Reading Hospital School of Health Sciences
Medical Imaging Program
Beginning - Summer Semester 2021

Ethics Scenarios

Assignment

Throughout the entire MI curriculum, we have items in place to assess student learning outcomes and also to assess retention of concepts and material that be seen within the board examination.

Each student will review 2 scenarios looking for unethical, illegal or unacceptable patient care items. Below are 2 separate scenarios that you will read through carefully. Each scenario will include at MINIMUM 10 items that are incorrect or unacceptable. It is possible to identify more than 10 and the more you identify the better to ensure that all key 10 items are addressed. Items to look for or consider would be any of the following:

- Actions of the technologist/healthcare worker should have been different
- Legally or Ethically an item or action is wrong and unacceptable (according to the ARRT/ASRT Code of Ethics)
- Processes were not followed correctly
- Communication or patient care was not followed as should have been within our standard of care as a radiographer.

It is your goal to find at least 10 items per scenario. Please highlight any of the errors and then additionally identify what *SHOULD* have been done or how things should have been done differently. Also, explain why the action is incorrect. Please place your comments in a different color font so I can see your thoughts and reasoning in your decision of highlighting any portion of the text of the scenario.

This completed assignment is ***due Friday, May 21, 2021.*
**Please submit the completed assignment within the drop box on MI 116 Edvance Labeled "Ethics Scenarios"

Reading Hospital School of Health Sciences
Medical Imaging Program
Class of 2023—Level I Pre-Assessment

****Using your knowledge of the ARRT code of ethics, how would you ethically/legally handle this scenario? Address every unethical/illegal action(s) and explain what should have been done differently*

Scenario #1:

You are scheduled in the ED for the day and your next patient is a young woman in her sixth month of pregnancy. She was involved in a head on collision, fortunately her seat belt and airbag kept her from contact with the windshield. She sustained severe bruising and has not felt the baby move since the accident. The patient is very fearful, frantic, and uncomfortable with pain. The room she is in is very cold. She is trying desperately to listen to all of the health care workers around her to grasp onto any information she can of her and her baby being ok. During the exam, you are the only imaging professional present in the room. You are running in and out to expedite this process as quickly as possible and you don't have time to listen to the numerous questions the patient is throwing your way. You continue to image the patient only in the end realizing that you forgot to shield her for any of her extremity images and didn't even run this exam by a radiologist to see if any images could be eliminated to reduce exposure for this patient. During the imaging process, she partially overhears a conversation from an opened door to a common area within the x-ray department. Some of the phrases or partial sentences included: crushing injuries, fetal death, oxygen deprivation, internal injuries.

The patient becomes hysterical and demands answers from you the next time you enter the room. You are angry that your co-workers have put you in this position and are also becoming increasingly worried about this patient as she is growingly becoming more upset and hysterical. She begs you for answers and you instruct her to continue to hold still or else this process will only take longer which is probably something that she doesn't want to happen.

To make matters worse the patients' friends are outside of the ED in the waiting area demanding to know how their friend (the patient) is doing or if she is even admitted to this health care facility. In speaking with the security guard, you realize that the friends of this patient make no mention of the unborn baby and from your understanding they do not even know that a baby is in the picture. The friends are demanding answers, updates, and results of their friend that is behind the ED doors in a private area. You end your exam with the patient and head to the waiting area where the patient's friends are frantically waiting. You discuss with them that the patient is in good hands and the doctor will be out momentarily to discuss any findings or results that were found with the patient as well as her baby. At that point, the patient's friends became hysterical with concern not only for the patient but in finding out that a baby was involved and until that point they didn't even know anything about.

You then return to your patient, explain that there are numerous people in the waiting area concerned for her as well as her baby, would she like them to come in to visit with her? The patient already irate and hysterical from not having answer questions becomes even more upset by you disclosing information to her friends. She goes into premature labor and her baby spends the next 4 months in the NICU.

1. Instead of letting the patient freeze, give them a warm blanket.
2. you should not be the only imaging professional in the room, you should have at least one other person with you.
3. You shouldn't be running in and out of the room. You need to stay with the patient.
4. There is no excuse for not having time to listen. Communication is important and can help to calm the patient.
5. Forgetting to shield a patient is uncalled for, let alone one who is pregnant. Not only should you check to make sure that this patient is able to get imaging done, but if they can, you need to make sure that the proper shielding is presented to the patient.
6. You should never take images without checking with a technologist first. Instead of rushing a picture, you should always double check with the technologist about how much radiation you should expose the patient to.
7. Conversations about patients should be in a room with a closed door, with the technologist. Instead of talking loudly with the door open, close the door and talk in a quieter pitch.

8. You should never rush a patient, calmly keep them in the loop and let them know what you are doing at all times.
9. You should not be talking to the security guard about a patient, violation of HIPAA. Instead, let the patient know that people are asking about them.
10. It is not your job to go into the waiting room to talk to the patient's friends and family, especially when there is no consent. Instead, you leave that to the technologist.
11. You should not bring up any of the patient's personal information, instead just say that the patient is okay.
12. You should never disclose information without the patient's consent. Ask the patient if they would like you to give a message instead.

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Scenario #2:

Your patient is a 17-year-old female who arrived in the imaging department for a shoulder arthrogram. She is registered and brought back to the changing booth and given changing instructions. The following information is verified: correct last name, DOB, and the date of her last menstrual cycle which was 38 days ago. After the patient was changed into a patient gown and the patient was identified, you strike up a conversation as to which shoulder will be imaged for this procedure. The 17-year-old seems confused about why her shoulder is the area of interest and states that she is not having shoulder pain but rather her wrist seems to be the problem. In reviewing the order, you notice that it states, "Shoulder Arthrogram w/ MRI to follow." In double checking with the patient, she still insists that it should be her wrist. You proceed with the exam disregarding the patients comment and explain that we always follow the physician's orders and today she will be going through the process of a shoulder arthrogram with an MRI to follow. The patient proceeds through the informed consent process between the Radiologist, the patient, and the witness (the technologist), and they head to the fluoroscopy room. The patient is at this point visibly confused, cold (only wearing a patient gown, underwear, shoes/socks) and upset. As the patient is lying on the exam table, her shoulder was cleaned with a sterile solution and the Time Out Process was completed. The procedure is a success, and the patient is on her way for the remainder of the exam, an MRI.

Two weeks later, you learn that the patient was intended to have a wrist arthrogram instead of a shoulder arthrogram and on the day of the scheduled wrist arthrogram she cancels

due to the fact that she is 8 weeks pregnant. The patient's initial exam was also found to be under her twin sisters' medical records and charged to the incorrect insurance company.

1. The patient is still a minor and needs to have a guardian with her, this scenario never stated that there was a guardian with.
2. The date of her last menstrual cycle was 38 days ago, which means you now need to ask if there is any chance of pregnancy, instead of going right into the procedure.
3. Since the pain is in the patient's wrist, but a shoulder is the area of interest, you need to double check with not only the orders, but also the physician that referred this patient or you could check the ICD10 code on the patient's wristband.
4. Just because you double checked with the patient, does not mean that the patient is right. You need to take further action and ask the technologists.
5. You should never disregard a patients' comment or concern. Always listen to your patients and if there is a problem with the area of interest, check with someone else.
6. The patients' guardian needs to be present through the informed consent process. Then after the patient is done with that, the guardian can step aside.
7. If the patient is confused, communicate to let them know what is happening. If they are cold, give them a warm blanket
8. The patient was 8 weeks pregnant; this means that you did a procedure on someone who was pregnant because you did not ask the two-part question. Instead, you should be asking if there is any chance of pregnancy and then go with it from there.
9. You did not properly check all of the patient's information. Instead, you should check the DOB, name, address, possibly their social security number.
10. If you had the right information about the patient, then you would also have the right insurance company.