has not yet been established.

Why C is less appropriate. Screening scores do not replace functional assessment.

Why D is less appropriate. A diagnosis does not establish incapacity.

Source framework: Sabiston e215 to e216; chapter section 10. GMC capacity and supported communication guidance as relevant.

Question 022

Capacity voluntariness and supported decisions

A 57 year old woman with a psychiatric diagnosis is offered surgery for a painful condition. Her symptoms are well controlled, and she explains the proposed operation, alternatives and consequences coherently. She prefers nonoperative care because recovery would interrupt responsibilities she considers important. The surgeon disagrees with the weighting but identifies no delusion, severe mood disturbance or inability to use information. A family member asks that her psychiatric history automatically activate a surrogate pathway. The operation is elective, and another clinician can review any genuine uncertainty. The team is concerned about respecting autonomy without overlooking impairment, but the only stated reason to remove her authority is the diagnosis and refusal. She has not asked her relative to decide.

The patient can explain the potential harm of refusing and why another responsibility matters more. There is no evidence that the psychiatric condition is currently distorting the relevant facts. A review can address genuine uncertainty, but should not be used merely to obtain agreement with surgery.

Which response is most appropriate?

A. Delay indefinitely until every clinician supports her preference

B. Require agreement with surgery to demonstrate intact reasoning

C. Assess the actual decision process and respect a capable informed choice

D. Use the psychiatric diagnosis as sufficient grounds for surrogate consent

Correct answer C. Diagnosis and disagreement alone do not negate decision specific capacity.

Why A is less appropriate. Consensus about values is not required.

Why B is less appropriate. Agreement is not the capacity test.

Why D is less appropriate. The supplied assessment shows no relevant impairment.

Source framework: Sabiston e215 to e216; chapter section 10. GMC capacity and supported communication guidance as relevant.

Question 023

Capacity voluntariness and supported decisions

A 68 year old man with fluctuating delirium needs a nonurgent operation. He is inattentive overnight but participates clearly during a morning conversation after treatment of reversible contributors. The surgeon can revisit essential information and check whether he retains and uses it for the decision. His daughter says that once delirium has been diagnosed he cannot authorize anything until discharge. A trainee proposes taking a quick signature during a calm minute without evaluating understanding. Delay for supported reassessment is safe, but postponing for weeks would worsen symptoms and create substantial burden. The patient wants to decide when able and can communicate a consistent goal during lucid periods. No legal directive requires a specific fixed waiting period.

Nursing observations identify periods when attention improves, which can guide a supported assessment. The patient has not yet demonstrated the relevant abilities in a documented discussion. A signature or a calm appearance would therefore be inadequate evidence in either direction without examining the decision itself.

What is the best strategy?

A. Transfer all decisions permanently to the daughter because delirium occurred

B. Postpone every decision until the patient leaves hospital

C. Collect a signature whenever agitation briefly subsides

D. Assess the particular decision during supported reassessment and document the findings

Correct answer D. Capacity can fluctuate; calmness alone is insufficient, but a diagnosis does not permanently remove participation.

Why A is less appropriate. Authority is not permanently lost by diagnosis.

Why B is less appropriate. A blanket delay ignores possible recovered capacity.

Why C is less appropriate. Reduced agitation does not prove relevant abilities.

Source framework: Sabiston e215 to e216; chapter section 10. GMC capacity and supported communication guidance as relevant.

Question 024

Capacity voluntariness and supported decisions

A 71 year old woman agrees to a simple bedside treatment but cannot understand the implications of a complex high burden operation despite appropriate explanation and support. She has an acute cognitive impairment expected to improve, although not before the operative decision must be made. Her representative says agreeing to the simple treatment proves she can consent to everything. Another clinician says inability to decide about surgery means she should not be involved in any further care discussion. She can communicate comfort preferences and identify people she trusts. The team needs timely authorization for the complex decision while preserving her remaining involvement. There is no uncertainty about the representative's authority if it is required.

She can indicate preferred comfort measures and who should be present. Those abilities remain relevant while another person addresses the more complex authorization. The team can document the distinction, avoiding a global label that either overestimates or erases her remaining participation.

Which approach is best?

A. Exclude her from all decisions because one complex decision exceeds her abilities

B. Treat agreement to bedside care as consent capacity for the operation

C. Use the appropriate pathway for surgery while retaining her available participation

D. Delay necessary surgery until she can demonstrate every decision making skill

Correct answer C. Capacity is decision specific; appropriate representation and supported participation can coexist.

Why A is less appropriate. Impairment does not eliminate every ability.

Why B is less appropriate. The decisions have different informational demands.

Why D is less appropriate. The stated timeline does not permit that delay.

Source framework: Sabiston e215 to e216; chapter section 10. GMC capacity and supported communication guidance as relevant.

Question 025

Capacity voluntariness and supported decisions

A 54 year old man refuses surgery after a new diagnosis. He accurately repeats the facts but says the consequences cannot apply to him because a television presenter sends messages guaranteeing that his organs cannot fail. He cannot consider the possibility of deterioration despite repeated supported discussion. The surgeon recognizes that the refusal may be driven by a belief affecting his use of relevant information, not merely an unpopular value. The operation is not immediately necessary, and experienced mental health and ethics support can assess him promptly. His brother wants the surgeon to force treatment today, while a resident argues that repeating the complication list proves capacity.

The clinician can document which part of the reasoning is affected and obtain appropriate help without assuming that the brother acquires authority by demanding treatment. If the impairment improves, the patient's own participation should be revisited rather than considered permanently lost.

Which next step is most appropriate?

A. Use the brother's demand as immediate authority for treatment

B. Classify every refusal associated with unusual beliefs as incapable

C. Accept repetition of facts as sufficient proof of capacity

D. Obtain focused capacity assessment and address the suspected impairment before authorization

Correct answer D. The concern is impaired appreciation and use of information; targeted assessment is needed rather than automatic acceptance or override.

Why A is less appropriate. Authority and necessity require proper assessment.

Why B is less appropriate. Unusual beliefs alone are not a universal incapacity rule.

Why C is less appropriate. Recall alone does not establish the full process.

Source framework: Sabiston e215 to e216; chapter section 10. GMC capacity and supported communication guidance as relevant.

Question 026

Capacity voluntariness and supported decisions

A 64 year old patient refuses an operation that offers a substantial chance of prolonged survival. The patient explains the diagnosis, recognizes the possibility of death without treatment and compares the alternatives consistently. The choice reflects a longstanding preference to avoid a particular permanent functional loss. There is no evidence of coercion or impaired cognition. The surgeon asks for psychiatric review solely because a reasonable person would choose survival. A colleague proposes honoring the refusal immediately without checking whether the patient understands a newly available less burdensome alternative. There is time for one focused discussion. The patient remains willing to hear relevant information but does not want repeated pressure to change personal values.

The new alternative might reduce the very burden that drives refusal, but it may still be unacceptable to the patient. The surgeon should explain that difference rather than treat the conversation as a test that the patient passes only by choosing longer survival.

Which action best completes the decision process?

A. Declare incapacity because the patient risks losing years of life

B. Accept the refusal without mentioning the relevant new option

C. Request repeated assessments until one supports treatment

D. Explain the new alternative and confirm informed voluntary refusal without outcome based capacity judgments

Correct answer D. A material alternative needs discussion, while the chosen outcome is not itself the capacity test.

Why A is less appropriate. Grave consequences do not automatically negate capacity.

Why B is less appropriate. The informational basis has changed.

Why C is less appropriate. Assessment must not seek a preferred answer.

Source framework: Sabiston e215 to e216; chapter section 10. GMC capacity and supported communication guidance as relevant.

Question 027

Capacity voluntariness and supported decisions

A 60 year old woman communicates through a device after neurological injury. She answers slowly but demonstrates understanding of her condition and asks relevant questions about surgery. The team is under list pressure, and her spouse can answer much faster. A clinician proposes using the spouse as surrogate because inability to speak normally makes meaningful consent impractical. The patient signals that she wants to decide herself. Her operation can safely wait for an accessible consultation, and speech support staff can help. There is no evidence that delayed responses reflect confusion rather than the communication method. The surgeon must distinguish speed and convenience from the ability to express a choice, while ensuring adequate understanding rather than merely collecting a yes response.

The communication specialist can help distinguish difficulty operating the device from difficulty understanding the choice. The spouse can contribute background with permission. The patient's slow responses are a practical planning issue, not evidence that another person's preference should be substituted for hers.

What is the best strategy?

A. Proceed after obtaining one affirmative device response

B. Provide sufficient communication support and assess her own decision process

C. Use the spouse's faster answers as substitute authorization

D. Treat inability to speak as evidence that capacity is absent

Correct answer B. Accessible communication should enable substantive participation, not be bypassed for speed.

Why A is less appropriate. A single yes does not establish informed understanding.

Why C is less appropriate. Convenience does not establish surrogate authority.

Why D is less appropriate. Speech impairment is not automatically cognitive impairment.

Source framework: Sabiston e215 to e216; chapter section 10. GMC capacity and supported communication guidance as relevant.

Question 028

Capacity voluntariness and supported decisions

A patient is in severe pain before urgent but not immediately life saving surgery. He refuses discussion until analgesia is provided. The team worries that analgesics could affect cognition and considers withholding pain relief to preserve consent validity. He is currently distressed, unable to focus and asking the same question. A brief period for symptom treatment and reassessment is clinically safe. His partner says he usually makes clear decisions when comfortable. The surgeon wants neither to mistake distress for permanent incapacity nor assume any medication automatically makes consent invalid. The operation's main risks and alternatives can be explained after stabilization. No relevant advance directive exists, and he has not delegated the decision.

The patient has asked for relief rather than attempted to evade a decision. The team can assess attention and reasoning after treatment, taking account of medication effects and the clinical timeline. Neither uncontrolled distress nor a medication label is a satisfactory substitute for examining actual abilities.

Which next step best supports meaningful authorization?

A. Withhold analgesia until a signature is obtained

B. Assume every postanalgesic decision is invalid regardless of assessment

C. Use the partner's preference because distress proves incapacity

D. Treat pain appropriately and reassess decision abilities in the resulting clinical state

Correct answer D. Symptom relief may improve participation; effects require assessment rather than blanket assumptions.

Why A is less appropriate. Severe untreated pain can impair understanding.

Why B is less appropriate. Medication exposure alone does not settle capacity.

Why C is less appropriate. Temporary distress does not establish that authority pathway.

Source framework: Sabiston e215 to e216; chapter section 10. GMC capacity and supported communication guidance as relevant.

Question 029

Capacity voluntariness and supported decisions

A 73 year old man refuses another operation while his adult children stand at the bedside. Privately he explains that he wants treatment but fears losing their financial and housing support if he agrees. He understands the procedure and can compare outcomes. The children insist that he is free to choose and ask the surgeon to record the refusal now. The operation can wait for prompt support and assessment, although prolonged delay would reduce benefit. Social work and an independent interpreter or advocate are available if needed. The surgeon must address the influence without assuming that family involvement is inherently coercive or deciding the treatment outcome for him. The patient asks for confidentiality and practical help in considering his options safely.

The patient has not asked the surgeon to operate secretly or make the choice for him. He wants help understanding whether support can be arranged if family assistance changes. The team can explore those practical constraints while assessing whether the expressed refusal is genuinely voluntary.

What is the best next step?

A. Authorize surgery immediately because coercion makes agreement preferable

B. Assess voluntariness privately and arrange support before accepting the decision

C. Ask the children to certify that no pressure exists

D. Record refusal because cognitive capacity is intact

Correct answer B. Capacity and voluntariness are distinct; credible pressure needs assessment and support without predetermining treatment.

Why A is less appropriate. The patient must still make a supported choice.

Why C is less appropriate. The potential source cannot settle the concern.

Why D is less appropriate. Cognition alone does not resolve coercion.

Source framework: Sabiston e215 to e216; chapter section 10. GMC capacity and supported communication guidance as relevant.

Question 030

Capacity voluntariness and supported decisions

A sedated patient requires an urgent decision about further treatment. A surrogate discussion is underway when sedation is reduced and the patient begins communicating coherently. The team believes relevant capacity may have returned, but the representative has already agreed to the procedure. The patient asks what was decided and expresses uncertainty about the recovery burden. There is time for a focused assessment without harmful delay. The representative wants to avoid revisiting a difficult conversation, and a resident argues that surrogate authorization remains controlling because the form is complete. The patient has no known prior refusal, but his current wishes may affect the plan. The surgeon must preserve continuity while recognizing that authority can change with clinical state.

The patient can now ask about outcomes that the representative did not emphasize. Restoring participation does not invalidate the representative's earlier efforts, but it may change who makes the present decision. The team should explain that transition rather than frame it as a conflict of ownership.

Which action is most appropriate?

A. Proceed solely on the completed surrogate form

B. Assess current capacity and restore direct participation before continuing authorization

C. Require the representative to approve any return of decision authority

D. Wait until discharge before discussing the patient's new concerns

Correct answer B. Recovered capacity requires renewed patient involvement; prior representation does not permanently displace the person.

Why A is less appropriate. Completed paperwork does not override recovered participation.

Why C is less appropriate. Authority is not owned by the representative.

Why D is less appropriate. The relevant decision is current.

Source framework: Sabiston e215 to e216; chapter section 10. GMC capacity and supported communication guidance as relevant.

Question 031

Surrogates assent and patient centered standards

A 76 year old woman lacks capacity after an acute complication. A document names her partner as healthcare representative, but her adult son says relatives must take precedence and asks the surgeon to obtain his signature instead. The partner has detailed knowledge of the patient's goals; the son has important information about a recent conversation that may also matter. The document has not been checked for applicability or scope. The decision can wait several hours for verification, but not several days. The surgeon wants to avoid either assuming a universal family hierarchy or excluding useful information from someone who may not hold formal authority. There is no immediate threat requiring treatment before that review.

The son may hold clinically important information even if the document confirms the partner's authority. The partner's legal role likewise does not make every personal opinion decisive. The review should establish both who acts and what patient centered evidence guides the action.

Which strategy best establishes the decision pathway?

A. Accept the partner's view without checking the document

B. Let the family vote on the treatment and representative

C. Use the son's relationship as automatic authority

D. Verify authority and gather relevant patient information from both people

Correct answer D. Formal authority and useful knowledge are different questions that both require attention.

Why A is less appropriate. The scope and applicability remain unverified.

Why B is less appropriate. Voting does not establish patient authority.

Why C is less appropriate. Family priority depends on the applicable framework.

Source framework: Sabiston e216; chapter sections 24 to 26. AMA Opinion 2.1.2 as relevant.

Question 032

Surrogates assent and patient centered standards

A 69 year old man is unconscious and needs a treatment decision. His authorized representative says he would never want machines because he once disliked visiting an intensive care unit. A documented consultation, however, states that he would accept temporary ventilation for a reversible complication but not prolonged support without recovery. Clinicians believe temporary support may achieve recovery, although certainty is impossible. The representative is distressed and asks the surgeon to stop explaining probabilities. Other relatives believe the representative's interpretation is inaccurate. There is time for a supported discussion and rapid review if needed. The surgeon must not automatically disregard the representative, but also must not substitute a vague statement for a relevant conditional preference.

The representative fears causing suffering and may be using a general phrase to express that concern. The team can support the person while explaining the documented conditional preference. Further review is appropriate if interpretation remains incompatible with the patient's reasonably established wishes.

What is the best next step?

A. Ignore the representative and act solely on technical judgment

B. Explore the conflict and apply the documented preference to the current prognosis

C. Follow the representative's current preference without further interpretation

D. Treat any dislike of machines as a refusal of temporary ventilation

Correct answer B. The specific conditional instruction needs contextual interpretation with the representative and appropriate review if conflict persists.

Why A is less appropriate. Clinical expertise does not eliminate the representative's role.

Why C is less appropriate. Representative wishes do not replace known patient values.

Why D is less appropriate. The statement is broader than its supported meaning.

Source framework: Sabiston e216; chapter sections 24 to 26. AMA Opinion 2.1.2 as relevant.

Question 033

Surrogates assent and patient centered standards

A patient with severe cognitive impairment has never expressed preferences about major surgery. The intervention could relieve substantial pain but carries a prolonged recovery burden and uncertain functional gain. The authorized representative asks what the patient would choose, but no reasonable evidence supports an answer. One clinician proposes inventing a likely preference based on what most adults want; another recommends against surgery because dependence is already present. The patient still shows pleasure in familiar activities and distress with pain. Less burdensome symptom options exist but have been only partially effective. The decision is not emergent and can be reviewed carefully.

The representative can describe what causes distress and which activities remain meaningful, without inventing a preference about surgery. The clinicians can compare symptom relief with expected recovery burdens. Neither familiarity with the patient nor technical expertise alone settles how those considerations should be integrated.

Which standard and focus are most appropriate?

A. Treat existing dependence as sufficient reason to withhold surgery

B. Use best interests to compare achievable benefit, burden and lived experience

C. Let the representative's personal tolerance of burden determine care

D. Use an assumed majority preference as substituted judgment

Correct answer B. Unknown preferences require a patient centered best interests analysis rather than invented autonomy or categorical disability judgments.

Why A is less appropriate. Dependence does not alone establish lack of benefit.

Why C is less appropriate. The representative acts for the patient.

Why D is less appropriate. Population preference is not this person's known wish.

Source framework: Sabiston e216; chapter sections 24 to 26. AMA Opinion 2.1.2 as relevant.

Question 034

Surrogates assent and patient centered standards

A 71 year old man's designated representative requests continued invasive treatment because stopping would make the representative feel guilty. The patient's prior clear statements rejected prolonged dependence without recovery, and current assessments suggest that recovery to the condition he valued is no longer realistic. The representative does not dispute the statements or prognosis but says family distress should control the decision. The team has provided support, yet disagreement continues. There is no immediate requirement to add another intervention while a review is arranged. The surgeon must maintain compassionate care without either automatically obeying or unilaterally dismissing the representative. An ethics service and independent clinician are available promptly.

The representative's grief deserves support, but the requested treatment may serve that distress rather than the patient's stated wishes. Review can examine the disagreement while the team continues appropriate care. The purpose is not to punish the representative for emotion or to avoid an uncomfortable conversation.

What is the best next action?

A. Provide every requested treatment because the representative has authority

B. Seek appropriate review of the conflict while supporting the representative and patient

C. Dismiss the representative permanently without a review process

D. Use the family's distress as the patient's best interests standard

Correct answer B. Persistent departure from known wishes requires review; authority does not become unrestricted personal choice.

Why A is less appropriate. Authority remains directed toward the patient.

Why C is less appropriate. Fair process remains necessary.

Why D is less appropriate. Third party distress is not the patient standard.

Source framework: Sabiston e216; chapter sections 24 to 26. AMA Opinion 2.1.2 as relevant.

Question 035

Surrogates assent and patient centered standards

A 65 year old woman lacks capacity temporarily. Her representative consents to a high burden operation, reasoning that she always fought illness and wanted to live. Other records describe a strong wish to avoid a permanent stoma, which the operation is very likely to require. She previously accepted temporary intensive treatment, but nobody discussed this exact scenario. The operation may improve survival, and a less burdensome alternative offers less durable disease control. Several hours are available for deliberation. The surgeon must reconcile general resilience with a more specific value, rather than cherry pick a statement that supports the preferred operation. The representative is open to a discussion and asks which information should carry most weight.

The representative recalls that the patient accepted other burdens for important goals but consistently discussed the stoma concern. The surgeon can clarify how likely each outcome is with each option. This creates a reasoned interpretation task, not a competition between isolated quotations or relatives.

Which strategy is best?

A. Ask relatives to select the statement they prefer

B. Treat the stoma concern as refusal of every possible intervention

C. Use the general wish to live as authorization for every burden

D. Examine the statements' context and compare outcomes against her values

Correct answer D. Substituted judgment requires contextual interpretation, not automatic dominance of a broad slogan or an overextended specific concern.

Why A is less appropriate. Family preference does not determine evidentiary meaning.

Why B is less appropriate. The statement may not reject all alternatives.

Why C is less appropriate. A general value does not authorize everything.

Source framework: Sabiston e216; chapter sections 24 to 26. AMA Opinion 2.1.2 as relevant.

Question 036

Surrogates assent and patient centered standards

An unrepresented adult lacks capacity and has a nonurgent surgical condition. No directive or representative is immediately identified. The team expects capacity may improve with treatment of an acute illness, and a short delay is safe. The operating room has an opening today, and the surgeon suggests using presumed consent because finding a representative is inconvenient. Another clinician proposes indefinite delay even if capacity does not recover. The hospital has a process for unrepresented patients and staff able to search relevant records. The patient can communicate basic comfort needs but not the complex decision. The team must preserve participation and avoid turning operational convenience into an emergency exception.

A named clinician can review whether capacity is improving and oversee the search for relevant preferences. Basic comfort care can continue with the patient's participation. The decision pathway should be explicit so that safe short delay does not become indefinite neglect under an apparently respectful label.

What is the best next step?

A. Support recovery and use the appropriate unrepresented patient pathway if needed

B. Wait indefinitely without assigning review responsibility

C. Treat basic comfort communication as authorization for major surgery

D. Proceed today under presumed consent because no relative is present

Correct answer A. Safe delay and a proper pathway should replace an invented emergency while remaining participation is supported.

Why B is less appropriate. Unowned delay can also harm.

Why C is less appropriate. The decisions require different abilities.

Why D is less appropriate. Convenience is not emergency necessity.

Source framework: Sabiston e216; chapter sections 24 to 26. AMA Opinion 2.1.2 as relevant.

Question 037

Surrogates assent and patient centered standards

A patient without capacity needs urgent surgery for a life threatening condition. No representative can be reached in time. An accessible prior directive clearly addresses the current treatment and appears applicable, but the team has not verified a disputed detail. A resident says emergency status erases all prior refusals; another wants to stop all stabilization until legal review is complete. Senior clinical and institutional advice can be obtained immediately while supportive care continues. The surgeon must distinguish necessary emergency action from treating known preferences as irrelevant, and must not assume that every uncertainty justifies either delay or override. The clinical timeline is short, and the consequences of the disputed decision are substantial.

The team can distinguish reversible stabilization measures from the disputed definitive intervention. Any urgent advice should address the document's actual applicability rather than assume the emergency itself answers that question. The record should explain what could be established within the short clinical window.

What is the best approach?

A. Manage immediate needs while urgently clarifying applicability and the governing decision pathway

B. Let whichever relative answers first override the document

C. Stop all care until a lengthy formal hearing occurs

D. Ignore the directive because presumed consent always overrides it

Correct answer A. Emergency care must consider relevant known preferences and obtain rapid appropriate advice about genuine uncertainty.

Why B is less appropriate. Authority and applicability cannot be decided by convenience.

Why C is less appropriate. Immediate supportive needs still require management.

Why D is less appropriate. Emergency status is not a blanket override.

Source framework: Sabiston e216; chapter sections 24 to 26. AMA Opinion 2.1.2 as relevant.

Question 038

Surrogates assent and patient centered standards

A 14 year old patient is offered a nonurgent operation. The legally appropriate adult authorization route has been established, but the patient objects because nobody has explained pain control or recovery. The parents consent and ask staff not to involve the child further because this will slow scheduling. The patient can understand an age appropriate account and asks specific questions. There is no immediate threat requiring intervention before discussion. The surgeon wants to recognize developing participation without assuming that assent and legal consent are identical or that a universal age threshold resolves every case. Support staff can help address fear, and the team can reassess the disagreement after explanation.

The patient asks whether treatment will prevent ordinary activities during recovery, a question that can be answered in accessible terms. The parents can remain involved without excluding the child's perspective. If disagreement persists after support, the appropriate local process can address it rather than a universal age assumption.

What is the best next step?

A. Exclude the parents because the child asks relevant questions

B. Provide age appropriate information and seek participation alongside valid authorization

C. Proceed solely because parental paperwork is complete

D. Treat the child's objection as automatically decisive in every jurisdiction

Correct answer B. Ethical assent supports developing participation without replacing the applicable legal framework.

Why A is less appropriate. Adult authorization may still be required.

Why C is less appropriate. A signature does not exhaust participation obligations.

Why D is less appropriate. Legal consequences are jurisdiction and context specific.

Source framework: Sabiston e216; chapter sections 24 to 26. AMA Opinion 2.1.2 as relevant.

Question 039

Surrogates assent and patient centered standards

A woman lacking capacity has two possible treatments with similar survival prospects but different burdens. Her authorized representative accurately describes her longstanding preference for avoiding repeated hospitalizations and favors the option with fewer future admissions. The surgeon personally favors the other option because it is more familiar technically, although both remain appropriate. A relative accuses the representative of choosing convenience, but the records support the stated patient preference. There is no evidence of coercion or personal gain. The team can explain uncertainty about future admissions without pretending to guarantee an outcome.

The representative is willing to hear the uncertainty in the predicted admission burden. The surgeon can verify that both choices remain clinically reasonable. The relative's concern merits discussion, but it does not erase reliable evidence that avoiding repeated hospitalization was a genuine patient priority.

Which approach best respects the representative's role and the surgeon's duties?

A. Override the representative because the surgeon prefers the familiar option

B. Replace substituted judgment with what most relatives would choose

C. Reject the option because its benefit cannot be guaranteed

D. Assess clinical appropriateness and support the evidence based substituted judgment

Correct answer D. A grounded patient preference can guide choice among appropriate options despite uncertainty or different clinician values.

Why A is less appropriate. Personal familiarity is not the sole ethical criterion.

Why B is less appropriate. Family consensus does not replace the patient standard.

Why C is less appropriate. Uncertainty does not invalidate every reasonable preference.

Source framework: Sabiston e216; chapter sections 24 to 26. AMA Opinion 2.1.2 as relevant.

Question 040

Surrogates assent and patient centered standards

A patient has documented a preference for his sister to help with medical decisions, but the document's legal status and scope are unclear. He currently has capacity and wants her present during a discussion of major surgery. She begins answering every question and says her designation allows her to decide now. The patient says he wants her advice but wishes to make the final choice himself. The surgeon has time to clarify the arrangement before treatment. No emergency or coercion is identified, and the sister is willing to listen when the distinction is explained. The team must recognize both supported decision making and the conditions under which a representative might acquire authority later.

The sister can assist with recall and questions, and her future role can be clarified separately if capacity later changes. There is no need to resolve every future contingency before recognizing the patient's current ability and explicit desire to make this particular choice.

What is the best response?

A. Exclude the sister entirely because she is not currently deciding

B. Ask the sister to authorize any change in her role

C. Support her involvement while retaining the capable patient's current decision authority

D. Treat the designation as permanently replacing his choices

Correct answer C. Assistance and future representation do not automatically displace a patient's present capable decision.

Why A is less appropriate. Supported participation can remain useful.

Why B is less appropriate. The patient's current authority is not hers to grant.

Why D is less appropriate. Designation is not blanket loss of autonomy.

Source framework: Sabiston e216; chapter sections 24 to 26. AMA Opinion 2.1.2 as relevant.

Question 041

Treatment limits uncertainty and conflict resolution

A critically ill man has progressive organ failure after surgery. Another operation might achieve short term source control, but return to his previous function is very unlikely. His representative asks for treatment to allow time for a relative to arrive, not because long term recovery is expected. The team has not established whether surgery would actually provide that time or whether less burdensome support could do so. One clinician calls all further intervention futile, while another believes any possible physiological effect requires surgery. There is time for prompt senior review while current appropriate care continues. The patient's own preferences are poorly known. The surgeon must evaluate the proposed goal without treating the family's desire as either irrelevant or automatically sufficient.

An independent review can address whether the proposed operation would actually alter the short timeline. The representative has not asked for survival at any cost. Symptom support and less invasive measures must therefore be compared with surgery rather than assumed to be either equivalent or irrelevant.

Which next step is best?

A. Decline solely because long term recovery is unlikely

B. Operate solely because brief physiological survival remains possible

C. Clarify goal specific effectiveness, burdens and alternatives through timely review

D. Treat family reunion as sufficient best interests justification

Correct answer C. A different goal changes analysis but does not eliminate the need for proportional benefit and an appropriate patient standard.

Why A is less appropriate. Poor prognosis does not settle every goal.

Why B is less appropriate. Possibility alone does not justify burdens.

Why D is less appropriate. Third party wishes require patient centered evaluation.

Source framework: Sabiston e216; chapter sections 27 to 31. AMA 5.3 and 5.5; ATS partner society statement 2015 as relevant.

Question 042

Treatment limits uncertainty and conflict resolution

A patient remains on a treatment that produces the intended physiological effect but has not improved the outcome the patient previously valued. Clinicians believe continued escalation may be inappropriate because burdens are rising. The representative argues that the treatment cannot be called futile if it still affects the measured physiological variable. The team agrees that the physiological effect is possible and is not debating that fact. No immediate new intervention is required while a structured discussion occurs. An independent opinion can review prognosis and alternatives. The surgeon must choose language that accurately distinguishes technical effectiveness from a contested ethical judgment, without using terminology to end discussion or promising indefinite escalation.

The family wants the clinician to distinguish a measurable effect from an outcome worth pursuing for this patient. The review can examine uncertainty and values without denying the physiological response. Language should make the source of disagreement visible rather than hide it behind a technical sounding label.

Which description best fits the unresolved concern?

A. Strict physiological futility because the overall prognosis is unfavorable

B. Potentially inappropriate treatment requiring explicit benefit burden reasoning and review

C. A purely family decision beyond any professional judgment

D. Mandatory treatment because one physiological variable responds

Correct answer B. An achievable physiological effect can coexist with disputed overall appropriateness requiring reasoned review.

Why A is less appropriate. The specified physiological effect is not impossible.

Why C is less appropriate. Professional judgment remains relevant.

Why D is less appropriate. Effect does not alone establish justification.

Source framework: Sabiston e216; chapter sections 27 to 31. AMA 5.3 and 5.5; ATS partner society statement 2015 as relevant.

Question 043

Treatment limits uncertainty and conflict resolution

A 77 year old woman has uncertain reversibility after a major complication. Temporary organ support may reveal whether recovery toward an agreed meaningful goal is possible. Her representative understands the uncertainty but fears that starting support will make stopping it ethically impossible. The team can identify measurable signs of improvement and a clinically relevant review interval. No promise of recovery can be made. A trainee proposes calling the intervention a trial without discussing what failure would mean, believing this will reduce distress. The surgeon wants a plan that provides a genuine opportunity for recovery without indefinite treatment by default. Appropriate symptom care will continue regardless of the later decision.

The representative is willing to agree on meaningful observations but does not want an arbitrary deadline that ignores recovery. Clinicians can explain which changes would support continuation and which would prompt another recommendation. The trial should create decision relevant information, not simply defer a difficult conversation to another team.

Which approach is best?

A. Avoid support because starting always obliges indefinite continuation

B. Begin a trial without defining review conditions

C. Agree on trial goals, measures, review and possible next decisions in advance

D. Guarantee withdrawal at a fixed date regardless of clinical findings

Correct answer C. A meaningful trial defines what will be learned and how reassessment informs continued appropriate care.

Why A is less appropriate. Initiation does not ethically mandate permanence.

Why B is less appropriate. An undefined trial postpones disagreement.

Why D is less appropriate. Review must consider findings and the governing process.

Source framework: Sabiston e216; chapter sections 27 to 31. AMA 5.3 and 5.5; ATS partner society statement 2015 as relevant.

Question 044

Treatment limits uncertainty and conflict resolution

A surgeon proposes a major irreversible operation followed by a time limited trial of intensive care. The patient lacks capacity, and the representative asks whether this makes the operation itself reversible if recovery fails. The operation has uncertain benefit and substantial immediate burdens. A less invasive option might achieve some goals with less recovery cost. The team has discussed withdrawal of organ support but has not separately justified the surgical intervention. Several hours are available for a focused review without harmful delay. The representative is not refusing care and wants to understand which burdens cannot be undone.

The representative wants a comparison with the less invasive alternative, including what recovery might require under either strategy. The surgical team can explain which burdens occur immediately and which later support decisions remain revisable. That distinction matters before describing the entire plan as a reversible experiment.

Which recommendation process best addresses the problem?

A. Treat the support trial as sufficient justification for surgery

B. Justify the operation separately and define any support trial afterward

C. Avoid discussing irreversible burdens to preserve agreement

D. Describe withdrawal of support as undoing the operation

Correct answer B. A support trial does not erase the operation's independent irreversible costs or need for a beneficial objective.

Why A is less appropriate. Trial language does not supply proportionality.

Why C is less appropriate. Material burdens must be discussed.

Why D is less appropriate. The surgical effects cannot generally be reversed that way.

Source framework: Sabiston e216; chapter sections 27 to 31. AMA 5.3 and 5.5; ATS partner society statement 2015 as relevant.

Question 045

Treatment limits uncertainty and conflict resolution

A patient with capacity asks to stop a burdensome life sustaining treatment after a supported discussion. The patient understands that death may follow and that symptom care can continue. A relative says withdrawal is morally different from never starting and demands continuation because the team already committed. The treating clinicians agree that the request reflects the patient's stable values rather than untreated confusion or coercion. The surgeon wants to respect the decision while using the appropriate institutional and legal process. No uncertainty about capacity has been identified. The team must avoid both treating prior initiation as an irrevocable contract and interpreting treatment withdrawal as withdrawal of all care.

The patient is not requesting abandonment and asks for relief of distress if the intervention stops. The relative can receive support and an explanation of why previous initiation does not eliminate later choice. Implementation must follow the applicable process rather than treating the ethical principle as every jurisdiction's complete legal rule.

Which ethical response is best?

A. Respect the informed request through the appropriate process and continue symptom care

B. Stop every form of care once the treatment is withdrawn

C. Continue because starting treatment permanently removes the option to stop

D. Transfer authority to the relative because death may result

Correct answer A. An informed capable refusal can apply to continuing treatment; appropriate care and symptom management remain active duties.

Why B is less appropriate. Limiting one intervention is not abandonment.

Why C is less appropriate. Prior initiation is not permanent authorization.

Why D is less appropriate. Grave consequences do not transfer authority.

Source framework: Sabiston e216; chapter sections 27 to 31. AMA 5.3 and 5.5; ATS partner society statement 2015 as relevant.

Question 046

Treatment limits uncertainty and conflict resolution

A representative requests another intervention that the surgical team judges unlikely to achieve the patient's goals. Repeated meetings have clarified the prognosis, but the representative remains unconvinced and asks for an independent review. The patient lacks capacity. The team has not yet used the institution's dispute process, and the requested intervention is not needed within minutes. A clinician proposes unilateral withdrawal immediately because all treating physicians agree. Another believes disagreement obliges every requested procedure indefinitely. Appropriate current care can continue during timely review. The surgeon must maintain clinical integrity without pretending that professional consensus alone establishes legal authority to act in every setting.

The representative is willing to meet an independent clinician and does not demand an immediate unreviewed procedure. The team can explain the dispute mechanism and maintain appropriate support during it. The process should address both clinical judgment and legitimacy, not merely obtain another signature endorsing the treating team's view.

Which next step is best?

A. Withdraw immediately solely on treating team consensus

B. Use the applicable fair review process while continuing appropriate care

C. Provide every requested intervention until the family independently changes its mind

D. Refuse any second opinion because it may undermine trust

Correct answer B. Persistent conflict requires appropriate review; neither automatic compliance nor unreviewed unilateral action resolves the ethical and procedural issues.

Why A is less appropriate. Consensus alone does not establish every required authority.

Why C is less appropriate. Requests do not compel medically inappropriate treatment.

Why D is less appropriate. Independent assessment can improve legitimacy.

Source framework: Sabiston e216; chapter sections 27 to 31. AMA 5.3 and 5.5; ATS partner society statement 2015 as relevant.

Question 047

Treatment limits uncertainty and conflict resolution

An elderly patient has a low chance of survival after another major operation. Clinicians disagree about whether the chance is negligible or merely small. A resident quotes a precise mortality percentage from a different population and calls this objective proof of futility. The family asks whether that number means recovery is impossible. The surgeon knows the estimate has limited applicability and that outcomes include different levels of dependence. The patient cannot decide, but prior values are available. There is time for focused clarification before the next treatment decision. The team wants to avoid either inventing certainty or describing every outcome as equally likely.

The representative can explain the patient's prior attitude toward dependence, which may change the meaning of survival estimates. The independent assessment can distinguish lack of certainty from lack of useful knowledge. The family is asking for calibrated explanation, not a promise that another test will eliminate every possible outcome.

Which response is most appropriate?

A. Present the borrowed percentage as an exact individual prediction

B. Avoid numerical or qualitative prognosis because uncertainty exists

C. Treat any nonzero survival probability as an obligation to operate

D. Explain estimate limits and compare relevant outcomes against known patient goals

Correct answer D. Useful prognosis includes calibrated uncertainty and outcome context, not false precision or complete silence.

Why A is less appropriate. Population mismatch undermines that claim.

Why B is less appropriate. Uncertainty does not prevent meaningful counseling.

Why C is less appropriate. Probability alone does not determine proportionality.

Source framework: Sabiston e216; chapter sections 27 to 31. AMA 5.3 and 5.5; ATS partner society statement 2015 as relevant.

Question 048

Treatment limits uncertainty and conflict resolution

A man with advanced dementia experiences distress from a surgically treatable complication. He cannot express a treatment preference, and no prior wishes are known. The intervention might relieve pain but would not improve dementia. A clinician dismisses surgery because cognitive recovery is impossible; another recommends it without discussing burdens because pain relief is possible. His representative describes valued daily experiences and asks how the procedure would affect them. Less invasive symptom treatment has some benefit and can be continued. The condition allows a careful timely decision. The surgeon must distinguish the complication's treatment goal from a goal the operation cannot achieve and avoid equating disability with absence of worth.

The representative can describe how pain has altered the patient's daily experience. Clinicians can identify the likely recovery demands and whether less invasive support remains effective. The decision should not use failure to reverse dementia as proof that no symptom related benefit can matter.

Which assessment is best?

A. Reject surgery because it cannot reverse the underlying dementia

B. Base treatment solely on the representative's own quality of life preference

C. Compare achievable symptom benefit and procedural burdens using best interests

D. Operate because any possible pain relief outweighs all burdens

Correct answer C. The relevant goal may be relief of the complication, assessed against burdens and the patient's lived experience.

Why A is less appropriate. That is not the only possible goal.

Why B is less appropriate. The standard is the patient's interests.

Why D is less appropriate. Possible benefit still requires proportionality.

Source framework: Sabiston e216; chapter sections 27 to 31. AMA 5.3 and 5.5; ATS partner society statement 2015 as relevant.

Question 049

Treatment limits uncertainty and conflict resolution

A family requests continued invasive treatment while a patient has a potentially reversible condition, but the patient previously rejected a particular prolonged outcome. The team is uncertain whether that outcome is now inevitable. One consultant interprets the directive as requiring immediate limitation; another ignores it until prognosis is certain. The representative asks for a brief interval to obtain relevant assessments, and the clinicians believe a defined period of current support is clinically feasible. There is no need for an additional irreversible intervention today. The surgeon must connect the conditional preference with evolving evidence rather than either discard it or treat uncertainty as proof that its condition is met.

The focused assessments can address whether the feared prolonged outcome is increasingly likely or whether temporary reversible illness remains plausible. The representative wants a defined review, not indefinite treatment. A clear handoff is needed so that the conditional preference remains visible when different clinicians take over.

Which plan is most defensible?

A. Continue indefinitely without specifying what information will change care

B. Treat the feared outcome as established without assessing its likelihood

C. Ignore the directive until every uncertainty disappears

D. Define a focused reassessment of the directive's condition and the clinical trajectory

Correct answer D. Conditional wishes require applicable facts; bounded review can clarify them without indefinite drift.

Why A is less appropriate. A review needs a decision relevant purpose.

Why B is less appropriate. The condition has not been established.

Why C is less appropriate. Perfect certainty may never occur.

Source framework: Sabiston e216; chapter sections 27 to 31. AMA 5.3 and 5.5; ATS partner society statement 2015 as relevant.

Question 050

Treatment limits uncertainty and conflict resolution

A patient nearing the end of life has no further disease directed surgical option likely to help. A trainee tells the family that nothing remains to be done and cancels further bedside discussions. The patient has pain, anxiety and unresolved questions about what support can continue. The family interprets the statement as abandonment and demands an operation to ensure that care will not stop. The surgeon believes the operation would add burden without achieving the stated goal, but recognizes that the request may reflect a misunderstanding of the care plan. Palliative expertise and nursing support are available now.

The patient has not asked for a technically possible intervention regardless of outcome. The family fears being left without practical help. Clarifying that concern may change the request, but does not authorize falsely promising that symptom care or any other strategy guarantees a particular remaining lifespan.

Which response best addresses both the request and the continuing obligation?

A. Offer surgery primarily to demonstrate that the team still cares

B. Explain the operative limit and provide a concrete active symptom and support plan

C. Repeat that no further treatment exists and end the encounter

D. Transfer all communication without confirming ongoing care responsibility

Correct answer B. A clear alternative care plan can correct the false choice between surgery and abandonment while preserving clinical judgment.

Why A is less appropriate. Symbolic reassurance does not justify harmful surgery.

Why C is less appropriate. Disease treatment limits do not end care.

Why D is less appropriate. Handoff requires actual continuity and ownership.

Source framework: Sabiston e216; chapter sections 27 to 31. AMA 5.3 and 5.5; ATS partner society statement 2015 as relevant.

Question 051

Innovation evidence and learning curves

A 55 year old woman is offered a procedure established at expert centers but new to her surgeon. He has extensive experience with a related operation and has completed a short course, but has not performed the proposed technique independently. She believes the published results represent his own outcomes. The institution has authorized supervised adoption, and an experienced assistant can attend if the case is rescheduled. Today that support is unavailable. The patient is stable, accepts a short delay and would consider the established alternative. The surgeon worries that disclosure will undermine confidence and that rescheduling wastes equipment time.

The patient wants a choice between real available plans, not merely disclosure of a problem followed by the same unsupported proposal. The institution's permission was conditional on supervision. A supported delay could preserve the new approach as an option, while the established alternative remains clinically acceptable now.

Which strategy is best?

A. Recommend the new method primarily to preserve the program schedule

B. Use expert center outcomes without distinguishing personal experience

C. Disclose relevant experience and select a genuinely supported treatment plan

D. Proceed today after adding a learning curve sentence

Correct answer C. Disclosure and deliverable competence are separate requirements; missing support is not cured by consent wording.

Why A is less appropriate. Program needs are not patient benefit.

Why B is less appropriate. Collective results are not personal results.

Why D is less appropriate. A sentence does not supply assistance.

Source framework: Sabiston e215 to e216; chapter sections 16 to 23. AMA 1.2.11; SAGES adoption and innovation ethics guidance as relevant.

Question 052

Innovation evidence and learning curves

A surgeon proposes a novel operation for a complex recurrent condition. Evidence consists of a small series with short follow up, and the patient's anatomy differs from that series. The patient has limited conventional options and says that accepting risk should permit treatment. The surgeon has not explained uncertainty about late complications or why the evidence may not transfer. An expert colleague can review the rationale, and institutional oversight requirements remain unresolved. The condition is stable enough for prompt review. The patient is capable, wants realistic symptom relief and mistakenly believes innovative means proven superior.

The patient is willing to hear that the potential benefit is uncertain and would consider another opinion. The surgeon can ask whether the anatomical difference changes the proposed mechanism of benefit. Scarcity of options may motivate innovation, but it cannot provide the missing evidence or settle institutional requirements by itself.

Which next action best supports responsible innovation?

A. Reject the option solely because any uncertainty remains

B. Clarify evidence limits, rationale, alternatives and oversight before offering treatment

C. Describe the small series as proof of superior outcomes

D. Proceed because limited alternatives make review unnecessary

Correct answer B. Limited alternatives can justify consideration, not concealment or bypass of preparation and review.

Why A is less appropriate. Uncertainty requires evaluation rather than automatic prohibition.

Why C is less appropriate. The evidence cannot establish that claim.

Why D is less appropriate. Need does not erase safeguards.

Source framework: Sabiston e215 to e216; chapter sections 16 to 23. AMA 1.2.11; SAGES adoption and innovation ethics guidance as relevant.

Question 053

Innovation evidence and learning curves

A patient asks for a numerical estimate of added risk from the surgeon's early learning curve. Published reports vary widely, and none supports a precise personal increment. The surgeon can describe training, relevant experience, available assistance and established alternatives. A colleague recommends inventing a modest percentage because saying uncertain may frighten the patient. Another suggests providing no recommendation until perfect evidence exists. The procedure is elective, and the patient wants to understand both known risks and what remains unresolved. The surgeon believes supported treatment may be appropriate but must not imply certainty unsupported by evidence.

The patient asks specifically whether the number would come from evidence or intuition. A supported recommendation can include an explanation that some uncertainties are not quantifiable. The surgeon can describe what has been done to reduce avoidable risk without implying that those safeguards eliminate every unknown complication.

What is the best response?

A. Provide an invented precise increment to aid comparison

B. Withhold every recommendation until all risk estimates are exact

C. Explain the limits honestly and give a reasoned supported recommendation

D. Avoid mentioning the learning curve because it cannot be quantified

Correct answer C. Useful counseling distinguishes known evidence from uncertainty without abandoning clinical guidance.

Why A is less appropriate. False precision misrepresents knowledge.

Why B is less appropriate. Perfect certainty is not required for judgment.

Why D is less appropriate. Unquantified information may still be material.

Source framework: Sabiston e215 to e216; chapter sections 16 to 23. AMA 1.2.11; SAGES adoption and innovation ethics guidance as relevant.

Question 054

Innovation evidence and learning curves

A hospital purchases an expensive device and schedules its first clinical cases. The surgeon is competent with the familiar operation, but nursing and anesthesia staff have not rehearsed the new setup or emergency conversion. The selected patient has an unusually difficult anatomy that may require rapid rescue. The institution wants a public launch this week. The patient has received a general explanation of novelty and is enthusiastic. There is no harmful delay in choosing another date or established approach. A senior clinician says personal surgical experience and patient consent are enough.

The nursing lead reports that emergency conversion equipment has not been confirmed. The patient believes the launch date was chosen for clinical reasons. The team can clarify readiness before obtaining a revised decision, distinguishing system capability from the surgeon's comfort with the underlying operation or the institution's investment.

Which readiness assessment is most appropriate?

A. Proceed because enthusiasm establishes acceptance of every local risk

B. Use publicity commitments to determine the first case date

C. Proceed because the surgeon knows the underlying operation

D. Assess system and rescue capability as well as operator competence

Correct answer D. A procedure can be familiar to the operator yet unsupported by the local system.

Why A is less appropriate. Consent does not create missing capability.

Why B is less appropriate. Publicity is not a clinical justification.

Why C is less appropriate. Individual skill is not complete team readiness.

Source framework: Sabiston e215 to e216; chapter sections 16 to 23. AMA 1.2.11; SAGES adoption and innovation ethics guidance as relevant.

Question 055

Innovation evidence and learning curves

A surgeon modifies an established procedure substantially while describing it as routine care. A prospective protocol includes additional procedures performed only to answer a research question. The patient understands the clinical operation but has not heard about those additional activities. The surgeon believes calling the program quality improvement eliminates any need to clarify review requirements. An institutional research office is available before recruitment, and delay for review is safe. The patient is interested in helping future patients but does not want extra procedures represented as necessary treatment.

The extra procedures add burden even if they do not change the main operation. The patient is free to consider clinical treatment separately from participation where the applicable arrangement permits. The institutional office can assess the actual protocol rather than accept the surgeon's preferred classification as conclusive. Review can occur before any additional protocol procedures are performed.

Which step is best?

A. Clarify the activity's classification and obtain required review and authorization

B. Avoid oversight by retaining the preferred program label

C. Assume all surgical modifications automatically have identical research requirements

D. Use the clinical consent form to cover every protocol activity

Correct answer A. Classification depends on actual activities and applicable processes, not a label or generic signature.

Why B is less appropriate. Naming does not decide requirements.

Why C is less appropriate. Not every modification is the same.

Why D is less appropriate. Research specific activities need appropriate authorization.

Source framework: Sabiston e215 to e216; chapter sections 16 to 23. AMA 1.2.11; SAGES adoption and innovation ethics guidance as relevant.

Question 056

Innovation evidence and learning curves

A 62 year old man is offered an innovative intervention by a surgeon with a financial interest in the device company. The recommendation has a plausible clinical rationale, but an established alternative remains appropriate. The surgeon discloses the ownership relationship and believes this automatically resolves the conflict. Independent advice is available, and the patient asks whether the financial interest affects which option is being emphasized. There is no emergency, and the surgeon can explain evidence limits and transfer care if an arrangement is unsuitable. The institution has a relevant conflict review process.

The patient wants an explanation of whether independent advice could change the recommendation. The surgeon can separate evidence about the intervention from personal financial advantage. Relevant governance may require more than a verbal disclosure, and the patient should not be left responsible for designing the conflict management process.

Which approach best addresses the remaining responsibility?

A. Omit the established alternative because ownership was disclosed

B. Treat disclosure alone as sufficient resolution

C. Disclose and manage the conflict while reassessing the recommendation's basis

D. Assume any financial relationship makes every intervention impermissible

Correct answer C. Disclosure is necessary information but may not be sufficient management of influence or role conflicts.

Why A is less appropriate. A conflict disclosure does not erase alternatives.

Why B is less appropriate. The arrangement still needs assessment.

Why D is less appropriate. The required response is contextual, not automatic prohibition.

Source framework: Sabiston e215 to e216; chapter sections 16 to 23. AMA 1.2.11; SAGES adoption and innovation ethics guidance as relevant.

Question 057

Innovation evidence and learning curves

A new technique has been used in eight selected patients with favorable immediate results. Two later develop complications, but their follow up occurs at another service and is absent from the program presentation. The surgeon wants to advertise the immediate success rate as evidence that the learning curve is complete. Case difficulty has also increased, and the original assistant is no longer routinely present. The team has time to review data before offering further elective cases. The next patient asks whether the method is established locally.

The next patient's disease is more complex than the initial series, so crude comparison may also be misleading. The program can obtain the delayed outcome records and review who actually performed each case. The question concerns complete truthful interpretation, not whether any complication necessarily proves the technique should be abandoned.

Which action best supports honest adoption and counseling?

A. Use immediate technical success as proof that learning is complete

B. Exclude late events because another service treated them

C. Review complete outcomes, case mix and support before updating claims or proceeding

D. Continue expansion until a fixed case target is reached

Correct answer C. Technical completion and incomplete follow up cannot establish durable safety or independent readiness.

Why A is less appropriate. Efficiency does not equal comprehensive competence.

Why B is less appropriate. Late outcomes remain relevant to the technique.

Why D is less appropriate. A target must not override emerging signals.

Source framework: Sabiston e215 to e216; chapter sections 16 to 23. AMA 1.2.11; SAGES adoption and innovation ethics guidance as relevant.

Question 058

Innovation evidence and learning curves

A patient with capacity hears that the surgeon has limited experience with an accepted technique and readily agrees, saying everyone has to learn. The surgeon has not completed the training or supervision required for independent performance and lacks an appropriate rescue arrangement. An established approach can be offered safely. The patient prefers the new method because of expected cosmetic benefits and says accepting responsibility should release the surgeon from concern. The operation is elective and there is time for additional preparation or referral.

The patient is not asking the surgeon to acquire skills during an unsupported high risk case. Additional preparation or referral could preserve access to the preferred approach. The surgeon should explain that professional responsibility remains even when a patient generously accepts uncertainty or offers to sign a broad statement.

Which response best balances autonomy and professional limits?

A. Proceed because explicit risk acceptance establishes ethical adequacy

B. Proceed if the patient signs a liability statement

C. Decline unsupported performance and offer appropriate preparation or alternatives

D. Present the established alternative as unavailable to preserve agreement

Correct answer C. Consent cannot convert inadequate readiness into competent care.

Why A is less appropriate. Autonomy does not eliminate professional duties.

Why B is less appropriate. A signature does not create safety capability.

Why D is less appropriate. Misrepresenting alternatives undermines choice.

Source framework: Sabiston e215 to e216; chapter sections 16 to 23. AMA 1.2.11; SAGES adoption and innovation ethics guidance as relevant.

Question 059

Innovation evidence and learning curves

A surgeon with twenty cases of a new procedure asks whether further disclosure of limited experience is unnecessary. The cases differed greatly in difficulty, several were performed mainly by a supervising colleague and long term outcomes remain incomplete. The patient now being considered has more complex disease. A trainee proposes a universal numerical threshold, while the surgeon believes overall seniority should settle the issue. The patient asks about experience because an expert referral is available. The procedure is not urgent.

The assisting colleague can clarify the surgeon's actual role in earlier cases. The patient regards that experience as relevant to choosing between local treatment and referral. A count may contribute information, but it cannot describe the differences in case complexity, supervision and independent performance by itself. The referral option gives the patient a practical alternative to unsupported local confidence.

Which approach best reflects the textbook's learning curve discussion?

A. Describe relevant experience and competence in context rather than use a universal count

B. Stop disclosure automatically because twenty cases were recorded

C. Use years in general practice as equivalent procedural experience

D. Assume assisted cases prove readiness for every complexity level

Correct answer A. No universal count replaces relevance to the patient's decision or actual procedural readiness.

Why B is less appropriate. The chapter provides no such cutoff.

Why C is less appropriate. Adjacent experience is not identical experience.

Why D is less appropriate. Difficulty and actual role matter.

Source framework: Sabiston e215 to e216; chapter sections 16 to 23. AMA 1.2.11; SAGES adoption and innovation ethics guidance as relevant.

Question 060

Innovation evidence and learning curves

A patient requests a new operation after reading enthusiastic hospital marketing. The surgeon believes both an established method and the new approach are reasonable, but evidence does not show the new option is superior. Recovery burdens differ and the patient's primary goal is rapid return to caregiving. The patient assumes a higher device cost means a better result. The surgeon has enough time to discuss evidence and personal experience, but a coordinator says balanced counseling may reduce uptake of the new service.

The patient would accept repeat treatment if it reduced immediate recovery burden, but wants to know the actual tradeoff. The surgeon can present personal experience and relevant evidence without equating institutional marketing with comparative effectiveness. The coordinator's target is separate from the patient's caregiving objective. Both approaches remain available after a balanced discussion of these tradeoffs.

Which strategy best supports an informed choice?

A. Compare realistic outcomes, uncertainty and alternatives against the caregiving goal

B. Use cost and novelty as proxies for expected benefit

C. Recommend the established method without hearing the patient's priorities

D. Emphasize only favorable findings to correct low uptake

Correct answer A. Balanced advice must distinguish marketing, evidence and patient relevant outcomes.

Why B is less appropriate. Price and novelty do not establish superiority.

Why C is less appropriate. Patient priorities still guide appropriate options.

Why D is less appropriate. Program uptake is not the consent objective.

Source framework: Sabiston e215 to e216; chapter sections 16 to 23. AMA 1.2.11; SAGES adoption and innovation ethics guidance as relevant.

Question 061

Professional duties integrity and competing pressures

A surgeon learns that a patient experienced a preventable delay because a critical result was not reviewed. The patient is now stable and asks why treatment started late. The exact contributors remain under investigation, but the delay and its clinical consequences are established. A colleague recommends saying nothing until every cause is known, fearing that uncertainty will damage trust. Another recommends blaming the laboratory before verifying its role. The surgeon can explain known facts, ongoing care and how unanswered questions will be reviewed. The patient wants honesty rather than a premature assignment of fault.

The patient asks which facts are established and when the remaining questions will be revisited. The surgeon can provide a concrete review plan and avoid promising that the investigation will identify a single cause. Honest communication need not wait for a complete causal account, and it should not substitute unsupported speculation for that account.

Which approach best demonstrates integrity and accountability?

A. Explain established facts and uncertainty while ensuring care and follow up

B. Attribute fault to the laboratory to give a definite answer

C. Use reassurance alone because the patient is currently stable

D. Delay all communication until the investigation is complete

Correct answer A. Honesty requires neither concealment nor unsupported blame; known facts and ongoing responsibility can be explained now.

Why B is less appropriate. The cause has not been verified.

Why C is less appropriate. Stability does not remove the information need.

Why D is less appropriate. Uncertainty does not justify indefinite silence.

Source framework: Sabiston professionalism discussion; chapter sections 32 to 47. ACS Statement on Principles and responsibility statement 2026 as relevant.

Question 062

Professional duties integrity and competing pressures

A patient changes hospitals after surgery. A pending result may alter treatment, but each team assumes the other will review it. The discharge summary lists the result as pending without a named owner. The receiving clinician can accept responsibility if contacted, and the patient does not know whom to call. A trainee argues that including the result in the document completes the surgeon's obligation. Another suggests waiting for the result before clarifying ownership. The patient is stable, but a delay in review could reduce treatment benefit. The surgeon must distinguish transfer of information from effective transfer of responsibility.

The receiving clinician has not yet seen the report and does not know that the sender assumes transfer. The result could arrive after the patient has left both services. A short direct communication can establish ownership now and give the patient a reliable contact rather than another ambiguous document.

Which action is best?

A. Ask the patient to choose whichever team answers first

B. Treat mention in the summary as a completed handoff

C. Confirm a named reviewer and communicate the follow up plan

D. Wait for a complication to identify the responsible service

Correct answer C. A reliable transition needs accepted ownership and an actionable plan, not merely documentation.

Why A is less appropriate. The patient should not arbitrate service ambiguity.

Why B is less appropriate. Information alone does not assign responsibility.

Why D is less appropriate. The risk is foreseeable and preventable.

Source framework: Sabiston professionalism discussion; chapter sections 32 to 47. ACS Statement on Principles and responsibility statement 2026 as relevant.

Question 063

Professional duties integrity and competing pressures

A surgeon posts an educational account of an unusual complication online. Names are removed, but the combination of hospital, timing and rare features could identify the patient locally. The patient authorized clinical treatment but was not asked about this use. The post has educational value, and colleagues praise its honesty. A trainee notes the privacy concern before publication. The surgeon says professionalism requires teaching and that absence of a name is enough. There is time to seek institutional guidance and use a less identifying approach.

The educational lesson can be conveyed with altered details or a different format after appropriate review. The privacy concern is not resolved merely because the surgeon's motive is teaching. The patient may be recognizable to a small community even if the wider public cannot infer identity from the account.

Which next step best balances education and confidentiality?

A. Publish because educational benefit overrides the remaining privacy concern

B. Pause publication and assess identifiability and the appropriate authorization pathway

C. Assume treatment consent authorizes every teaching use

D. Remove only the hospital name and presume no further assessment is needed

Correct answer B. Teaching duties do not remove confidentiality obligations; identifiability requires contextual assessment and appropriate authorization.

Why A is less appropriate. Benefit does not automatically settle privacy.

Why C is less appropriate. Treatment authorization has a different scope.

Why D is less appropriate. One deletion may not resolve contextual identification.

Source framework: Sabiston professionalism discussion; chapter sections 32 to 47. ACS Statement on Principles and responsibility statement 2026 as relevant.

Question 064

Professional duties integrity and competing pressures

A respected surgeon has a personal professional objection to a requested intervention that other qualified clinicians regard as medically appropriate. The patient is stable, seeks timely care and has not been told why the surgeon is reluctant. The surgeon considers describing the treatment as medically ineffective to avoid discussing the actual concern. Institutional advice and another qualified clinician are available. A trainee proposes either abandoning the patient immediately or requiring the surgeon to pretend to endorse a treatment judgment not genuinely held. The team must separate conscience, clinical facts and continuity without inventing a universal legal rule.

The patient wants to understand whether the objection is clinical or personal before choosing the next step. Another clinician can provide a separate assessment. The applicable framework may govern referral or transfer duties, so the surgeon should seek timely institutional guidance rather than misstate a value conflict as a settled scientific conclusion.

Which response is best?

A. End all care without addressing continuity or urgency

B. Describe the objection as proven medical ineffectiveness

C. Delay discussion indefinitely to avoid revealing disagreement

D. Explain the concern honestly and arrange an appropriate timely care pathway

Correct answer D. Professional disagreement requires honesty and continuity through the applicable framework, not misrepresentation or abandonment.

Why A is less appropriate. Care obligations do not vanish.

Why B is less appropriate. Values and clinical effectiveness are distinct.

Why C is less appropriate. Delay can harm access without resolving the issue.

Source framework: Sabiston professionalism discussion; chapter sections 32 to 47. ACS Statement on Principles and responsibility statement 2026 as relevant.

Question 065

Professional duties integrity and competing pressures

A surgeon is asked to certify that a consent discussion occurred before an elective procedure. The form was signed, but records and the patient confirm that key alternatives were never discussed. The patient is now recovering and asks what those alternatives were. Leadership suggests backdating a detailed note to protect the institution. The surgeon can document current findings, clarify what actually occurred and arrange appropriate clinical and institutional review. No emergency requires altering historical facts. A colleague argues that the intended discussion was standard and therefore can be assumed.

The surgeon did not witness a different undocumented conversation that would resolve the discrepancy. The patient has a legitimate current information need, and correcting processes can occur without rewriting history. The institution can investigate how the form was completed while the clinical team ensures appropriate follow up and candid communication.

Which action best demonstrates professional integrity?

A. Record facts accurately and address the patient and process gaps

B. Backdate the expected discussion because the form was signed

C. Assume standard practice proves the conversation occurred

D. Leave the record unchanged and avoid further explanation

Correct answer A. Accurate records must distinguish actual events from intended practice; current disclosure and corrective review remain necessary.

Why B is less appropriate. A signature does not justify false documentation.

Why C is less appropriate. A routine is not evidence of an event.

Why D is less appropriate. Silence leaves the established gap unaddressed.

Source framework: Sabiston professionalism discussion; chapter sections 32 to 47. ACS Statement on Principles and responsibility statement 2026 as relevant.

Question 066

Professional duties integrity and competing pressures

A surgeon has promised a patient that an experienced colleague will participate in a difficult operation. On the day, that colleague is unavailable, and the surgeon plans to proceed with a different support arrangement. The operation is established and the surgeon is qualified, but the promised arrangement materially influenced the patient's choice. An alternative date or referral is feasible without clinical harm. The patient has not yet been sedated and asks whether the same team is present. A coordinator suggests answering vaguely because the substitute is licensed.

The substitute may be clinically suitable, but suitability does not make the previous representation accurate today. The patient can consider the changed arrangement if it is explained. A revised discussion can preserve trust without assuming that every staffing change requires cancellation or that every original promise is irrelevant once a form exists.

Which approach best respects trust and current authorization?

A. Use a vague answer because all team members are licensed

B. Explain the change and reassess the acceptable plan with the patient

C. Proceed because the original signature covers any staffing change

D. Postpone without explaining the reason or discussing options

Correct answer B. A material change in the represented plan requires honest communication and reassessment, not necessarily automatic cancellation.

Why A is less appropriate. Licensure does not answer the patient's specific concern.

Why C is less appropriate. A signature does not erase material representations.

Why D is less appropriate. The patient needs an informed choice.

Source framework: Sabiston professionalism discussion; chapter sections 32 to 47. ACS Statement on Principles and responsibility statement 2026 as relevant.

Question 067

Professional duties integrity and competing pressures

A surgeon recommends a procedure that benefits the hospital financially but has no demonstrated clinical advantage over a less costly appropriate alternative. The patient has limited resources and values avoiding repeated treatment. The surgeon believes the more costly option may still fit those priorities, but has not compared relevant outcomes or disclosed an ownership interest. The institution encourages use of its own service and discourages mentioning outside alternatives. There is no urgency preventing balanced discussion or conflict review. The patient asks whether the recommendation reflects personal need or the hospital's investment.

The patient is willing to hear why the more costly option might suit particular goals. The alternative's disadvantages should also be explained honestly. The institution can review the ownership arrangement, but neither that process nor a price disclosure replaces a patient specific explanation of why this treatment is recommended.

Which next step is best?

A. Offer only in house options because other services are inconvenient

B. Use institutional investment as evidence that the option is preferable

C. Reassess clinical fit, disclose and manage interests, and compare reasonable alternatives

D. Assume disclosure of price alone resolves the ownership conflict

Correct answer C. Clinical rationale, alternatives and relevant interests need transparent assessment rather than investment driven advice.

Why A is less appropriate. Relevant alternatives should not be concealed.

Why B is less appropriate. Financial commitment does not establish patient benefit.

Why D is less appropriate. Price and clinician interest are different information.

Source framework: Sabiston professionalism discussion; chapter sections 32 to 47. ACS Statement on Principles and responsibility statement 2026 as relevant.

Question 068

Professional duties integrity and competing pressures

A clinician loudly challenges a planned operation during a multidisciplinary meeting, presenting accurate evidence and a specific safety concern. The manner is forceful but contains no insult, threat or refusal to cooperate. A department leader labels the challenge unprofessional because it embarrasses a senior surgeon. Other staff fear that reporting a similar concern could affect evaluations. The proposed operation is elective and the evidence can be reviewed before treatment. The team must maintain respectful dialogue without treating agreement with leadership as a professional requirement.

The patient has not yet been exposed to the disputed intervention, so a timely evidence review can still influence care. The team can address respectful communication separately if needed. Protecting the senior clinician from embarrassment is different from protecting a discussion from threats or personal abuse. The clinician also wants the relevant evidence considered before treatment is finalized.

Which response best addresses the situation?

A. Evaluate the clinical concern and distinguish good faith criticism from disruptive conduct

B. Discipline the clinician solely because a senior colleague felt challenged

C. Treat every forceful disagreement as harmless without examining context

D. Ignore the evidence to preserve team cohesion

Correct answer A. Good faith criticism deserves substantive review; manner and effects still warrant contextual assessment rather than automatic labeling.

Why B is less appropriate. Status does not define misconduct.

Why C is less appropriate. Context still matters to professional assessment.

Why D is less appropriate. Cohesion cannot justify ignoring safety information.

Source framework: Sabiston professionalism discussion; chapter sections 32 to 47. ACS Statement on Principles and responsibility statement 2026 as relevant.

Question 069

Professional duties integrity and competing pressures

A high volume surgeon is offered an additional list after several demanding shifts. The surgeon notices fatigue affecting concentration but fears that requesting coverage will appear weak. Qualified assistance is available, although reassignment would require explaining a short delay to patients. A manager emphasizes waiting time targets and says professional commitment means completing every scheduled case personally. The cases are elective and can be covered or rescheduled safely. The surgeon has no established chronic impairment and wants to preserve both patient care and personal responsibility.

The available colleague must actually accept responsibility, and affected patients need an appropriate explanation of any change. Requesting help does not mean leaving work unowned. The immediate functional concern can be addressed without assuming a permanent diagnosis or treating a short delay as an unacceptable professional failure. The covering clinician can accept responsibility before any patient is transferred to theatre.

Which action best reflects professionalism?

A. Acknowledge the functional limit and arrange safe accepted coverage

B. Leave immediately without transferring responsibility

C. Proceed unsupported to demonstrate commitment

D. Conceal fatigue because disclosure may affect reputation

Correct answer A. Reliable care includes recognizing limits and completing safe handoffs, not unsupported endurance or abandonment.

Why B is less appropriate. Departure alone does not ensure continuity.

Why C is less appropriate. Commitment does not restore concentration.

Why D is less appropriate. Concealment prevents appropriate risk management.

Source framework: Sabiston professionalism discussion; chapter sections 32 to 47. ACS Statement on Principles and responsibility statement 2026 as relevant.

Question 070

Professional duties integrity and competing pressures

A surgeon obtains a technically excellent result but repeatedly fails to answer a patient's questions about recovery and dismisses distress as unnecessary. The patient follows instructions yet feels unable to report worsening symptoms. Staff describe the surgeon as pleasant with colleagues and highly efficient. A trainee concludes that technical success and courtesy to peers establish professionalism. The surgeon has time to improve communication, and the patient wants a clear contact and follow up plan rather than a different operation.

The patient has new questions about which symptoms require urgent review and has not received a usable contact plan. The surgeon can correct that gap directly. Courtesy toward colleagues may coexist with unmet obligations to the patient, so assessment should examine the actual relationship and care process rather than social popularity alone. A named follow up contact can make reporting symptoms practically possible.

Which response best addresses the professional gap?

A. Treat peer politeness as evidence that patient concerns are unfounded

B. Recognize unmet patient communication and accountability duties despite technical success

C. Recommend another operation to restore confidence

D. Use technical outcome as the complete professionalism assessment

Correct answer B. Professionalism includes reliable communication and care ownership, not just technical skill or social manner.

Why A is less appropriate. Peer experience does not invalidate patient experience.

Why C is less appropriate. The problem is not a new operative indication.

Why D is less appropriate. Outcome alone misses the identified duty.

Source framework: Sabiston professionalism discussion; chapter sections 32 to 47. ACS Statement on Principles and responsibility statement 2026 as relevant.

Question 071

Identity formation and the hidden curriculum

A resident knows the department's formal rule that uncertain clinicians should seek help. During a difficult operation, the supervisor requests expert assistance and later explains why the concern exceeded personal experience. The resident sees the request improve care but hears another senior describe it as weakness. The resident asks which behavior represents being a real surgeon. The training program wants to teach professional identity without simply instructing loyalty to the most powerful voice. There is no current unresolved safety issue, so a reflective discussion can occur. The resident can describe the observable events but has not examined the values or assumptions behind them.

The resident has not been asked to choose a role model wholesale. The supervisor can explain how recognizing limits supports dependable care, while also acknowledging that assistance must be organized rather than merely requested. The disagreement offers a concrete opportunity to examine what local comments imply about belonging and professional worth.

Which educational response is best?

A. Debrief the reasoning and connect help seeking with responsible surgical identity

B. Tell the resident to copy whichever senior has higher status

C. Avoid discussion because role models should not be questioned

D. Use only a checklist of whether help was requested

Correct answer A. Making reasoning explicit helps learners examine identity and values rather than infer that status or toughness defines practice.

Why B is less appropriate. Hierarchy is not the ethical standard.

Why C is less appropriate. Critical reflection supports formation.

Why D is less appropriate. Observation alone may miss the meaning.

Source framework: Sabiston e217 to e220; chapter sections 32 to 39. Irby and Hamstra 2016 as relevant.

Question 072

Identity formation and the hidden curriculum

A program teaches accurate handoffs but praises residents almost exclusively for rapid discharge. A resident copies plans efficiently yet leaves pending results without accepted ownership. The resident can recite the correct standard and says asking another service to accept responsibility is discouraged as inefficient. A patient experiences delayed review. The faculty proposes repeating the lecture, while another member blames the resident's permanent character. Immediate result review can be secured. The program has not examined incentives or senior examples.

The delayed result still needs clinical review today, before the educational meeting. The resident's stated understanding can be compared with actual actions during subsequent handoffs. The program can also examine whether senior examples reward the same incomplete behavior, avoiding the assumption that either individual motivation or software alone explains the whole pattern. Supervisors can check whether the improvement persists when the workload becomes demanding again.

Which response best integrates the three professionalism frameworks?

A. Repeat the same lecture as the sole response

B. Remove individual responsibility because incentives contributed

C. Address the behavior, its meaning and the environment with monitored improvement

D. Treat one recurring behavior as proof of unchangeable character

Correct answer C. Behavior, internal responsibility and socialization interact; immediate care and observable change remain necessary.

Why A is less appropriate. Knowledge alone is not the only gap.

Why B is less appropriate. Context explains without absolving.

Why D is less appropriate. Assessment should not rely on a fixed label.

Source framework: Sabiston e217 to e220; chapter sections 32 to 39. Irby and Hamstra 2016 as relevant.

Question 073

Identity formation and the hidden curriculum

A trainee consistently uses respectful phrases during observed assessments but belittles patients in unobserved team discussions. The program's checklist scores remain high. A mentor notices that the trainee considers compassion merely a technique for avoiding complaints. The trainee is willing to discuss this but argues that passing the measured behaviors proves professionalism. No single severe incident requires an emergency disciplinary decision, though the pattern warrants action. The mentor wants to preserve fair behavioral evidence while addressing motives and identity without claiming access to an immutable inner character.

Other team members can provide specific observations rather than guesses about private motives. The trainee can practice respectful communication under less supervised conditions and discuss why patient dignity matters even when complaints are unlikely. The mentor should avoid pretending that a reflective discussion alone proves future reliability or that a checklist has no educational value.

Which approach is best?

A. Accept checklist scores as a complete assessment

B. Judge permanent moral character without further discussion

C. Discard all behavioral assessment because motives matter

D. Combine specific feedback and real practice observation with reflection on responsibility

Correct answer D. Observable conduct and reflection complement each other; neither a score nor a character label captures the full developmental issue.

Why A is less appropriate. Measured compliance can miss other conduct.

Why B is less appropriate. Labels do not replace assessment.

Why C is less appropriate. Behavior remains essential evidence.

Source framework: Sabiston e217 to e220; chapter sections 32 to 39. Irby and Hamstra 2016 as relevant.

Question 074

Identity formation and the hidden curriculum

A surgical resident raises a discrepancy in patient identifiers before an irreversible step. The supervising surgeon dismisses it and warns that questioning decisions will reduce operative opportunities. A nurse confirms the discrepancy, and an anesthetist can help verify it immediately. The patient is stable, and checking will not create a clinical hazard. The department teaches speaking up but has tolerated similar threats before. The resident must choose both an immediate action and a later response to the environment. A colleague suggests staying quiet now and discussing culture only at the annual meeting.

The anesthetist can support a factual request to verify identifiers without turning the initial response into a public judgment of character. After care is secured, the threat about training opportunities requires appropriate review. Immediate verification and later examination of retaliation risk address different parts of the same event.

Which strategy is best?

A. Focus first on a public character accusation rather than verification

B. Request immediate verification using team escalation, then seek supported review of the pattern

C. Wait for the annual meeting to avoid conflict during surgery

D. Accept the senior's confidence as resolution of the discrepancy

Correct answer B. Present safety requires action now; culture review follows rather than substitutes for that action.

Why A is less appropriate. The immediate task is factual protection.

Why C is less appropriate. Delay leaves a preventable current risk.

Why D is less appropriate. Status does not establish identity matching.

Source framework: Sabiston e217 to e220; chapter sections 32 to 39. Irby and Hamstra 2016 as relevant.

Question 075

Identity formation and the hidden curriculum

A program introduces a professionalism lecture on respect, but faculty routinely mock residents who request clarification. Residents learn to hide uncertainty and some begin copying the behavior with junior learners. Leadership says the lecture proves the curriculum is adequate and describes the problem as individual sensitivity. Several residents can give concrete examples of how questions were punished. There is no immediate patient emergency, but the pattern affects learning and information sharing. The program wants a response that recognizes both faculty responsibility and trainee accountability.

The residents are not asking for immunity from evaluation or for every question to be answered without time limits. They describe penalties for appropriate clarification. The program can distinguish efficient communication standards from ridicule and examine whether its actual incentives contradict the formal message about safe participation. The trainees want clear expectations that apply to senior and junior clinicians alike.

Which action best addresses the hidden curriculum?

A. Review enacted incentives and role modeling alongside individual behaviors

B. Require trainees to demonstrate loyalty by remaining silent

C. Add another lecture without examining daily practice

D. Treat all adaptation to the environment as unavoidable and acceptable

Correct answer A. The hidden curriculum is conveyed by actual consequences and examples, which can undermine stated teaching.

Why B is less appropriate. Silence perpetuates the unsafe lesson.

Why C is less appropriate. Formal content alone does not change reinforcement.

Why D is less appropriate. Context does not excuse harmful conduct.

Source framework: Sabiston e217 to e220; chapter sections 32 to 39. Irby and Hamstra 2016 as relevant.

Question 076

Identity formation and the hidden curriculum

A senior surgeon apologizes for an error, describes uncertainty honestly and invites a junior colleague to explain a missed warning. Learners observe the meeting but interpret the apology as evidence that only inexperienced surgeons make mistakes. The educator realizes that observing good conduct does not guarantee the intended lesson. The patient care issues have been addressed, and time is available for teaching. The group can examine how accountability, humility and technical expertise coexist. A faculty member proposes leaving the example unexplained because values should be absorbed naturally.

The apology's purpose and the invitation to hear a junior warning can be discussed without presenting the senior surgeon as flawless. Learners may need help separating honest accountability from incompetence. The educator can use the case to show that a technically experienced surgeon still benefits from reflection, feedback and team information.

Which approach best supports professional identity formation?

A. Assume observation alone transmits the intended professional meaning

B. Discuss the reasoning and allow learners to examine their interpretations

C. Reduce the event to whether the apology was recorded

D. Teach that senior expertise eliminates the need for further learning

Correct answer B. Role models are more useful when motives and interpretations are made explicit and open to reflection.

Why A is less appropriate. Learners may infer the wrong lesson.

Why C is less appropriate. Documentation alone misses developmental meaning.

Why D is less appropriate. Expertise does not create immunity from error.

Source framework: Sabiston e217 to e220; chapter sections 32 to 39. Irby and Hamstra 2016 as relevant.

Question 077

Identity formation and the hidden curriculum

A resident from a different cultural background communicates more quietly than local colleagues but reliably follows through, seeks help appropriately and listens to patients. An evaluator gives low professionalism marks because the resident does not resemble the department's confident traditional style. No specific unsafe or disrespectful behavior is identified. Another evaluator proposes high marks solely to avoid appearing biased. The program can review concrete observations and discuss whether cultural assumptions are shaping judgments. The resident wants useful feedback rather than either a vague negative label or unexamined praise.

The evaluator can identify punctual follow through, respectful exchanges and appropriate escalation rather than rely on a vague impression of confidence. The resident's style may still warrant specific communication feedback if it impairs care, but no such effect should be inferred solely from difference from local manner or background.

Which assessment strategy is best?

A. Give an automatic high score without reviewing evidence

B. Use behavior and obligations rather than conformity to a preferred personality

C. Require imitation of local manner before assessing actual work

D. Retain the low score because cultural fit defines professional identity

Correct answer B. Fair assessment distinguishes professional duties from stylistic conformity while retaining meaningful standards.

Why A is less appropriate. Fairness still requires evidence.

Why C is less appropriate. Appearance cannot replace performance assessment.

Why D is less appropriate. Belonging should not require one personality.

Source framework: Sabiston e217 to e220; chapter sections 32 to 39. Irby and Hamstra 2016 as relevant.

Question 078

Identity formation and the hidden curriculum

A trainee makes a difficult handoff error, promptly acknowledges it and helps protect the patient. The mentor wants to explore why it occurred. The trainee explains competing workload, uncertainty about ownership and fear of appearing incompetent. A colleague recommends a reflective essay as the entire remediation, while another recommends punishment without examining contributors. The expected handoff behavior can be observed during future work, and workflow changes may help. The trainee accepts responsibility and asks how improvement will be judged.

The trainee can identify where the handoff should have been clarified and wants a practical rehearsal. The service can allocate time and specify ownership rules. A plan combining those changes with observed performance is more informative than an isolated essay or a punishment that leaves the workflow unchanged. The mentor can define specific handoff actions rather than rely on a global impression.

Which plan best connects reflection with accountable learning?

A. Accept an essay as proof that practice has changed

B. Treat workload as removing all individual responsibility

C. Ignore context and judge only the trainee's stated motives

D. Specify replacement actions, relevant support and observed follow up

Correct answer D. Reflection should inform concrete practice change and review while recognizing both choices and system conditions.

Why A is less appropriate. Written reflection is not performance evidence.

Why B is less appropriate. Context does not erase duty.

Why C is less appropriate. Motives alone do not explain implementation.

Source framework: Sabiston e217 to e220; chapter sections 32 to 39. Irby and Hamstra 2016 as relevant.

Question 079

Identity formation and the hidden curriculum

A resident sees an admired surgeon provide excellent patient communication but routinely demean staff when patients are absent. The resident asks whether technical excellence and kindness to patients make the staff behavior acceptable. Another senior advises copying the surgeon's entire style to gain belonging. The program wants to teach critical use of role models rather than either idealization or dismissal of everything the surgeon does. Specific examples can be discussed without interrupting current care. The resident is beginning to reproduce the demeaning language with medical students.

The trainee can admire the surgeon's communication strengths while rejecting demeaning behavior. The program can explain why both observations matter. Current imitation with students provides an actionable concern; waiting for graduation would allow the harmful lesson to become more established and leave junior learners without support. The program can address the current student interactions through respectful specific feedback.

Which educational response is best?

A. Endorse the whole style because the surgeon is clinically successful

B. Avoid feedback until the resident finishes training

C. Dismiss every good practice because one domain is deficient

D. Separate constructive and harmful behaviors and address their effects explicitly

Correct answer D. Identity formation requires critical appraisal of examples, not wholesale imitation or loss of accountability.

Why A is less appropriate. Success does not excuse harmful treatment.

Why B is less appropriate. The emerging harmful pattern needs timely attention.

Why C is less appropriate. Good examples can still be identified.

Source framework: Sabiston e217 to e220; chapter sections 32 to 39. Irby and Hamstra 2016 as relevant.

Question 080

Identity formation and the hidden curriculum

A faculty group evaluates a resident who meets technical requirements but repeatedly avoids difficult patient conversations. The resident says these tasks belong to more empathic colleagues and that being a surgeon means operating well. The group can identify delayed discussions and unowned follow up, not merely a difference in personality. The resident is receptive to coaching but views responsibility as separate from professional identity. A mentor proposes discussing what patients entrust to a surgeon and linking that meaning to supervised practice. Another proposes simply assigning a professionalism score.

The resident's next clinical assignments can include supervised discussions with explicit expectations and feedback. Patients should not wait while identity issues are explored in the abstract. The mentor can connect daily responsibilities with the trust granted to surgeons and then examine whether that understanding leads to reliable follow through.

Which approach is best?

A. Assign a score without explaining the required behaviors

B. Let other colleagues permanently absorb the neglected duties

C. Connect professional obligations with practiced communication and monitored responsibility

D. Use technical competence as sufficient evidence of readiness

Correct answer C. Professional identity should integrate communication and accountability with technical skill, supported by observable practice.

Why A is less appropriate. A number alone offers no developmental plan.

Why B is less appropriate. Redistribution does not resolve the resident's obligations.

Why D is less appropriate. Technical ability does not fulfill every duty.

Source framework: Sabiston e217 to e220; chapter sections 32 to 39. Irby and Hamstra 2016 as relevant.

Question 081

Disruptive conduct fair review and functional safety

Several staff report intimidation by a high volume surgeon. Some accounts contain specific threats and delayed escalation, while another describes good faith criticism of a treatment plan. Technical outcomes are favorable. Leadership wants either to dismiss all complaints because the surgeon is valuable or suspend permanently based on the number of reports. The surgeon has not received a meaningful opportunity to respond. A reviewer has a financial relationship with the surgeon, and staff fear retaliation. Tomorrow's list creates a need to assess current safety without pretending the facts are already settled. Independent review can be arranged promptly.

Some reports concern delayed communication rather than injury, so the institution should avoid claiming a proven complication pathway without evidence. Staff still deserve protection and a credible review. The surgeon's opportunity to respond can help distinguish specific patterns from unsupported assumptions, while immediate safeguards address any current risk identified by leadership.

Which response is best?

A. Protect current care, manage conflicts and verify reports through a fair process

B. Label every criticism disruptive to simplify the review

C. Dismiss the reports because technical outcomes remain good

D. Use complaint counts alone as the final finding

Correct answer A. Protection and fair assessment are simultaneous duties; status and counts are not substitutes for evidence.

Why B is less appropriate. Good faith criticism must remain distinguishable.

Why C is less appropriate. Good outcomes do not exclude communication harm.

Why D is less appropriate. Allegations require contextual verification.

Source framework: Sabiston e218 to e220; chapter sections 40 to 43. AMA 9.4.4; ACS conduct guidance as relevant.

Question 082

Disruptive conduct fair review and functional safety

A surgeon sharply challenges a colleague's decision during an emergency meeting. The criticism identifies a genuine risk and proposes a feasible alternative, but witnesses differ about whether a personal threat was also made. The colleague requests punishment for disloyalty. The patient needs the clinical concern resolved now, while the conduct dispute can be reviewed afterward. The institution has a reporting mechanism with procedural safeguards. A manager suggests ignoring the safety argument because the speaker has a difficult reputation. The surgeon must protect the patient without prejudging whether the disputed conduct is acceptable.

The clinical alternative can be reviewed without deciding the truth of the alleged threat first. Later conduct assessment can hear witnesses and the speaker's response. Treating the questions separately avoids either ignoring useful evidence because of a reputation or excusing unacceptable behavior because the criticism happened to be correct.

Which strategy best addresses both issues?

A. Decide misconduct from the senior colleague's embarrassment alone

B. Reject the safety argument because the speaker is unpopular

C. Evaluate the immediate clinical concern and separately review specific conduct

D. Assume accurate criticism excuses any accompanying threat

Correct answer C. Clinical validity and professional manner require distinct assessments with appropriate urgency.

Why A is less appropriate. Embarrassment is not a sufficient finding.

Why B is less appropriate. Reputation does not answer the evidence.

Why D is less appropriate. Truth does not excuse intimidation.

Source framework: Sabiston e218 to e220; chapter sections 40 to 43. AMA 9.4.4; ACS conduct guidance as relevant.

Question 083

Disruptive conduct fair review and functional safety

A nurse reports a single severe threat during surgery. No physical injury occurred, but the nurse felt unable to communicate a medication concern afterward. Leadership has previously used informal coaching for minor incidents and assumes three warnings are required before formal review. The surgeon disputes the account and asks for an opportunity to respond. The next case is scheduled soon, and a supervisor can assess immediate protection needs. The team must avoid both automatic guilt and a rigid minor incident sequence that may leave a serious risk unmanaged.

The nurse is willing to provide a factual account through the reporting process. The surgeon can respond, and appropriate leadership can consider whether temporary arrangements are needed for the next case. A serious allegation should neither be minimized into a minor coaching threshold nor converted into a final finding without assessment.

Which action is best?

A. Require several additional incidents before any formal response

B. Make a permanent disciplinary finding without hearing the response

C. Treat absence of physical injury as proof that no action is needed

D. Assess severity and current risk and use proportionate safeguards and fair review

Correct answer D. A serious single event can justify prompt action while facts and procedural rights are assessed.

Why A is less appropriate. A universal warning sequence is inappropriate.

Why B is less appropriate. Protection does not eliminate fairness.

Why C is less appropriate. Communication suppression can itself threaten care.

Source framework: Sabiston e218 to e220; chapter sections 40 to 43. AMA 9.4.4; ACS conduct guidance as relevant.

Question 084

Disruptive conduct fair review and functional safety

A clinician reports a safety concern about a senior colleague. Shortly afterward, the clinician loses teaching opportunities and is told that reporting harms team loyalty. The underlying report has not yet been verified, and the senior colleague denies wrongdoing. Leadership worries that protecting the reporter implies accepting the allegation as true. The reporter requests fair review and an end to retaliation rather than automatic punishment. The service can investigate both the original concern and the subsequent conduct. Patient care may be affected if future concerns are suppressed.

The change in opportunities has been documented and can be assessed separately from the original report. Leadership can explain that protection concerns the integrity of reporting, not automatic acceptance of every allegation. If retaliation is established, it can undermine the process even when the first concern ultimately has a different explanation.

Which response best preserves the process?

A. Treat protection as proof that the accused is guilty

B. Ignore changes in opportunities because no patient injury is documented

C. Withhold protection until the first allegation is conclusively established

D. Protect reporting and investigate both allegations without assuming either is proven

Correct answer D. Protection from retaliation and evidence based review can coexist; neither requires a premature conclusion.

Why A is less appropriate. Safeguards are not findings of guilt.

Why B is less appropriate. Workplace effects can undermine future safety communication.

Why C is less appropriate. Delay can suppress legitimate reporting.

Source framework: Sabiston e218 to e220; chapter sections 40 to 43. AMA 9.4.4; ACS conduct guidance as relevant.

Question 085

Disruptive conduct fair review and functional safety

A department reviews allegations against a surgeon using a committee chaired by the surgeon's business partner. The chair promises impartiality and has substantial clinical expertise. The accused clinician and complainants both request a credible process, but leadership says replacing the chair would be inconvenient. No immediate treatment decision depends on that individual's participation, and another qualified reviewer is available. Confidential information must remain protected while the report is assessed.

The substitute reviewer can use the same clinical evidence, so independence does not require abandoning expertise. Confidentiality should be preserved through the authorized process. The conflict is relevant because the decision may affect a business relationship, not simply because committee members belong to the same professional community. The clinician and complainants can be heard by an available reviewer without a financial stake in the decision or its consequences.

Which next step best addresses the procedural concern?

A. Disclose and manage the conflict with appropriately independent review

B. Dismiss the case because every reviewer may know someone involved

C. Retain the chair solely on a personal assurance of fairness

D. Publish all allegations to let public opinion determine credibility

Correct answer A. A relevant conflict needs management; expertise and goodwill do not alone establish credible independence.

Why B is less appropriate. Manageable relationships do not justify abandoning review.

Why C is less appropriate. An assurance does not remove the conflict.

Why D is less appropriate. Public accusation undermines confidentiality and fair assessment.

Source framework: Sabiston e218 to e220; chapter sections 40 to 43. AMA 9.4.4; ACS conduct guidance as relevant.

Question 086

Disruptive conduct fair review and functional safety

A surgeon receives repeated reports of demeaning comments but says they cannot matter because postoperative complication rates are low. Staff describe avoiding necessary questions and residents withholding uncertainty. No causal link to a particular patient injury has been proved. The institution has clear respect standards and can review specific observations. A colleague proposes waiting for a measurable adverse event before acting, while another proposes ignoring technical performance entirely in every aspect of review. The task is to assess the conduct and its effect without inventing unsupported outcome claims.

Staff can give examples of questions left unasked, which merit review even if no permanent injury is linked. The surgeon should have a chance to respond to those examples. The institution can act on verified conduct and plausible safety mechanisms while remaining careful not to convert association or fear into unproved specific causation.

Which approach is best?

A. Wait for a preventable injury before considering intervention

B. Use low complication rates as complete reassurance

C. Claim that every reported comment has already caused a specific complication

D. Review the documented behavior and communication risks without requiring prior injury

Correct answer D. Professional duties and staff dignity matter before proven injury; claims should remain proportionate to evidence.

Why A is less appropriate. Prevention need not await harm.

Why B is less appropriate. Technical outcomes do not settle conduct.

Why C is less appropriate. Specific causation has not been established.

Source framework: Sabiston e218 to e220; chapter sections 40 to 43. AMA 9.4.4; ACS conduct guidance as relevant.

Question 087

Disruptive conduct fair review and functional safety

A resident is accused of being unprofessional after refusing to falsify a completed safety checklist. The resident explains that the underlying check was not performed and requests actual verification. The supervisor calls this obstructive and threatens a poor evaluation. The patient is stable, and the check can be completed before surgery without harmful delay. The institution's reporting route is available, but the resident fears escalation will affect training. Another trainee suggests signing now and privately recording the disagreement later.

The trainee can describe exactly which check remains incomplete and can ask available team members to help. Accurate documentation protects the patient and clarifies the event. A later private note would not make the earlier false certification or the unperformed preoperative check acceptable, even if the underlying surgery happened to proceed without harm. The anesthetist is available to support immediate factual verification before any irreversible step begins.

Which response best demonstrates professionalism?

A. Seek the actual safety verification and supported escalation with accurate documentation

B. Treat the supervisor's label as proof of misconduct

C. Delay the verification until after surgery to protect the list

D. Sign the checklist to preserve team harmony

Correct answer A. Integrity requires truthful records and the underlying safety action, with support against misuse of professional labels.

Why B is less appropriate. Authority does not settle factual conduct.

Why C is less appropriate. The check matters before the intervention.

Why D is less appropriate. Harmony does not justify false documentation.

Source framework: Sabiston e218 to e220; chapter sections 40 to 43. AMA 9.4.4; ACS conduct guidance as relevant.

Question 088

Disruptive conduct fair review and functional safety

A physician is the subject of a complaint about rude behavior. Review finds a clear communication lapse but also shows that one report was deliberately embellished by a colleague pursuing a personal dispute. Leadership proposes dismissing every concern because one source was unreliable. Another proposes retaining every allegation unchanged to avoid discouraging reporting. The physician acknowledges the verified lapse and agrees to feedback. A fair response can distinguish findings and protect legitimate reports without endorsing malicious ones. No immediate unresolved clinical threat is present.

The verified lapse remains relevant to feedback, while deliberate false reporting is itself a separate concern. Both can be assessed through appropriate procedures without treating them as cancelling each other. Protecting good faith reports is compatible with requiring factual accuracy and allowing a clinician to know which findings remain supported. The clinician wants feedback on the established lapse and clarification of the rejected allegation.

Which approach is best?

A. Discard all evidence because one allegation was malicious

B. Treat all allegations as equivalent despite contradictory evidence

C. Avoid notifying the physician of what findings remain

D. Separate verified conduct from unsupported claims and act proportionately on both

Correct answer D. Fair review evaluates evidence specifically rather than using all or nothing credibility judgments.

Why A is less appropriate. One false claim does not erase verified conduct.

Why B is less appropriate. Reporting protection does not validate false evidence.

Why C is less appropriate. The clinician needs a meaningful response opportunity.

Source framework: Sabiston e218 to e220; chapter sections 40 to 43. AMA 9.4.4; ACS conduct guidance as relevant.

Question 089

Disruptive conduct fair review and functional safety

A surgeon's behavior changes after a period of illness and heavy workload. Missed calls and unusual errors raise concern, but no diagnosis or substance exposure has been established. On arrival for elective surgery, the surgeon acknowledges difficulty concentrating. Qualified coverage is available. Leadership suggests proceeding after a warning because postponement affects access, while another clinician proposes publicly announcing a psychiatric diagnosis. The surgeon asks for help and fears permanent loss of career. The institution can arrange confidential appropriate assessment and actual handoffs.

The surgeon can participate in arranging a responsible handoff rather than be sent away without explanation. The service can address current concentration limits without predicting a permanent career outcome. A qualified assessment can later guide support and duties, while leadership examines whether workload or other contributors require change. The available replacement can accept the cases and complete appropriate communication with patients.

What is the best immediate response?

A. Allow unsupported operating after issuing a warning

B. Address functional safety with coverage and qualified confidential assessment

C. Publicly assign a diagnosis to explain the change

D. Send the surgeon away without transferring patient responsibilities

Correct answer B. Current function drives protection; assessment and support should avoid invented diagnoses and unowned care.

Why A is less appropriate. A warning does not restore performance.

Why C is less appropriate. The diagnosis is not established.

Why D is less appropriate. Removal alone does not complete continuity.

Source framework: Sabiston e218 to e220; chapter sections 40 to 43. AMA 9.4.4; ACS conduct guidance as relevant.

Question 090

Disruptive conduct fair review and functional safety

An experienced surgeon reports a well managed chronic health condition with no evidence of impaired clinical performance. A colleague proposes automatic removal from duties based solely on the diagnosis. Another insists health can never be relevant to practice assessment. The surgeon has appropriate follow up, reliable outcomes and no new functional concerns. Institutional occupational support can review any actual uncertainty confidentially. The department wants both fair treatment and patient protection without equating illness with incompetence. There is no emergency requiring an immediate restriction.

The surgeon is willing to discuss role relevant concerns with appropriate professionals but does not want private medical details circulated as gossip. The department can maintain standards through evidence about safe performance. Neither stigma based exclusion nor an absolute refusal ever to consider health related functional effects would serve that aim. Any future change in performance can trigger a new assessment under the same fair standards.

Which approach is most appropriate?

A. Remove duties automatically because a health label is present

B. Exclude all health information from any future functional assessment

C. Assess relevant function and support needs rather than diagnosis alone

D. Require the surgeon to disclose private details publicly to retain duties

Correct answer C. Illness and impairment are distinct; relevant functional evidence and appropriate confidential support should guide action.

Why A is less appropriate. Diagnosis alone does not prove unsafe performance.

Why B is less appropriate. Health may become relevant when function changes.

Why D is less appropriate. Public disclosure is not the appropriate default.

Source framework: Sabiston e218 to e220; chapter sections 40 to 43. AMA 9.4.4; ACS conduct guidance as relevant.

Question 091

Remediation measurement and integrated judgment

A clinician apologizes after repeated intimidating exchanges and completes an online communication module. Leadership plans to close the case because the certificate is filed. Staff have not yet worked with the clinician again, so no evidence of changed behavior exists. The clinician sincerely wants to improve but says time pressure triggers the old response. A mentor can observe relevant encounters and practice alternative responses, while workflow changes may reduce recurrent triggers. The service must protect patients and staff without assuming that either sincerity guarantees success or every lapse is permanently irreparable.

The mentor can define what respectful urgent communication would look like during actual pressure, not only in a classroom. The clinician is willing to rehearse and receive feedback. Review should also examine how the service responds when the new behavior takes more time than intimidation, so improvement is not silently punished by the environment.

Which plan best establishes remediation?

A. Return to unrestricted work without specifying review ownership

B. Treat recurrence risk as proof that remediation is impossible

C. Define replacement behavior, support and observed review before concluding improvement

D. Close the case on the apology and certificate alone

Correct answer C. Remediation requires demonstrated sustainable alternatives in relevant practice, not completion of an administrative task.

Why A is less appropriate. Unowned review cannot verify progress.

Why B is less appropriate. Risk can guide intervention rather than prove inevitability.

Why D is less appropriate. Intent and attendance are not performance evidence.

Source framework: Sabiston e219 to e220; chapter sections 43 to 53. Williams and Williams 2020; AMA 9.4.4; ACS principles as relevant.

Question 092

Remediation measurement and integrated judgment

A surgeon has no new complaints during a remediation period. Leadership interprets this as durable improvement, but the surgeon has worked fewer shifts, avoided the reporting team and performed only low pressure tasks. Previous problems occurred during complex operations. The surgeon has attended coaching and demonstrates good communication in simulation. Staff request a review that does not assume either success or failure from missing exposure. Appropriate safeguards can permit observation in relevant work.

The safety arrangements reduced opportunities for the old behavior, which was appropriate but complicates interpretation. A gradual relevant observation plan can preserve protection while obtaining better evidence. The clinician should know the criteria used and have a chance to discuss barriers rather than face an unexplained moving target after completing the formal tasks. The clinician can discuss what support would make the observed improvement reliable across different settings.

Which conclusion and next step are best?

A. Declare sustained success solely from the complaint count

B. Ignore simulation because only complaints can inform assessment

C. Declare failure because exposure was reduced for safety

D. Treat current evidence as incomplete and assess behavior under relevant conditions

Correct answer D. Improvement evidence must account for opportunity and context; multiple appropriate observations can inform the next decision.

Why A is less appropriate. Missing exposure can explain fewer reports.

Why B is less appropriate. Simulation is useful but insufficient alone.

Why C is less appropriate. Reduced exposure does not itself prove failure.

Source framework: Sabiston e219 to e220; chapter sections 43 to 53. Williams and Williams 2020; AMA 9.4.4; ACS principles as relevant.

Question 093

Remediation measurement and integrated judgment

A resident repeatedly omits ownership of pending results during discharge. The resident understands the rule but reports that the electronic workflow obscures responsibility and senior staff reward speed. A patient has already experienced delay. The program proposes either a lecture alone or redesigning the software without any individual feedback. The resident accepts that asking for clarification remains a duty. Supervisors can observe handoffs and the service can modify the workflow. The challenge is to avoid a false choice between individual and system responsibility while ensuring current results are reviewed.

The software can prompt ownership, but someone must still confirm that another clinician has accepted it. The resident can practice that action during observed discharges. The immediate result review, individual feedback and system redesign operate on different timescales, so none should be used to postpone the others or substitute for present patient protection.

Which plan is best?

A. Redesign software and remove all individual accountability

B. Issue a vague warning to be more professional

C. Secure current follow up and combine behavioral coaching with workflow changes

D. Repeat knowledge teaching without examining implementation

Correct answer C. A combined response addresses immediate harm, personal action and the environment that reproduces the gap.

Why A is less appropriate. System factors do not erase duty.

Why B is less appropriate. The target and evidence remain undefined.

Why D is less appropriate. Knowledge is not the sole deficit.

Source framework: Sabiston e219 to e220; chapter sections 43 to 53. Williams and Williams 2020; AMA 9.4.4; ACS principles as relevant.

Question 094

Remediation measurement and integrated judgment

A physician undergoing remediation performs respectfully when an evaluator is present but reverts during unscheduled interactions. The physician can describe why the old behavior is harmful and has learned alternative phrases. Team feedback suggests that the new response is not yet reliable under stress. The clinician argues that passing the formal assessment should end review. The program can provide further supported practice and clarify the relevant expectations. No evidence justifies assuming an immutable character defect, but ongoing risk cannot be ignored.

The clinician can identify stressful triggers but has not yet shown a consistent alternative response when those triggers occur. Further work can focus on implementation rather than merely repeat the same theory. Review should remain proportionate and transparent, with explicit safeguards and a clear route for escalation if harmful conduct persists. The program can explain why further observation is needed rather than change expectations without notice.

Which next step is most appropriate?

A. Conclude that reflection and skills training can never help

B. End remediation because the observed test was passed

C. Continue targeted implementation support and assess generalization in real work

D. Replace monitoring with another promise of good intentions

Correct answer C. A sustainable replacement must transfer beyond the test setting; insight alone does not establish reliable practice.

Why A is less appropriate. The findings identify a remaining target.

Why B is less appropriate. Performance is not yet generalized.

Why D is less appropriate. Promises do not measure the required change.

Source framework: Sabiston e219 to e220; chapter sections 43 to 53. Williams and Williams 2020; AMA 9.4.4; ACS principles as relevant.

Question 095

Remediation measurement and integrated judgment

A remediation plan tells a surgeon to be collegial and avoid future problems. It names no behaviors, reviewers or review dates. The surgeon asks whether requesting a second opinion will be seen as undermining colleagues and whether urgent direct communication is prohibited. Staff also do not know what to report. The institution wants fair expectations and a way to distinguish improvement from recurrence. Previous concerns involved personal insults during disagreements, not criticism itself. The surgeon is willing to participate and patient protection arrangements are already in place.

Staff can supply examples of insults and describe the effect on questions, while the surgeon can respond and ask what direct communication remains appropriate during urgency. A behavior specific plan can preserve necessary decisiveness. It should also distinguish legitimate criticism from personal attack so that efforts to reduce conflict do not silence clinical judgment.

Which revision is most useful?

A. Prohibit all disagreement so no further conflict can occur

B. Specify respectful communication behaviors, review evidence and escalation criteria

C. Retain vague language to allow maximum managerial discretion

D. Use absence of complaints as the sole success measure

Correct answer B. Actionable expectations should target harmful conduct while preserving legitimate criticism and defining how progress will be judged.

Why A is less appropriate. Disagreement is not itself the problem.

Why C is less appropriate. Vagueness undermines fair assessment.

Why D is less appropriate. Complaint absence needs context and exposure.

Source framework: Sabiston e219 to e220; chapter sections 43 to 53. Williams and Williams 2020; AMA 9.4.4; ACS principles as relevant.

Question 096

Remediation measurement and integrated judgment

A surgeon completes a health related assessment after temporary functional impairment. The clinician feels better and requests immediate return to a full complex operating schedule. The treating support team has not yet assessed the specific duties or recommended conditions. Qualified coverage remains available, and a staged supported plan could be arranged if appropriate. Leadership wants to avoid both unjustified exclusion and unsupported return based only on self reported recovery. The surgeon has no established finding of permanent incapacity.

The treating clinician's view is relevant but may not address every surgical demand or institutional requirement. The hospital can define who evaluates readiness for specific duties and who authorizes changes. The patient handoffs remain necessary until the agreed plan is implemented, and improved health should not be confused with automatic approval of every prior task.

Which approach best addresses the next decision?

A. Let the surgeon's personal physician alone allocate hospital privileges

B. Use appropriate functional assessment and duty specific return conditions with review

C. Permanently exclude practice because impairment once occurred

D. Restore every duty immediately because symptoms feel improved

Correct answer B. Return depends on relevant assessment and institutional responsibilities, not automatic reinstatement or permanent exclusion.

Why A is less appropriate. Clinical advice and institutional authority have distinct roles.

Why C is less appropriate. A past episode does not prove permanent inability.

Why D is less appropriate. Subjective improvement may not establish readiness.

Source framework: Sabiston e219 to e220; chapter sections 43 to 53. Williams and Williams 2020; AMA 9.4.4; ACS principles as relevant.

Question 097

Remediation measurement and integrated judgment

A hospital's review confirms serious recurring harassment despite prior feedback. Current safeguards have not adequately protected staff, and the clinician declines the proposed assessment and behavior plan. Leadership continues informal conversations because the clinician is influential. Another manager proposes bypassing all applicable procedures because the findings are distressing. The institution has formal mechanisms for proportionate restrictions and review, and immediate safety concerns can be addressed through them. The team must avoid both indefinite coaching without protection and arbitrary action without fairness.

The surgeon's refusal of assessment should be documented accurately, including any reasons or alternative proposals. Staff require protection from continuing conduct while fair procedures run. Formal escalation can be necessary without making permanent conclusions in advance, and temporary measures should reflect actual risk rather than the institution's desire either to avoid controversy or demonstrate severity.

Which course is best?

A. Use influence and revenue to justify continued unrestricted practice

B. Impose permanent consequences without the required process

C. Restart informal advice indefinitely without changing safeguards

D. Escalate through the applicable formal safety and accountability process

Correct answer D. Persistent serious risk may require formal escalation with proportionate protection and procedural safeguards.

Why A is less appropriate. Institutional benefit does not excuse harm.

Why B is less appropriate. Findings do not erase procedural requirements.

Why C is less appropriate. The prior approach has not protected people.

Source framework: Sabiston e219 to e220; chapter sections 43 to 53. Williams and Williams 2020; AMA 9.4.4; ACS principles as relevant.

Question 098

Remediation measurement and integrated judgment

A program evaluates a trainee after a communication lapse that occurred under exceptional workload. The trainee reports the error, helps correct it and demonstrates improved handoffs over subsequent supervised shifts. Review also identifies a service staffing problem being addressed. One evaluator insists that any lapse proves permanent unprofessionalism; another wants to erase the event because the system contributed. The program must make a proportionate developmental judgment using actual progress and remaining risk. The trainee asks for clear criteria rather than either a fixed character label or undeserved reassurance.

The resident can explain what has changed in the handoff process, and supervisors have examples from relevant work rather than a single ideal performance. Staffing changes may improve reliability for others too. The assessment should retain the history without using it as a permanent identity label or treating improvement as proof that no lapse ever occurred.

Which response is most appropriate?

A. Recognize the event and observed improvement while defining further review needs

B. Use the original lapse as an irreversible character verdict

C. Remove all individual responsibility because staffing was inadequate

D. Declare complete remediation solely because an apology was prompt

Correct answer A. Fair assessment incorporates conduct, context, change and continuing uncertainty rather than all or nothing labels.

Why B is less appropriate. One event does not define permanent character.

Why C is less appropriate. System contribution does not erase personal action.

Why D is less appropriate. An apology alone is insufficient evidence.

Source framework: Sabiston e219 to e220; chapter sections 43 to 53. Williams and Williams 2020; AMA 9.4.4; ACS principles as relevant.

Question 099

Remediation measurement and integrated judgment

A leadership team wants to reduce reports of disruptive behavior and introduces a policy that penalizes every department with more complaints. Reporting then falls sharply, while anonymous staff accounts describe greater fear of retaliation. Some clinicians have genuinely improved, but the institution has not examined which mechanism explains the overall change. Leadership wants to announce success. A patient safety group can review reporting accessibility, exposure and observed behavior. The problem is to measure improvement without rewarding concealment or assuming every reduction is false.

Anonymous information can help identify patterns and questions for review without automatically proving individual allegations. Leadership can assess whether people still feel able to report and whether relevant work exposure changed. A credible measure of culture should examine actual conduct and the reporting environment together rather than reward departments for making complaints disappear.

Which evaluation strategy is best?

A. Triangulate behavior, reporting conditions and exposure before judging success

B. Restore higher complaint numbers as the sole performance target

C. Use lower report counts as sufficient evidence of cultural improvement

D. Treat anonymous concerns as automatically proven findings against individuals

Correct answer A. Reporting frequency reflects both conduct and willingness to report; interpretation needs multiple sources and fair verification.

Why B is less appropriate. A count alone is not the desired outcome.

Why C is less appropriate. Suppressed reporting can create a misleading decline.

Why D is less appropriate. Individual findings still need assessment.

Source framework: Sabiston e219 to e220; chapter sections 43 to 53. Williams and Williams 2020; AMA 9.4.4; ACS principles as relevant.

Question 100

Remediation measurement and integrated judgment

A surgeon faces a time sensitive treatment decision for a patient who currently lacks capacity. Prior wishes are conditional, relatives disagree and an experienced assistant for a proposed new technique is unavailable. An established alternative can be delivered by another team. A resident who raises the support problem is criticized for delaying care. Several hours remain for focused coordination, but waiting indefinitely would worsen prognosis. The clinical team has enough information to identify the separate issues, yet asks for a single label of futile or cleared to end debate. The surgeon must protect the patient, establish authority and recommend an actually deliverable strategy without silencing the concern.

The representative can be verified while the clinical teams clarify prognosis and practical support. The resident's concern is a concrete operational fact, not merely opposition to innovation. A named coordinator can keep the review within the safe interval, preventing either an unsupported shortcut or a prolonged search for unanimous agreement that the patient's condition cannot tolerate.

Which next step best integrates the chapter's framework?

A. Proceed with the unsupported new technique after a broad signature

B. Use the clearance label to avoid revisiting support and preferences

C. Coordinate goal and authority review, compare deliverable options and assign timely ownership

D. Wait indefinitely until every family member agrees

Correct answer C. The decision needs separate resolution of authority, goals, clinical appropriateness and operational safety within the available time.

Why A is less appropriate. Consent does not supply missing support.

Why B is less appropriate. A label cannot resolve the identified gaps.

Why D is less appropriate. Unbounded delay ignores clinical harm.

Source framework: Sabiston e219 to e220; chapter sections 43 to 53. Williams and Williams 2020; AMA 9.4.4; ACS principles as relevant.

Question bank answer key

Check the letter against the case explanation. The learning objective is the management reasoning and the limits of each competing strategy.

Questions 1 to 20	Questions 21 to 40	Questions 41 to 60	Questions 61 to 80	Questions 81 to 100
001 D	021 A	041 C	061 A	081 A
002 B	022 C	042 B	062 C	082 C
003 A	023 D	043 C	063 B	083 D
004 D	024 C	044 B	064 D	084 D
005 D	025 D	045 A	065 A	085 A
006 C	026 D	046 B	066 B	086 D
007 A	027 B	047 D	067 C	087 A
008 C	028 D	048 C	068 A	088 D
009 A	029 B	049 D	069 A	089 B
010 B	030 B	050 B	070 B	090 C
011 C	031 D	051 C	071 A	091 C
012 C	032 B	052 B	072 C	092 D
013 A	033 B	053 C	073 D	093 C
014 A	034 B	054 D	074 B	094 C
015 D	035 D	055 A	075 A	095 B
016 B	036 A	056 C	076 B	096 B
017 D	037 A	057 C	077 B	097 D
018 A	038 B	058 C	078 D	098 A
019 B	039 D	059 A	079 D	099 A
020 A	040 C	060 A	080 C	100 C

Question bank source guide

Primary textbook

Angelos P, Mellinger JD. Ethics and Professionalism in Surgery. Sabiston Textbook of Surgery, 22nd edition, copyright 2026. Chapter 16, e214 to e221; supplied PDF pages 256 to 263. The cases apply the original teaching units and explicitly identified supplements in this chapter.

Consent capacity and surrogate decisions

AMA Code of Medical Ethics: 2.1.1 Informed Consent; 2.1.2 Decisions for Adult Patients Who Lack Capacity; 2.1.3 Withholding Information from Patients. GMC Decision making and consent, including supported communication and capacity. WMA International Code of Medical Ethics, revised 2022. https://code-medical-ethics.ama-assn.org/ https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent

Treatment limits and fair review

AMA Opinions 5.3 and 5.5. ATS AACN ACCP ESICM SCCM. Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units. 2015. doi:10.1164/rccm.201505-0924ST. Clinical recommendations, disputed values and legal authority should remain distinct.

Innovation and adoption

AMA Opinion 1.2.11, Ethically Sound Innovation in Medical Practice. SAGES Guidelines for the Introduction of New Technology and Techniques; SAGES Ethical Considerations Regarding Implementation of New Technologies and Techniques in Surgery. https://www.sages.org/publications/guidelines/

Professionalism identity and remediation

Irby DM, Hamstra SJ. Acad Med. 2016;91:1606–1611. doi:10.1097/ACM.0000000000001190. Williams BW, Williams MV. Ann Thorac Surg. 2020;109:317–324. PMID:31479640. AMA Opinion 9.4.4, Physicians with Disruptive Behavior. ACS Statement on Principles; Statement on Harassment, Bullying, and Discrimination; surgeon responsibility statement revised June 9, 2026. https://www.facs.org/about-acs/statements/

The cases and explanations are original educational applications. Source frameworks do not supply a universal surrogate hierarchy, consent statute, research classification rule or disciplinary sequence.