Is blood thicker than water? Belgian and Dutch perceptions on the role of stepparents in medical decision-making for minors

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Is blood thicker than water? Belgian and Dutch perceptions on the role of stepparents in medical decision-making for minors

Abstract: Alternative family configurations are becoming more prevalent, yet current legislative statutory does not support stepparents in medical decisions for their stepchildren. We investigate opinions of Belgian and Dutch adults regarding inclusion of stepparents in medical decision-making in minors. We make two observations. First, participants wanted stepparents to be involved in cases when medical information had to be shared or informed consent signed. Second, when stepparents object against previously approved medical interventions by a biological parent, respondents were less likely to support stepparents. Participants with stepchildren were likely to favour inclusion of stepparents in decision-making. Overall, our findings indicate that Belgian and Dutch adults view stepparents as potential executive actors in medical decision-making for minors, but not as primary decision-makers. This study is a first step in showing to what extent stepparents could be included in medical information and decision-making regarding stepchildren. We reflect on these findings in light of implications for medical practice and legislative shortcomings.

Keywords: Stepparents; Clinical decision-making; Child; Casuistry

Introduction

Nuclear families composed of two parents and their biological child(ren) living together in a single household are becoming less prevalent (De Coninck et al., 2021). In recent decades, the number of marriages and childrearing in families have been declining (Corijn & Van Peer, 2013; Matthijs & Vanassche, 2016; Vasileva et al., 2013). At the same time, unmarried cohabitation (pre- and postmarital), extramarital childbearing and divorce have increased (De Coninck et al., 2021). Particularly in Western Europe, the increase in divorce rates since the 1960s and subsequent repartnering has been notable (Matthijs & Vanassche, 2016; Vasileva et al., 2013). As a result, alternative family configurations – including the presence of stepparents –have become increasingly normalized (Boone et al., 2017; Ferrera-Riba, 2016).

In many European countries, the legal framework regarding family relations is still largely based on nuclear families consisting of a couple and their own children (D'Angelo, 2014). In spite of this, everyday realities show that stepparents often care for their stepchildren and share responsibilities with biological parents (Ferrera-Riba, 2016; Sodermans et al., 2013; Vanassche et al., 2013). In contemporary societies, there are multiple ways to fill a parental role; either biological, legal or social. In the past, the biological parents fulfilled all possible parental roles, but medical and societal changes have resulted in a separation of those roles (De Coninck et al., 2021). For example, in case of donor assisted reproduction, the male donor is the biological father but generally, he is not the legal or social parent (Heaton & Kemelmajer, 2023).

A social parent, defined as "any persons who are not biological or adoptive parents but who take care of children and are otherwise interested in their upbringing" (Law & Martin, 2022, p. 352). This may be a role taken up by a stepparent but it can also refer to a grandparent or foster parent who is taking care of the child (Ferrera-Riba, 2016). An increasing number of European legal systems take social parents into consideration when regulating parental responsibilities. There are however significant differences between national legal systems in approaching this issue (D'Angelo, 2014; Ferrera-Riba, 2016).

Many legal systems recognize the role of stepparents in the upbringing of the child by allowing them to acquire certain parental responsibilities and rights with respect to the stepchild (Heaton & Kemelmajer, 2023). In Germany, a stepparent may participate in decision-making

on matters relating to the child's everyday life. However, this right is limited to the stepparent who is married to a legal (or custodial) parent who does not share custody with the other parent (Sanders, 2023). Some other European countries have opted for a more inclusive approach, where stepparents can have full parental responsibility, in addition to the parents (D'Angelo, 2014). An example of the approach can be found in England, where more than two persons can hold full parental responsibility for a child, according to the Children's Act 1989. Hence, stepparents can acquire parental responsibility by agreement with the parents, or if their consent cannot be obtained, by court order (Fenton-Glynn & Scherpe, 2023). The current study takes place in two other European countries: Belgium and The Netherlands.

In Belgium, with the exception of foster parents, only the legal parents (usually the biological or adoptive parents) have parental authorities, and as a rule, a child can have no more than two legal parents (Boone, 2016; Swennen & Goossens, 2022). A stepparent can become a legal parent by adopting the child. This way, the stepparent has the same legal responsibilities and rights as the parent with whom the stepparent shares a household (Swennen & Goossens, 2022). The other legal parent, however, loses their parental rights (Boone et al., 2017). Thus, stepparent adoption is not a solution when both parents wish to retain parental responsibility over their children after divorce or separation (Boone, 2018). Also in The Netherlands, a child can only have two legal parents and stepparents usually have no legal ties with their stepchildren (Schrama, 2023). Stepparent adoption is extremely rare in the Netherlands because the conditions are strict and not easily met (Schrama, 2023). The legal parent and their partner can request joint parental responsibilities through court order (art. 1:253t Dutch Civil Code). However, this is only possible when the other legal parent never had parental responsibilities or no longer has them, which is rarely the case (Nikolina, 2015; Schrama, 2023).

In medical contexts, alternative family configurations add another layer of complexity, especially with regards to medical decision-making (Donck et al., 2023; Montreuil et al., 2020; Reeder & Morris, 2021). The Belgian legal framework regarding the representation of minor patients in medical decision-making stipulates that the right to consent (i.e., providing or refusing consent for medical treatment) and the right to confidentiality (i.e., non-disclosure of medical information of the patient) are exercised by the parents on behalf of the child, unless a physician decides that the minor is capable of a reasonable assessment of their

situation (Vanwymelbeke et al., 2022). In that case, all patient rights revert back to the minor (Donck et al., 2023). They are then considered mature enough to make decisions without parental interference and they can invoke physician-patient confidentiality to withhold information from the parents (Art. 12 Patient's Rights Act 2002, FOD Volksgezondheid, 2002). In The Netherlands, medical decision-making for minor patients is based on the age of the child. If the child has not yet reached the age of 12, medical decisions are made by the parents who have parental responsibilities (Art. 7:465 Dutch Civil Code). If the child is at least 12 years old but not yet 16, the parents and the child have to decide together (art. 7:450 Dutch Civil Code). Adolescents aged 16 or over are legally capable of making their own medical decisions (Art. 7:447 Dutch Civil Code; Bruning, 2013).

Physicians and other health care workers take care of young patients who are accompanied by their stepparents on a daily basis. To illustrate: approximately 12% of Belgian and 16% of Dutch minors currently grow up in alternative family configurations (De Coninck et al., 2021; van Gaalen & van Roon, 2020). This means that statistically, a maximum of about one in eight children in a physician's waiting room may have at least one stepparent (De Coninck et al., 2021; Stavleu et al., 2022).

Nonetheless, the Belgian and Dutch legal frameworks do not provide a strong position for 'social parents' (e.g. stepparents) who might play a significant role in the care, welfare and even development of a child. As a rule, stepparents are not the legal parents and they do not hold parental responsibilities towards their stepchildren (Swennen & Goossens, 2022; Schrama, 2023). In a clinical context, this means that stepparents cannot be involved in medical decisions, and – as patient-physician confidentiality is at play – they may be excluded from meetings or information sessions regarding minors' health status (Boone, 2016). The same applies to grandparents or other non-legal parents who informally take up family roles (Swennen & Goossens, 2022).

Aim

To examine the public opinion about the role of stepparents in medical decision-making in Belgium and The Netherlands through hypothetical clinical cases. Additionally, we will

compare perceptions of Belgian and Dutch citizens and link potential discrepancies to the legal context in these countries.

Materials and methods

Study design

We used a case-based online questionnaire (see supplementary materials for a full overview of the cases) to examine opinions about the role of stepparents in medical decision-making for minors. We constructed four cases. Each case dealt with a specific topic in the medical treatment of a minor that could lead to discord between stepparents, biological parents, and/or the physician. The KU Leuven Social and Societal Ethics Committee approved the study (case number G-2020-1670-R4). Participants were recruited through a survey agency with large opt-in panels (over 150,000 individuals) in Belgium (mainly in its Dutch-speaking northern region, Flanders) and The Netherlands. E-mails were sent out to potential respondents with the request to participate in this study – no subject matter was specified. The survey took about 10 minutes to complete and was fielded for three weeks in October 2020. Only participants who completed each question were included in the final dataset. As such, there were no missing data.

Because the fictional cases that we presented mostly pertained to adolescents, we chose to set an age range from 35 to 55 years old for inclusion in the study to increase the chances of participants having an adolescent biological or stepchild. However, having a biological or stepchild was not a prerequisite to be included in the study – the role of stepparents in society is an issue that extends beyond childbearing individuals. Thus, apart from age, there were no other inclusion or exclusion criteria. In the final dataset, 1,000 Belgian and 1,000 Dutch respondents were included. More information on the study can be found in De Coninck et al. (2022).

Measures

First, participants completed some questions on demographic characteristics (see Table 1).Second, we presented participants with four cases and asked them to indicate which course of action the physician should (ethically) take in the cases. The cases concerned a minor's medical issue regarding confidentiality (disclosure of laboratory results), decisions on

urgent (blood sampling in a sick infant) and non-urgent (immunization) medical interventions and informed consent (for a gastroscopy). The authors constructed the cases drawing on real-life experiences in pediatric consultations in Belgium and The Netherlands. The cases were piloted among colleagues and family members of the authors in the age range of 35 to 55 years old prior to fielding the study. Following this, some minor changes in terminology were implemented. An overview of the specific wording of the cases can be found in the supplementary materials.

Statistical analysis

Descriptive statistics were used to calculate and present the demographic information. Cross tables were used to provide a descriptive overview of participants' responses to the case-based questions. Because the case-based questions had two answer options, we conducted binomial logistic regressions (one per case) to identify which sociodemographic factors were significantly associated with preferences regarding stepparental involvement in medical decision-making. Prior to analysis, we controlled for multicollinearity among independent variables and the linearity of independent variables and log odds in the full sample; all necessary assumptions were met to proceed with binomial logistic regression. The results of these preliminary analyses can be requested from the authors. The descriptive analysis and binomial logistic regressions were conducted in SPSS Version 26. For the latter, p-values $< .05$ were interpreted as statistically significant.

Results

The sociodemographic characteristics of the questionnaire are shown in Table 1. 61% of the sample (n = 1,211) was aged between 45 and 55 years old. Slightly more women (57%, n = 1,156) then men participated in the study. Most respondents had at least one child: 69% (n = 1,382) had a biological/adopted child, 12% (n = 242) had a stepchild.. Nearly two thirds (73%, n = 1,464) of the sample lived in an intact family, while 13% (n = 250) lived in a non-intact family. The majority of participants received a higher education (55%, n = 1,104).

Table 1. Sociodemographic characteristics (N = 2,000)

Participant characteristics	N (%)
Age	
35-44	789 (39.4)
45-55	1,211 (60.6)
Gender	
Female	1,156 (57.8)
Male	843 (42.2)
Children	
Biological/adopted child	1,382 (69.2)
Stepchild	242 (12.1)
Education	
Secondary education or lower	896 (44.8)
Higher education	1,104 (55.2)
Family situation	
Intact family	1,464 (73.2)
Non-intact family	250 (12.5)
Never married or widowed	286 (14.3)

A descriptive overview of the answers to the medical cases are shown in Table 2. Most participants wanted to include stepparents in decision-making in cases regarding medical information (76%, n = 1,523) and informed consent (61%, n = 1,236). This contrasts with findings about consent issues like vaccine administration (38%, n = 777) and taking a blood sample (26%, n = 533), where most participants did not want to include stepparents. Interestingly, there were sizeable national differences: a larger share of Belgian participants wanted to include stepparents in issues regarding medical information and informed consent (around 20% more than their Dutch counterparts). However, a smaller share of Belgians wanted to include stepparents in the case of vaccine administration and in the case of the blood sample.

Table 2. Number and share of participants that support stepparent inclusion

	Belgium	The Netherlands	Total
	N (%)	N (%)	N (%)
Case 1 (information)	839 (83.9)	696 (69.6)	1,535 (76.6)
Case 2 (informed consent)	703 (70.3)	533 (53.3)	1,236 (61.8
Case 3 (vaccination)	321 (32.1)	456 (45.6)	777 (38.9)
Case 4 (blood sample)	181 (18.1)	352 (35.2)	533 (26.7)

Findings of the binomial logistic regressions indicate a number of factors were linked to stepparental preferences. Gender differences were statistically significant in all regression analyses: female respondents were significantly less likely than male respondents to give autonomy to stepparents in cases regarding information sharing (*OR* = 0.61, 95% CI [0.47, 0.79]) or signing an informed consent (*OR* = 0.55, 95% CI [0.44, 0.68]). In cases where stepparents disagree with biological parents, female participants reported a higher likelihood than men to include stepparents in medical decisions (*OR* = 1.34, 95% CI [1.15, 1.76] for case 3, and *OR* = 1.62, 95% CI [1.27, 2.05] for case 4).

Belgian participants had a significantly lower likelihood than Dutch participants to support the inclusion of stepparents in cases regarding vaccination (*OR* = 0.54, 95% CI [0.44, 0.67]) and taking a blood sample (*OR* = 0.43, 95% CI [0.34, 0.55]). On the other hand, for cases regarding medical information sharing (*OR* = 2.33, 95% CI [1.80, 3.01]) and informed consent (*OR* = 2.09, 95% CI [1.68, 2.61]), Belgian participants reported a higher likelihood of allowing stepparents to be involved than Dutch participants. By and large, these findings mirror those from the descriptive overview in Table 2.

Participants with at least one biological/adopted child were more likely to give autonomy to stepparents than participants without children when information had to be shared (*OR* = 1.40, 95% CI [1.07, 1.89]). Similarly, stepparents were more likely to give autonomy to stepparents in cases regarding information sharing (*OR* = 1.70, 95% CI [1.14, 2.49]) and signing informed consent (*OR* = 1.70, 95% CI[1.22, 2.35]) than those who were not stepparents. Participants with a higher education were less likely than lower educated individuals to involve stepparents in decision-making with regards to information sharing (OR = 0.79, 95% CI [0.60, 0.95]). Family situation and age participants yielded no statistically significant results (Table 3).

Table 3. Binomial logistic regressions with stepparent preference as dependent variables

	Case 1 (information)		Case 2 (consent)		Case 3 (vaccine)		Case 4 (blood sample)	
	OR (SE)	95% CI	OR (SE)	95% CI	OR (SE)	95% CI	OR (SE)	95% CI
Gender (ref: male)								
Female	0.61*** (0.13)	0.47, 0.79	0.55*** (0.11)	0.44, 0.68	1.34** (0.12)	1.15, 1.76	1.62*** (0.14)	1.27, 2.05
Age (ref: 35–44)								
45–55	1.01 (0.01)	0.92, 1.53	1.01 (0.01)	0.84, 1.31	1.00 (0.01)	0.92, 1.42	1.01 (0.01)	0.82, 1.32
Education (ref: secondary or lower)								
Higher education	0.79* (0.13)	0.60, 0.95	0.93 (0.11)	0.74, 1.16	1.19 (0.13)	0.96, 1.48	1.07 (0.14)	0.89, 1.44
Children	1.40* (0.15)	1.07, 1.89	1.00 (0.13)	0.78, 1.30	0.96 (0.07)	0.73, 1.20	1.01 (0.08)	0.62, 1.06
Stepchildren	1.70** (0.20)	1.14, 2.49	1.70** (0.11)	1.22, 2.35	1.05 (0.18)	0.81, 1.48	1.26 (0.19)	0.97, 1.85
Family situation (ref: intact family)								
Non-intact family	0.42 (0.67)	0.36, 1.03	0.43** (0.24)	0.28, 0.73	1.19 (0.68)	0.58, 1.45	0.81 (0.82)	0.46, 1.27
Never married or widowed	1.21 (0.49)	0.15, 0.88	1.10 (0.86)	0.20, 5.93	0.43 (1.17)	0.02, 1.73	2.43 (1.02)	0.14, 4.15
Region (ref: Netherlands)								
Belgium	2.33*** (0.13)	1.80, 3.01	2.09*** (0.11)	1.68, 2.61	0.54*** (0.11)	0.44, 0.67	0.43*** (0.14)	0.34, 0.55
Constant	2.41** (0.19)		1.64** (0.17)		0.65* (0.17)		0.43*** (0.19)	
Nagelkerke R^2	0.08		0.09		0.04		0.07	

Note: *** $p < .001$; ** $p < .01$; * $p < .05$.

Discussion

The findings provide novel insights about perceptions towards stepparent inclusion in medical decision-making – the main aim of this study. We found that Belgian and Dutch adults support the inclusion of stepparents in minor's medical decision-making in the two cases regarding medical information sharing and signing informed consent. In vaccination and blood sample cases, most participants were not in favour of including stepparents. One possible explanation for differences in preferred stepparent involvement could be that in those first cases, the stepparent is not expected to make a decision themselves but rather execute what has been decided previously with the biological parent. The stepparent is merely present because the biological parent is unable to attend – an 'executive' stepparent role.

In the other cases, the stepparent's opinion is discordant with either the biological parent or physician. In the vaccination case, the biological parents explicitly gave their permission to administer the vaccine in a previous consultation. By granting autonomy to stepparents in this case, participants agree to disregard the opinion of the child's biological parent. In the blood case, the opinion of the biological parent was not specified whereas the physician's opinion was: they wanted to take the sample. Granting autonomy to the stepparent would counteract the expertise of a medical professional, which may be something participants are unwilling to do. Thus, participants appear unsupportive of a 'decision-making' stepparent role in minor medical decision-making at this time.

It is relevant to know that Belgian law stipulates that a physician can go against the wishes of a patient (or their representatives) if there is a threat to the physical health of the patient in urgent cases (art. 15 § 2 Patient's rights act). In Dutch law, the consent of both legal parents is necessary to perform medical interventions on children under 12 years. A physician is legally allowed to disregard parental preferences in emergencies where medical intervention is necessary to avoid serious harm to the child. When children are 12 to 15 years old, parental and adolescent consent are required. If parents refuse a necessary medical treatment in this age range, the child can give permission for the medical intervention without parental consent (Bruning, 2013). As such, not granting autonomy to stepparents may be a case of giving more weight to medical/(biological) parental preferences , rather than a general hesitancy to involve stepparents in the medical decision-making process.

Belgian and Dutch participants had different perceptions in every case. Belgian participants were more likely to support the 'executive' stepparent role and allow physicians to provide medical information to stepparents than Dutch participants. This is remarkable considering that stepparents in either country are not entitled to receive medical information in most cases. Only the legal parents with parental responsibilities are entitled to do so (see the Introduction). Although stepparents in these countries usually do not have parental responsibilities in respect of the stepchild, 70% of Belgian and 53% of Dutch participants allowed stepparents to sign an informed consent. This shows a clear discrepancy between existing legal frameworks and preferences regarding these practices.

Dutch participants were somewhat more in favour of the 'decision-making' stepparent role than Belgian participants by granting autonomy to stepparents in cases regarding blood sample and vaccination. This difference in perceptions between Belgium and The Netherlands may be linked to recent developments in the legal framework in these countries. The Netherlands tend to pioneer family law reforms (Boone, 2018). In recent years, the Dutch government has appointed a Committee on the Reassessment of Parenthood to assess whether current legislation regarding social parenthood should be reformed (Cammu, 2019; Government Committee on the Reassessment of Parenthood, 2016). This Committee recommended to introduce legal multi-parenthood and multi-parent responsibilities for a maximum of four persons (Government Committee on the Reassessment of Parenthood, 2016). In reaction to this recommendation, the Dutch Government proposed a system of partial parental responsibilities for social parents, in which stepparents are granted some parental authorities. Stepparents could, for example, take stepchildren to a physician or to a school meeting (Dutch Government, 2019). In 2021, the new Dutch government stated that they will strive to introduce new legislation on multi-parenthood and multi-parent responsibilities in the next years (Schrama, 2023). This new legislation has not yet been approved, but it could be a step forward to solve problems experienced by social parents (Schrama, 2023). In Belgium, there have been several proposals to introduce a specific statute for social parents, yet so far without any concrete legal changes (Boone et al., 2017).

Limitations

Some strengths and limitations of this study should be addressed. This is the first study to assess the public opinion on the role of stepparents in clinical scenarios in Belgium and The

Netherlands and, as such, provides novel insights. The large sample size and presentation of realistic case-based scenarios are strengths of this study.

There are also some limitations. First, we used casuistry with close-ended answer options. Consequently, we do not know the reasoning of a participant to select a specific option. It could be influenced by their own predetermined opinion regarding an unrelated topic (e.g., opinion on vaccination) or previous experiences. A qualitative study could be designed to elucidate these motivations (Donck et al., 2023). Here, we could have focused on alternative family configurations and include questions about parents' trust of their child's stepparent. Second, we do not know what participant's perceptions were towards alternative family configurations, nor did we test their knowledge on the legislative context regarding the inclusion of stepparents.

Third, the parent-physician relationship is an important aspect in medical decision-making (Pyke-Grimm et al., 2006). In this study, the relationship between parent and physician was not specified and this might have influenced the results (e.g., family physician may be trusted more than hospital staff). Fourth, we did not specify in the fictional cases whether the stepparent in question had legally adopted the child. This would make a significant difference in reasoning: stepparents who legally adopt their stepchildren are granted the same parental rights as biological parents. Having said this, it remains notable that in cases where stepparents were presented as decision-makers, perceptions towards stepparent inclusion were largely negative in our sample.

Implications for practice

With this study, we provide the first insights regarding public opinions on the role of stepparents in medical decision-making. Future research should broaden the scope by incorporating additional psychological, sociological, and medical factors, develop qualitative study designs and a wider range of case-based scenarios At present, physicians do not have clear guidelines nor a legal framework for including stepparents in medical decision-making for minors, which makes them legally vulnerable if a conflict would arise.

Our study provides physicians and policy makers with evidence that there is considerable support among Belgian and Dutch adults for the inclusion of stepparents in medical decision-making for minors, particularly when they are carrying out decisions previously taken with/by

the biological parent(s). Adapting the legal framework to reflect changes in societal viewpoints and realities (non-traditional family composition) may prove imperative in the future. At the same time, it remains clear that support for stepparents to act as decision-makers independently of biological parents remains a controversial issue, indicating that legal support for stepparents in this context should not be equal to that of biological parents at this time.

The broader implications of this study for youth health emphasize the critical need for a nuanced approach in healthcare decision-making for minors within blended families. Understanding the diverse perspectives on stepparent involvement allows for the development of more effective healthcare policies and practices. Striking a balance between respecting parental rights, including stepparents, and prioritizing the best interests of the child is crucial. This study encourages health professionals and policymakers to consider evolving family dynamics and legal frameworks, ultimately aiming to ensure comprehensive and informed medical decisions that promote the health and well-being of youth in blended family structures. Additionally, it underscores the necessity of ongoing dialogues and legal reforms to address the unique needs and rights of youth in diverse family settings.

Conclusion

We investigated the opinions of Belgian and Dutch adults on involving stepparents in medical decision-making about minors. Based on these data, Belgian and Dutch adults are in favour of an ‘executive’ role for stepparents in a medical context, despite the fact that the legal framework does not formally allow or support this. However, when stepparents take up a ‘decision-making’ role due to disagreement between biological parent or physician and stepparent, perceptions remain skewed against the latter group. With the growing numbers of stepparents in contemporary societies, the legislative statutory may need an update to meet society's changing expectations, values and norms.. This study is a first step in showing to what extent stepparents could be included in medical information and decision-making regarding stepchildren.

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Supplementary materials

The following questions are always about alternative family configurations. When talking about the stepfather or stepmother, this always refers to the new partner of the biological mother or father of the child. The child in this case is called 'stepson' or 'stepdaughter'.

Case 1

A biological father consults his family doctor with his own 6-year-old daughter because of fever and abdominal pain. The doctor suspects a bladder infection and sends a urine sample from the girl to the laboratory for analysis. In the afternoon, the stepmother visits with the girl (her stepdaughter) to discuss the results because the father has to work.

What decision do you think the physician should make?

□ The physician does not give any medical information to the stepmother.

□ The physician does give medical information to the stepmother.

Case 2

A stepfather accompanies his 6-year-old stepson who comes to the hospital to perform a gastroscopy (stomach examination). This examination was discussed at a previous consultation, where both biological parents were present, and scheduled after general agreement. Because this examination will be done under sedation (a type of drug-induced "intoxication"), a parental consent document must be signed today (informed consent form or "informed consent").

What decision do you think the physician should make?

□ The physician has the stepfather sign the document and performs the examination.

□ The physician does not have the stepfather sign the document and postpones the examination.

Case 3

A stepmother consults the general practitioner with her stepson of 6 years old because of constipation/fatigue. Two weeks ago the biological father had already visited the GP with the boy for this problem and for a scheduled vaccination. It was then decided to start a treatment

(fiber in powder form to make the stool easier to come), the consultation today was among other things to see if this has improved. Because the boy was also sick two weeks ago, the planned vaccination was postponed until today. The physician says that he wants to give the vaccine today, but the stepmother - who is worried about vaccines and possible side effects - says that the physician should not give the vaccine.

What decision do you think the physician should make?

□ The physician places the vaccine.

□ The physician does not place the vaccine.

Case 4

A stepfather comes to the emergency department with a 6-month-old baby because of a high fever, the (biological) mother herself is ill in bed at home. Because the physician wants to exclude a serious infection, a blood sample is taken. But because the child is feverish, the first injection attempt fails. When the physician wants to perform a second puncture attempt, the stepfather refuses and wants to take the child back home.

What decision do you think the physician should make?

□ The physician performs the blood draw.

□ The physician does not perform the blood draw.