

CHAPTER 200 **Bioethics**

Kenneth V. Iserson

■ PERSPECTIVE

Definitions

Ethics is the application of values and moral rules to human activities. *Bioethics*, a subset of ethics, uses ethical principles to find reasoned and defensible solutions to actual or anticipated moral dilemmas facing clinicians. The moral precepts that underpin ethical decisions are derived from a variety of sources, including individual, cultural, and community value systems. Unlike the law, which is relatively rigid and, particularly in the case of scientific and medical issues, can lag years or even decades behind modern developments, the bioethical construct allows a greater flexibility in decision-making. This is a crucial factor in the emergency department (ED), which demands reasonable action. Emergency physicians (EPs) often are called on to identify a patient's personal, cultural, religious, or community values and to balance these values with their own personal and professional ethos. A working knowledge of bioethics greatly enhances the EP's ability to make reasonable, ethical decisions in the limited time frame common to the practice of emergency medicine.¹

Unlike professional etiquette, which relates to standards governing the relationships and interactions between practitioners, bioethics deals with relationships between practitioners and patients, practitioners and society, and society and patients. Issues within the realm of professional etiquette include billing, referrals, advertising, competition, conflicts of interest, professional courtesy, employment and supervision of auxiliary personnel, the use of secret remedies and exclusive methods, and the location and appearance of an office, ED, or urgent care center. These are quite different from bioethics' concerns of basic moral values and patient-centered issues. Although the two areas occasionally overlap, each relies on different standards, values, and problem-solving methods.

Ethics and Emergency Medicine

In the ED, the focus is inevitably on the inherent "medical" nature of each case; therefore, it should come as no surprise that ethical dilemmas often are not recognized as being in the ethical rather than the strictly medical realm. A second, related failing of the specialty is to misperceive ethics as embodying the "commands" of secular or religious law, or as a discipline that describes irresolvable issues.¹

This chapter addresses a number of ethical issues in emergency medicine. What follows are brief discussions of the relation of law to bioethics; bioethical values and principles; moral imperatives in emergency medicine; ethical oaths and codes; applying bioethics to clinical situations; bioethical dilemmas in emergency medicine; a rapid decision-making model for ethical dilemmas; advance directives; the relationship between consent, decision-making capacity, and surrogate decision makers; ethical issues in resuscitation; and ethical issues in public policy.

■ BIOETHICS AND THE LAW

Basic Considerations

Emergency physicians often look to the law for answers to knotty dilemmas. Yet, except in the rare cases of "black-letter law," wherein very specific actions are delineated, they are best served by turning to bioethical reasoning and using bioethics consultations. It is said that good ethics makes good law but that good law does not necessarily make good ethics. Societal values are incorporated both within the law and within ethical principles and decisions. Laws are rules of conduct established by legislatures, administrative agencies, courts, or other governing bodies. They often vary from locale to locale and are enforceable only in the jurisdiction where they prevail. By contrast, ethics is more universal, incorporating the broad values and beliefs of correct conduct. The primary differences between law and bioethics are shown in Table 200-1.

Modern bioethics developed during the past 4 decades because the law often has remained silent, inconsistent, or morally wrong on matters vital to the biomedical community. The rapid increase in biotechnology, the failure of both the legal system and legislatures to deal with new and pressing issues, and the increasing liability crisis drove the medical community to seek answers to the difficult questions practitioners had to work through on a daily basis.

Although bioethical principles do not change because of geography (at least not within one culture), interpretation of the principles may evolve as societies change. The same evolution occurs within the law. For example, elective abortion, once illegal in most U.S. jurisdictions, is now legal in most circumstances and jurisdictions. Likewise, all basic ethical

Table 200-1 Relationship between Law and Bioethics

BIOETHICS	FUNCTION/PRINCIPLE	LAW
✓	Case-based (casuistic)	✓
✓	Has existed since ancient times	✓
✓	Changes over time	✓
✓	Strives for consistency	✓
✓	Incorporates societal values	✓
✓	Basis for health care policies	✓
	Some unchangeable directives	✓
	Formal rules for process	✓
	Adversarial	✓
✓	Relies heavily on individual values	
✓	Interpretable by medical personnel	
✓	Ability to respond rapidly to changing environment	

Adapted from Iserson KV: Ethical principles—emergency medicine. In Schears RM, Marco CA (eds): Ethical Issues in Emergency Medicine. Emerg Med Clin North Am 24:515, 2006.

principles do not have universal support, just as the values implicit in many legal changes have divided U.S. society.

Rights and Duties

Significant overlap exists between legal and ethical decision-making. Frequently there is concurrence on basic issues. On occasion, clarity within the law can lead to clearer thinking in bioethics, and vice versa. Both law and bioethics, for example, use the term *rights*, as in “patients’ rights” and “the right to die.” This term, often used to advance an ethical argument about medical care, frequently is misunderstood or applied erroneously. A legal right is a demand that a person can make on another person, embodied in *in personam* rights, or against the state for recognition and enforcement of this demand, as in *in rem* rights. Most rights involved in bioethical discussions are *in rem* rights. These most often are negative rights because they entail someone else’s duty to refrain from doing something. A common source of ethical conflict is between “active rights,” the right to act or not act as one chooses, and “passive rights,” the right to not be acted upon by others in certain ways.²

Without a duty to act, there can be no rights. Both a moral and a logical connection exist between the rights and the duties of individuals; one cannot exist in the absence of the other. In general, a duty is an action required by the rights of others, the law, a higher authority, or one’s conscience.² This obligation to act can be based on an individual’s personal values, professional position, or other commitments.³ For the physician, this duty to act is a role responsibility, at least specifically as a physician and possibly at all times. The role-duty link occurs “whenever a person occupies a distinctive place or office in a social organization, to which specific duties are attached to provide for the welfare of others or to advance in some specific way the aims or purposes of the organization.”⁴ In this circumstance, performance is not predicated on a guarantee of compensation but, rather, on a concern for another person’s welfare.⁵ The EP has just such a duty.

VALUES

Values are the standards by which human behavior is judged. Values are learned, usually at an early age, through indoctrina-

BOX 200-1 COMMONLY ACCEPTED MORAL RULES

Moral rules govern actions based on ethics and codes of conduct. These can justifiably be enforced and their violation punished. Although none of these rules is absolute, they all require one not to cause evil. Somewhat paradoxically, however, they may not require either preventing evil or doing good.

1. Do not kill.
2. Do not cause pain.
3. Do not disable.
4. Do not deprive of freedom.
5. Do not deprive of pleasure.
6. Do not deceive.
7. Keep your promise.
8. Do not cheat.
9. Obey the law.
10. Do your duty.

Modified from Gert B: *Morality: A New Justification of the Moral Rules*. Oxford, Oxford University Press, 1988.

tion into the birth culture: from observing behavior and through secular (including professional) and religious education. Although many of these learned values overlap, each source often claims moral superiority over the others, whether the values are generic and cultural, legal norms, religious and philosophical traditions, or professional principles.^{6,7} Societal institutions incorporate and promulgate values, often attempting to solidify old values even in a changing society. In a pluralistic society, clinicians treat people with multiple and differing value systems, so they must be sensitive to alternative beliefs and traditions.

This section discusses the role of religious, patient, institutional, and professional values, including professional oaths and codes specific to emergency medicine.

Religious Values

Organized religions are recognized as keepers of society’s values. Even though various religions may appear dissimilar, most hold the golden rule, “Do unto others as you would have them do unto you,” as a basic tenet. Other moral rules that are common to most religions are listed in Box 200-1. Problems surface in trying to apply religion-based rules to specific bioethical situations. For example, although “Do not kill” generally is accepted, the activities that constitute killing, active or passive euthanasia, or merely reasonable medical care vary with the interpretation of the world’s religions as they do with the interpretations of various philosophers.⁸⁻¹⁰ As members of a democracy with significant populations practicing a number of religions, EPs should behave in a manner consistent with each patient’s values. The underlying question must be “What is the patient’s desired outcome for medical care?”

Not only religious but also family, cultural, and other values contribute to patients’ medical care decisions. Without asking, it is impossible to know what decision a specific person would make. An important point is that religion influences modern secular bioethics, which uses many religion-originated decision-making methods, arguments, and ideals. In addition, clinicians’ personal spirituality may allow them to relate better to patients and families in crisis.⁹

The terms *good* and *evil* can be used to illustrate a stark dichotomy in ethical thought and values. The following is a current set of definitions that may help the physician find solutions to ethical problems. *Good* can be defined as what no rational person will avoid without a reason. Examples are freedom, pleasure, health, wealth, and knowledge. *Evil* can be defined as what all rational persons desire to avoid for themselves and for others they care about. Examples are untimely death, pain, disability, and loss of freedom or pleasure.¹¹ Rational persons with deeply held religious beliefs may, for example, refuse blood transfusion, choosing a likelihood of death over the permanent pain and anguish they feel would ensue if they should violate their religious injunction.

Patient Values and Ethical Decisions

A key to making bedside ethical decisions is to know the patient's values. Although many people cannot answer the question "What are your values?" physicians can get an operational answer by asking patients what they see as their goal of medical therapy and why they want specific interventions. The responses represent concrete expressions of patient values. In patients who are too young or are deemed incompetent to express their values, it may be necessary for physicians either to make general assumptions about what a normal person would want in a specific situation or to rely on surrogate decision-making. But with patients who are able to reason and communicate, care must be taken to discover what they hold as their own, uncoerced values.

Although each individual is entitled, and perhaps even required, to have a personal system of values, certain values have become generally accepted by the medical community, the courts, legislatures, and society at large. Autonomy and individual dignity, for example, are two such values: They have been considered fundamental and often are given overriding importance. Although some groups disagree about each of these values, this dissension has not affected their application to medical care.

■ FREQUENTLY CITED BIOETHICAL PRINCIPLES

Nonmaleficence and Autonomy

The basic tenet all medical students are taught is nonmaleficence: "First, do no harm." This credo, often stated in the Latin, *primum non nocere*, derives from the recognition that physicians can harm as well as help. With the physician's fallibility recognized, patient autonomy is and has been for several decades the overriding professional and societal bioethical value. Autonomy recognizes an adult person's right to accept or reject recommendations for medical care, even to the extent of refusing all care, if that person has appropriate decision-making capacity. It is the counterweight to the medical profession's long-practiced paternalism (or parentalism), wherein the practitioner determines what is "good" for the patient, regardless of whether the patient agrees. Coupled with paternalism is coercion, the threat or use of violence to influence behavior or choice. The august figure in white combined with implied or explicit threats remains a potent force for counteracting patients' wishes. The thrust of modern bioethics is to respect patients by honoring their autonomy (Box 200-2).

BOX 200-2

COMMONLY ACCEPTED SOCIETAL AND BIOETHICAL VALUES

Autonomy: Self-determination: a person's ability to make personal decisions, including those affecting personal medical care. Autonomy is the opposite of paternalism.

Beneficence: Doing good. A duty to confer benefits. Production of benefit.

Confidentiality: The presumption that what the patient tells the physician will not be revealed to any other person or institution without the patient's permission.

Distributive justice: Fairness in the allocation of resources and obligations. This value is the basis of and is incorporated into society-wide health care policies.

Nonmaleficence: Not doing harm, prevention of harm, and removal of harmful conditions.

Personal integrity: Adhering to one's own reasoned and defensible set of values and moral standards.

Beneficence

At the patient's bedside, beneficence (doing good) and confidentiality (holding information in confidence) have been long-held and nearly universal tenets of the medical profession. Similarly, personal integrity (the adherence to one's own moral and professional standards) is basic to thinking and acting ethically.

Justice

The concept of comparative or distributive justice suggests that a society's comparable individuals and groups should share similarly in the society's benefits and burdens. Many society-wide decisions affecting thoughts and actions about the allocation of limited health care resources are based on this principle. Yet for individual clinicians to limit or terminate care on a case-by-case basis is an erroneous extrapolation of the perceived need to limit health care resource expenditures.⁷ Distributive justice is a policy concept, rather than a clinical model.

Truth-Telling

Personal integrity involves adhering to one's own reasoned and defensible set of values and moral standards and is basic to ethical thought and action. Integrity includes a controversial value within the medical community—truth-telling. Some people feel that the patient has the right to know the truth, no matter what the circumstances, and have championed absolute honesty. Yet many of these same people, when patients themselves, have been appalled by their physician's lack of sensitivity when relating unfavorable medical news.¹² In this context, being honest does not mean being brutal; truth is best tempered with a modicum of compassion.

Physicians accept a lack of truth-telling, depending on the circumstances. When patient harm may result from failing to disclose the truth, such as happened in the infamous Tuskegee experiments on black men with syphilis, it is not only immoral but also probably illegal to withhold the information. Likewise, when failure to disclose information is strictly for the physician's benefit, such as not telling a patient about a dismal prognosis or a medical error, the clinician's behavior suggests serious ethical and legal deficits. Perhaps truth-telling is not universally accepted within the medical profession

because of poor role models, lack of training in interpersonal interactions, and bad experiences, rather than because the value itself has been discounted. The issues become murkier when truth-telling, or lack thereof, involves a third party, such as a sex partner who has been exposed to an infectious disease.¹³

Confidentiality versus Privacy⁹

Stemming at least from the time of Hippocrates, confidentiality is the presumption that what the patient tells the physician will not be revealed to any other person or institution without the patient's permission.⁹ Health care workers have an obligation (duty) to maintain patient confidentiality. Occasionally, the law, especially public health statutes, may conflict with this principle, because they require physicians to report specific diseases, injuries and injury mechanisms, and deaths. Drug-seeker lists, long used in EDs, can be seen as violations of patient confidentiality, and especially without firm controls on patient entry and clinician access to these lists, they can directly harm patients.¹⁴ Rarely discussed are similar computer lists of previous ED visits that can be easily generated from most ED computer systems. The Health Insurance Portability and Accountability Act of 1996, a U.S. federal law designed to protect patient information, however, takes the principle of confidentiality to the extreme, resulting, paradoxically, in greater difficulty in obtaining crucial information needed to treat ED patients.

Privacy, which often is confused with confidentiality, is a patient's right to sufficient physical and auditory isolation that they cannot be seen or heard by others during interactions with medical personnel.⁹ ED overcrowding, patient and staff safety issues, and ED design limit patient privacy in many cases.

The increasing use of telemedicine to render advice and guide procedures at remote sites also places a strain on both patient privacy and confidentiality. Suggested ethical guidelines for such practice can facilitate the use of these new technologies without sacrificing either patient rights or physician duties.¹⁵

Another recent development has been filming ED patients for public viewing. Such filming, whether for medical records, education, peer review, or "reality television," encroaches on ED patients' reasonable expectation of privacy and confidentiality, because the recording can easily be distributed or misused. Although good reasons exist to allow such filming with patient acquiescence,¹⁶ the standard is now to abstain from such filming for commercial purposes and to require patient or surrogate consent for educational purposes.¹⁷

■ MEDICAL AND MORAL IMPERATIVES IN EMERGENCY MEDICINE⁹

Professional Values

Emergency clinicians, in both the out-of-hospital care and ED environments, operate with four imperatives: to save lives when possible, to relieve pain and suffering, to comfort patients and families, and to protect staff and patients from injury. All but the last of these also are the imperatives of most other clinicians, although saving lives may occur more often and more dramatically in emergency medicine settings.

Clinical Competency

Although it is tempting to use the latest instruments or medications, physicians have a duty to obtain competency in new

technologies, and to be informed of new medications, to decrease any risks to patients. Because there is little oversight of individual practitioners in this area, it remains a substantial matter for personal ethics.⁹

Emergency Medical Services Personnel Values

Emergency medical services (EMS) personnel are required to attempt resuscitation except when there is no chance that life exists (e.g., with decapitation, rigor mortis, charring of a body beyond recognition, decomposition). They usually have little leeway in whom to resuscitate, resulting in prolonged dying for some patients. The real answer is for primary physicians to educate the families of homebound, hospice-type patients to call their clinician to pronounce death, rather than 911.

Safety: A Unique Value

The last imperative, safety, is nearly unique to emergency medical clinicians. Both in the out-of-hospital and ED settings, clinicians often encounter dangerous situations in which the environment (e.g., fires, wilderness, floods), the patient, or a family member poses a threat. Although most try to accommodate basic patient rights, clinicians' priority must be their own safety and the safety of their coworkers. This priority does not imply that clinicians should ignore patient safety, but only that they should first ensure their own safety if they or their colleagues are at risk.

■ CODIFYING PROFESSIONAL VALUES: ETHICAL OATHS AND CODES

Conflicting Principles

In the abstract, bioethical principles often appear simple. However, clinicians adhere not only to basic bioethical principles but also, at least tacitly, to a number of professional, religious, and social organizations' ethical oaths, codes, and statements.⁹ This complexity can make for a confusing array of potentially conflicting bioethical imperatives. Because bioethical principles seem to be neither universal nor universally applied, the principles that are most patient-centered normally hold sway.

Organizational and Institutional Values

Institutions, including health care facilities and professional organizations, have their own value systems. Health care facilities, although relatively well standardized under the requirements of regulatory bodies and government agencies, often have specific value-related missions. Religiously oriented or affiliated institutions may be the most obvious of these, but charitable, for-profit, and academic institutions also have specific role-related values. The values of professional organizations often are set forth in their ethical codes.

Professional Codes

Through the years, the medical profession has codified its ethics more rigorously than any other professional group, incorporating many standard bioethics principles into its ethical codes and oaths. For generations, the existing part of the Hippocratic Oath set the ethical standard for the medical profession.¹⁸ Yet its precepts clash with modern bioethical thinking, and many subsequent professional codes have included what may best be termed economic guidelines and

Table 200-2 Comparison of Six Ethical Codes for Physicians

PRINCIPLE/CONCEPT	SAEM	ACEP	EMRA	AMA	AOA	HIPPOCRATIC OATH
Protect patient confidentiality		×	×	×	×	×
Maintain professional expertise	×	×	×	×	×	×
Committed to serve humanity	×	×	×	×	×	
Patient welfare primary concern	×	×	×	×		×
Considerate to patients, colleagues	×	×	×	×		×
Respect human dignity	×	×	×	×		×
Safeguard public health	×	×	×	×		×
Protect vulnerable populations	×	×		×	×	×
Advance professional ideals	×	×	×	×		×
Honesty		×		×	×	
Report incompetent, dishonest, impaired physicians		×	×	×		
Moral sensitivity	×	×		×		
Obtain necessary consultation				×	×	×
Altruism in teaching	×					
Fairness to students, colleagues				×		×
Obey, respect the law			×	×	×	
Prudent resource use	×	×				
Work to change laws for patient benefit				×	×	
Not abuse privileges	×					×
Respect for students	×					×
Choose whom to serve except in emergencies				×	×	
Ensure beneficial research by employing competence, impartiality, compassion	×					
No abortions						×
No euthanasia						×
Do not compromise clinical judgment for money			×			
Universal access to health care				×		
Preserve human life						×

ACEP, American College of Emergency Physicians; AOA, American Osteopathic Association; AMA, American Medical Association; EMRA, Emergency Medicine Residents' Association; SAEM, Society for Academic Emergency Medicine.

Adapted from Iserson KV: Ethical principles—emergency medicine. In Schears RM, Marco CA (eds): Ethical Issues in Emergency Medicine. Emerg Med Clin North A 24:531, 2006.

professional etiquette, along with ethical precepts.¹⁹ EP professional values have been incorporated into organization codes, such as the American College of Emergency Physicians' *Code of Ethics*, and into a more personal oath developed by the Society for Academic Emergency Medicine.^{20,21}

Most modern ethical codes prescribe only the same basic moral behavior for members to follow that is expected by the society at large and do not require any higher level of duty or commitment. In fact, many of the ethical issues that would seem to be important to medical specialties usually are not addressed in their codes. Even when topics of interprofessional interactions are excluded, existing medical professional codes differ markedly (Table 200-2). All, however, try to give a "bottom line"—that is, minimally acceptable—course of action.

■ APPLYING BIOETHICS

Emergency Physician–Patient Relationship

The EP has a markedly different relationship with patients from that typical for other practitioners, especially those providing primary care²²⁻²⁴ (Table 200-3). EPs care for patients who are unfamiliar to them and to the institution. Practitioners who either know their patients or who care for them in less acute settings often have the time and the mechanisms for

making sound ethical decisions, but EPs have more limited options. A suggested method for rapid, ethical decision-making in the ED setting is outlined in Box 200-3 and discussed in a later section.²⁵

Recognizing Ethical Problems

Although physicians like to reduce all clinical situations to "medical problems," today's increasingly complex medical environment often produces problems that are inexorably intertwined with fundamental bioethical dilemmas. Some are obvious, but many are more difficult to recognize.

Prioritizing Conflicting Principles

Once such dilemmas are recognized, applying bioethical principles to clinical situations can be confusing. When two or more seemingly equivalent principles or values seem to compel different actions, a bioethical dilemma exists. This situation is often described as being "damned if you do and damned if you don't," in which any potential action appears, on first reflection, to be an option between two seemingly equivalent goods or evils. In the following real case, taken from the book *Ethics in Emergency Medicine*, the attending physician can be said to be on the horns of a dilemma (involving two prickly but seemingly equal choices): Although only two options for

Table 200-3 Relative Differences between Emergency Practice and Primary Care Practice

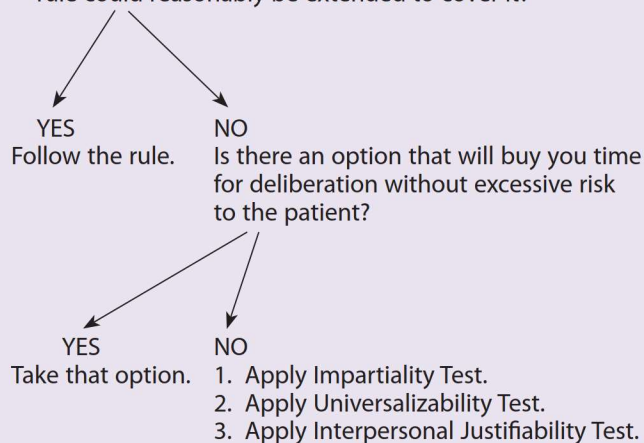
ED SETTING	PRIMARY CARE SETTING
Patient often is brought in by ambulance, police, or family.	Patient chooses to enter medical care system.
Patient does not choose physician.	Patient chooses physician.
ED personnel must gain patient's trust.	Physicians and nurses already enjoy patient's confidence and trust.
ED personnel do not know patient, family, values.	Physicians and nurses often already know patient, family, values.
Patient experiences an acute change in health status.	Patient has chronic medical problems.
Anxiety, pain, alcohol, and altered mental status are common.	Anxiety, pain, alcohol, and altered mental status are less common.
Decisions are made quickly.	There is usually time for reflection and deliberation.
Physician makes decisions independently.	Physician has greater opportunity to consult with patient, family, other physicians, ethics committees, lawyers, courts, ethicists.
Physician represents institution and medical staff.	Physician represents self or medical group.
Work environment is open and less controlled.	Work environment is private and controlled.
ED personnel frequently have a stressful work schedule.	Work schedule often is set or canceled by physician.

ED, emergency department.

Modified from Sanders AB: Unique aspects of ethics in emergency medicine. In Iserson KV, Sanders AB, Mathieu D (eds): Ethics in Emergency Medicine, 2nd ed. Tucson, Ariz, Galen Press, 1995.

BOX 200-3 A RAPID APPROACH TO ETHICAL PROBLEMS IN THE ED

Is this a type of ethical problem for which you have already worked out a rule, or is it at least similar enough that the rule could reasonably be extended to cover it?



ED, emergency department.

Modified from Iserson KV: An approach to ethical problems in emergency medicine. In Iserson KV, Sanders AB, Mathieu D (eds): Ethics in Emergency Medicine, 2nd ed. Tucson, Ariz, Galen Press, 1995.

action may be available, both options involve a number of conflicting bioethical principles.

Case Example: Conflicting Bioethical Principles

A 60-year-old man stabbed himself in the abdomen because of intractable pain from terminal pancreatic cancer, unrelieved by any medical therapy. A well-meaning friend, who happened to be in the house when the event occurred, called the paramedics, who brought him to the ED. Although the man will obviously bleed to death if not given aggressive care, neither the patient, who is still alert and oriented, nor his wife, who is present, wants any treatment other than pain control. A review of his chart confirms that his physicians are at a loss as to how to alleviate his pain and that he is expected to die within the next several weeks.²⁶ The physician believes in respecting a patient's autonomy, yet usually questions patients' decision-making capacity when they attempt suicide. Such patients' actions seem to raise the question of whether, in fact, they have a right or an ability to be autonomous. This physician also believes strongly in beneficence: helping those in need, relieving pain, and saving lives when possible. Beneficence suggests two alternative courses of action: palliative care or aggressive therapeutic intervention. Merely using analgesics and other comfort measures will abet a suicide; initiating aggressive medical and surgical interventions will prolong a dying process that the physician's colleagues have found to be unresponsive to even palliative treatment. Which value takes precedence: patient autonomy or beneficence? And if beneficence predominates, should it be aimed toward relieving suffering, prolonging life, or a third option that could include both? Bioethics deals with problems that are neither black nor white—only gray.²⁷

MEDICAL IMPERATIVES AND BIOETHICAL DILEMMAS

Clinicians have their own ethical values, as do professional organizations and health care institutions. Conscience clauses permit clinicians to “opt out” when they feel that they have a moral conflict with professionally, institutionally, or legally required actions. These conflicts, which may have a religious, philosophical, or practical basis, pose a barrier to use of the normal ethical decision-making algorithm. When such conflicts exist, it is morally and legally acceptable, within certain constraints, for the physician to follow a course of action based on his or her own value system. The constraint generally requires that timely and adequate medical care be provided for the patient—which may be particularly difficult to achieve in emergency medicine. When conflicts over values exist, however, it is essential for the practitioner to recognize the patient's identity, dignity, and autonomy, to avoid the error of blindly imposing personal values on another.⁹

Professional Value Conflicts

The imperative to save lives causes the most conflict between EPs and intensive care unit (ICU) clinicians. EPs recognize that some of the intubations and resuscitations they perform will be unwanted by patients or surrogates. Nearly all EPs have on occasion been berated by an irate intensivist or private practitioner for resuscitating a patient “who should not have been resuscitated.” Many families have heard these physicians criticize the ED and ambulance staffs for overaggressive resuscitative efforts. Nevertheless, the lifesaving imperative begins when the ambulance is called.

One classic dilemma is that posed by the exsanguinating adult patient, awake and still with medical decision-making

capacity, who explicitly states a refusal to accept any blood or blood products based on religious beliefs. The physician, with a professional duty and moral commitment to preserve life, does not agree with the patient's decision. Yet society (through the benchmark of court decisions) has repeatedly sided with the patient. In this case the patient's autonomy and right to practice his or her religion are recognized as the overriding values. The case becomes less clear when the patient does not have decision-making capacity, is a minor, or appears to be under external pressure to make a life-threatening decision.

Other examples of ethical problems and conflicts in emergency medical care are uncertainty regarding resuscitation efforts, especially when patients and families may not want such efforts; teaching, particularly in critical situations or using procedures performed on the newly deceased; EMS control, when administrative rules and good patient care conflict; helping others when one's own life may be placed at risk; and patient access, such as limited financial and personnel resources in the face of obvious patient need. Even if these problems do not fit into the classic form of a dilemma, they may be recognized as bioethical problems because they require the clinician to make a choice between two (or more) accepted values.

Rapid Ethical Decision-Making Model

The rapid ethical decision-making method of ethical case analysis, described in *Box 200-3*, is designed as a way of avoiding an ethically incorrect course of action for the EP in need of a fast answer to an ethical dilemma. A decision based on a known precedent—the first step—is the most productive way to use this method. However, such decision making requires advance planning, in-depth reading, and thought regarding ethical problems. Just as with the indications for any emergency procedure, EPs should at the very least be prepared with a course of action for the most common ethical dilemmas they may face in the ED.

Even the prepared clinician, however, can encounter cases without relevant known precedents. With no precedent to rely on and no way to “buy time,” the practitioner must select a possible course of action and test it for ethical validity. In such instances, three tests—the Impartiality Test, the Universalizability Test, and the Interpersonal Justifiability Test—can be used. The *Impartiality Test* asks whether the practitioner would accept this action if he or she were in the patient's place. In essence, this is a form of the golden rule. The *Universalizability Test* asks whether the practitioner would feel comfortable having all practitioners perform this action in all relevantly similar circumstances. This involves generalizing the action to all colleagues and then asking whether a rule for the contemplated behavior is reasonable. The *Interpersonal Justifiability Test* asks whether the practitioner can supply good reasons to others for the action. Will peers, superiors, or the public be satisfied with the answers? If the answer to the question posed in each of the three tests is affirmative, then the practitioner has identified a reasonable probability that the proposed action falls within the scope of ethically acceptable actions.²⁵

Advance Directives

The term *advance directive* describes several types of legal and quasilegal documents. These documents indicate what is to be done for a patient *in extremis* who is no longer able to give or withhold permission for medical treatment. Advance directives usually are written to avoid prolonging an inevitable, often painful or nonsentient dying process. However, they also can be used to instruct surrogates and the patient's medical team to “do everything,” whenever possible. Advance direc-

tives include the living will, durable power of attorney for health care (DPAH), prehospital advance directive (PHAD), and mental health advance directive (MHAD). Although do-not-attempt-resuscitation (DNAR), do-not-hospitalize, and out-of-hospital DNAR orders also are discussed in this section, they are not considered to be advance directives but rather are physician orders, because they are not patient- or surrogate-initiated. All play a role in emergency medicine.^{28,29}

Do-Not-Attempt-Resuscitation Orders

DNAR orders, also known as allow-natural-death (AND) and do-not-initiate-resuscitation (DNIR) orders (still somewhat naively called do-not-resuscitate [DNR] orders in many locales), are physician orders informing other medical personnel that they should not institute cardiopulmonary resuscitation (CPR) in the event of cardiopulmonary arrest. (The DNAR order is not strictly an advance directive but does serve to transmit a conditional order to other health care personnel and is operative only if the patient's condition follows a certain pattern.) Ideally, this order is written only after consultation with the patient (who possesses decisional capacity) or with the patient's family or surrogate decision maker. It usually is written only for patients for whom CPR will not achieve the patient's goals of therapy. These orders usually work well within a specific institution, but if patients are transferred to the ED from another facility, the act of transfer or the activation of the EMS system usually negates the order. This outcome can be directly contrary to a patient's wishes regarding terminal care. However, if a patient arriving in the ED still has the capacity to make a decision concerning resuscitation, part of the EP's duty is to document such a decision in the patient's chart, including the specific actions to be limited, the circumstances of the discussion, and the people present during the discussion.^{30,31} Many institutions have now recognized that simple DNAR forms are inadequate descriptions for other health care personnel to interpret and thus have changed to or added a limitation-of-treatment form specifying exactly what is not to be done for a patient (e.g., antibiotics, blood products, mechanical ventilation, surgery).

Do-Not-Hospitalize Orders

One type of physician order that has been used successfully in many locales is the do-not-hospitalize order. Normally used for hospice and nursing home patients, it prevents many unwanted ED resuscitation attempts and procedure-laden hospitalizations. Do-not-hospitalize orders instruct nurses not to send the patient to the hospital if further medical interventions are not desired either by the patient or the surrogate decision maker. Compliance with this physician order allows people to die peacefully, rather than having the “last rights of CPR” performed when such interventions would be futile or unwanted. The only caveat to applying do-not-hospitalize orders is that staff members must understand that patients should still be sent to a hospital if they need palliative care not available in the nursing facility.

Out-of-Hospital Advance Directives

As of 2003, 43 U.S. jurisdictions had enacted methods whereby patients outside of health care facilities can avoid unwanted resuscitation attempts. These methods usually take the form of preparing either an out-of-hospital DNAR order or a prehospital advance directive (PHAD).³² Although often confused, the two forms differ greatly in their philosophies. The out-of-hospital DNAR order is a physician-originated document.³³

The PHAD is generated by a patient or legal surrogate, with little or no involvement by health care personnel. Both instruct EMS personnel who have been erroneously called at the time of death not to attempt to resuscitate the patient, or to stop resuscitation efforts if they have already begun when such a form is found. Both types of form have proved effective.³²⁻³⁴ The most common reason for having physician-initiated forms is the fear that murders and suicides could be aided by patient-initiated documents. In practice, this has not occurred.

Of the existing protocols, 34 were specifically authorized by statute, usually supplemented by regulation or guidelines. Eight states implemented protocols solely through regulations or guidelines, without a change in their legal code. Eight states have no statewide protocol in place. In an affront to patient autonomy, 39 are physician orders requiring a physician's signature (7 states require only a physician's signature; 33 states require signatures of both a physician and the patient).³⁵ Three protocols are patient-initiated advance directives that are valid with a witnessed patient signature, with no physician involvement required.³⁵ These instruments are of variable complexity; some include liability protection for EMS personnel and base station providers, and some may be usable for pediatric patients.³²⁻³⁷ Table 200-4 contains a list of the elements ideally included in a PHAD/DNAR policy.

Out-of-hospital DNAR orders or directives must be understandable to all involved, including EMS personnel, physicians, patients, family members, and police, who also may

respond to a 911 call. These documents can take many forms, such as a uniform system of state forms, physician orders, standard wallet identification cards or identification bracelets, and other mechanisms approved by the local EMS system. The ideal out-of-hospital directive should continue to be effective if the patient is transferred to a health care institution, at least in the ED.³²

Living Will

The *living will* is a relatively standardized form adopted in most states and the District of Columbia. (Michigan and Massachusetts do not have authorizing statutes.) This document usually requests that health care workers not perform future resuscitative measures, but on occasion it requests the opposite—that all measures be taken to keep the patient alive. It goes into effect only if the patient lacks decision-making capacity; until that point, the patient continues to determine the medical course, despite anything said in a living will. Living wills normally require both that a physician certify a person as terminally ill and that the patient have the mental capacity to understand its provisions at the time it is signed. (Arizona, in a break with tradition, does not use “terminally ill,” because all extant definitions are unclear. No ill effects have resulted.³⁷) States allow various levels of specificity in the document, including, in some cases, the ability to refuse artificial nutrition and hydration.

Table 200-4 Guidelines for Developing an Out-of-Hospital Advance Directive Policy

Policy Scope

To ensure maximum coherence and compliance, a comprehensive out-of-hospital DNAR policy should be endorsed by the widest possible jurisdiction, comprising local, regional, state, and the medical community, including the EMS governing body. Whenever feasible, legislative support for such a policy should be sought.

Policy Guidelines

1. Note the established fact that current basic and advanced life support interventions may not be appropriate or beneficial in certain clinical settings.
 - Develop a means to educate the public about the appropriate use of 911 after expected deaths.
 - Establish the fact that comfort care and palliative care are affirmative actions for patients with DNAR orders. These appropriate interventions, including hospice and respite care, do not require EMS activation and often can be arranged by calling the patient's physician in anticipation of death.
 - Develop a means to educate health care workers on topics of advance directives, including information on local out-of-hospital DNARs, community hospice alternatives, and bereavement services.
2. Establish consensus on the ideal identification device for DNAR directives to ensure continuity of care across settings.
3. Reiterate that initial resuscitative attempts usually are indicated when the patient's wishes are not known.
4. Define the conditions under which an out-of-hospital DNAR order can be considered, including its use in long-term care settings and in the emergency department.
5. Define which patients have the decisional capacity to agree to a DNAR order and whether surrogates can sign such orders.
6. Establish a mechanism for determining the precedence of various directives, including living will, durable power of attorney for health care, and out-of-hospital advance directive (i.e., DNAR order).
7. Develop a statutory prioritized list of surrogates to use when there are no advance directives and the patient's decisional capacity is impaired.
8. Consider language acknowledging the growing home hospice movement as it concerns children, and incorporate provisions for document use in minors.
9. Establish that the decision not to attempt resuscitation must be an informed decision made by the patient or the surrogate.
10. Identify the information that should be contained in the DNAR order and the authority that will be responsible for developing such a mechanism.
11. Identify the clinical procedures that are to be provided and those withheld in the adherence to the DNAR order, or specify the authority that will verify adherence.
12. Define the exact manner in which the DNAR order is to be followed, including the role of online medical direction. Each system should ensure that a communication path to access online medical direction is immediately available, when necessary.
13. Establish legal immunity provisions for those who implement DNAR orders in good faith.
14. Establish data collection and protocol evaluation to perform periodic operational assessments.
15. Identify permissible exceptions to compliance with DNAR out-of-hospital directives. For example:
 - The patient is able to revoke a written directive at any time.
 - The EMS personnel can cancel the out-of-hospital DNAR order if there are doubts about the document's validity.

DNAR, do-not-attempt-resuscitation; EMS, emergency medical services.

Modified from Schears RM, Marco CA, Iserson KV: 'Do-not-attempt-resuscitation' (DNAR) policy in the out-of-hospital setting. *Ann Emerg Med* 44:68, 2004.

Most living wills specify that the patient's physician must have seen and accepted the document's provisions in advance. This requirement establishes a physician who will act on the patient's behalf. For physicians, it protects those whose value systems will not allow them to abide by the document's provisions. It also encourages families and physicians to discuss the circumstances surrounding the time of death and the actions they can take.³⁸ The EP will rarely, if ever, be in the position of having accepted a living will's provisions. In the setting of an ED resuscitation, the best that a living will can do, assuming that the patient is correctly identified, is to suggest what the patient's wishes were. It does not in any way restrict the EP's actions.³⁹

The limitation of living wills is that they list specific actions—either to take or to eschew—in a particular set of circumstances. This specificity reduces the usefulness of such documents and has led to a more flexible and powerful advance directive that names a trusted surrogate decision maker, the DPAH.

Durable Power of Attorney for Health Care

A more commonly used advance directive that specifies a surrogate decision maker is the *durable power of attorney for health care* (DPAH). It goes by many other names, including *durable power of attorney with medical provisions* and *medical directive*. All states and the District of Columbia have statutes authorizing such directives. In its usual form, a durable power of attorney (other than for health care) takes effect immediately. However, a DPAH takes effect only when the individual no longer has the capacity to make his or her own medical decisions.

Typically, a relative or close friend is named as a surrogate, because such persons should know something about the patient's values related to medical treatment. More than one surrogate may be named; they generally are listed in preferential order, with the first being someone who is able to be contacted and is willing and able to act as surrogate in making the decisions.³⁸

The DPAH allows more flexibility than a living will, because the surrogate is able to make any health care decisions that the patient would ordinarily make, including gathering new information and choosing among multiple treatment options as the medical situation changes. Optimally, the surrogate's decisions are guided by other written or oral directions the patient has left, including those in a living will. In reality, surrogates often consider many factors when making decisions.⁴⁰

Mental Health Advance Directives

Mental health advance directives (MHADs), also known as *psychiatric advance directives* (PADs), were introduced in the 1980s so that psychiatric patients could specify their preferences regarding future mental health treatment during acute psychiatric illnesses.⁴¹ MHADs allow psychiatric patients to document in advance their acceptance or refusal of particular types of mental health treatment and intervention. Some of these laws also incorporate authorization of proxy decision makers specifically for mental health treatment. Most MHADs can be revoked only if the patient regains decision-making capacity.⁴² In practice, civil commitment laws usually override MHADs, as do clinicians who, acting in good faith, consider the instructions to be inconsistent with accepted clinical standards of care.⁴³

Nonstandard Advance Directives

EPs occasionally encounter medallions, tattoos, or other indications that seem to be advance directives.^{44,45} To be useful,

advance directives must be available to the treating clinicians when they are needed, be a product of the patient's (or sometimes the surrogate's) deliberations, and be understandable, and must be applicable in the patient's current medical situation. Nonstandard directives, usually abbreviated or abstract (such as a tattooed symbol for "do not defibrillate"), fail to meet these requirements. Of special concern is whether the patient or the surrogate understood how this "directive" might be interpreted or whether it still communicates the patient's wishes. In general, EPs should not rely on these indicators to make critical patient decisions.

■ CONSENT, DECISION-MAKING CAPACITY, AND SURROGATE DECISION MAKERS

Respect for patients, the basis for patient autonomy, requires that adults consent before undergoing medical interventions. To give consent, they must retain decision-making capacity. When patients cannot make their own health care decisions, others must make such decisions for them. In such situations, three questions arise: What does "consent" mean in the ED? How can clinicians determine when patients lack such capability? Who then makes the decision?

Consent

Patients can provide three forms of consent: presumed, implied, and informed. Many patients may provide all three types of consent at different times during a single ED visit. Because clinicians use all three types of consent in EDs, and all are ethically and legally valid, clarifying the differences between them is in order.⁴⁶

The concept of *presumed consent* most commonly applies when patients are informed of what will occur and they do not refuse treatment. They allow themselves to be rolled on a gurney to the radiology suite to have a urethral catheter placed, and they remain still while being sutured. The more dramatic ED scenario involving presumed consent is the arrival of moribund patients with grave, often unstable conditions for which a reasonable person would be expected to want treatment. In those cases, clinicians "presume" that rational patients would want treatment. A question that must be raised, however, is whether those patients would want interventions even in the absence of a reasonable chance for meaningful (from the patient's standpoint) survival. Futility often is discussed from the clinician's perspective; whether patients would give consent in these circumstances raises the question from the more valid patient's perspective.⁴⁶

Implied consent is operative when patients actively cooperate with the procedure, such as when they extend the arm for phlebotomy or lift the blouse so ECG leads can be placed.⁴⁶ Working under presumed or implied consent does not signify absence of patients' concern regarding the procedure or its complications. Rather, patients may (1) believe they know enough about the procedure to permit it or to cooperate with it without further questioning, (2) be in a condition (e.g., unconscious) in which they are unable to communicate, or (3) feel too afraid (e.g., of the clinician or hospital authority) or uncomfortable (e.g., because of a language barrier) to ask.⁴⁶

Informed consent assumes that a patient who has decision-making capacity has been given all pertinent facts regarding the risks and benefits of a particular procedure, understands them, and voluntarily agrees to undergo the procedure.⁴⁶ Even if a patient with decisional capacity does not ask about a complex or potentially dangerous procedure, the clinician is obligated to provide information about the associated risks and benefits, unless the patient specifically asks not to be told. In

those cases, the patient should be asked if he or she would like a relative or friend present in the ED to be told. This person need not be the patient's surrogate but may later help to explain what occurred to the patient.⁴⁶

Informed consent relates to both law and ethics. Respect for persons is the requirement's ethical bulwark; statute and common law provide the legal rationale. Physicians have a professional and moral obligation to provide their patients with the information necessary to make informed decisions. Communicating honestly with patients so that they may participate in decision-making is a recent, rather than historical, imperative. Based on a respect for patients, this cooperative physician-patient relationship reverses the paternalism that, since Hippocratic times, has guided physician interactions with patients.^{46,47}

Virtually all states, either in statute or by common law, now require physicians to inform patients about treatment choices and the associated risks and benefits. The legal standard for the information provided is either the "community standard" (also known as the "professional community standard" or the "reasonable physician standard") or the "materiality standard" (also known as the "reasonable or prudent or subjective patient standard"). The former asks: "What would a prudent physician in the same community, with the same background, training, and experience have disclosed to a patient in the same or similar situation?" The latter asks: "What would a reasonable patient in the same or similar situation need to know to make an appropriate decision?"^{46,47}

Of interest, great variability exists in the legal requirements. For example, although most of the nation's EDs require informed consent for many regional anesthetic blocks, closed fracture reductions, abscess incision and drainage, lumbar punctures ("spinal taps"), injection of radiocontrast agents and radionuclides for radiography, and nonemergency thoracostomy (chest tube placement), Texas statutes eliminate any requirement to disclose the specific risks or hazards before these procedures are performed.^{46,48}

Decision-Making Capacity

Many ethical dilemmas in emergency medical care dissolve on ascertaining the patient's decision-making capacity, often linked with consent to (or, more commonly, refusal of) a medical procedure. A basic canon of both ethics and law, as stated by Justice Benjamin Cardozo, is that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body ..."⁴⁹ These situations often can be clarified by an appreciation of what is meant by decision-making capacity and how it relates to consent.

EPs must be prepared to decide quickly whether patients lack decision-making capacity—the ability to make their own health care decisions. Although a lack of capacity is obvious in the unconscious or delirious patient, it often is less apparent when the patient remains verbal and at least somewhat coherent. Because such decisions in emergency situations often are time sensitive, unlike in other medical venues, bioethics consultations may not be readily available.

In clinical practice, the word *competence* often is used to mean *capacity*. *Competence* is a legal term and can be determined only by the court. *Capacity* refers to a patient's ability to make decisions about accepting health care recommendations. Capacity is always decision-relative rather than global. Although an inebriated person can have the capacity to refuse to have a small laceration sutured, especially if there is evidence of prior refusal without remorse, the same person may not have the capacity to agree to an elective operation or to refuse to have an emergent lifesaving procedure or operation. To have ade-

BOX 200-4 COMPONENTS OF DECISION-MAKING CAPACITY

1. Knowledge of the options
2. Awareness of consequences of each option
3. Appreciation of personal costs and benefits of options in relation to relatively stable values and preferences*

*As part of the assessment for capacity, the patient should be asked about why he or she made a specific choice.

Modified from Buchanan AE: The question of competence. In Iserson KV, Sanders AB, Mathieu D (eds): *Ethics in Emergency Medicine*, 2nd ed. Tucson, Ariz, Galen Press, 1995.

quate decision-making capacity in any particular circumstance, the person must understand the options, the consequences of acting on those options, and the costs and benefits of the consequences in relation to a relatively stable framework of personal values and priorities^{50,51} (Box 200-4). Disagreement with the physician's recommendation is not in itself grounds for determining that the patient is incapable of making a decision. In fact, even refusing lifesaving medical care may not prove the person incapable of making valid decisions if it is done on the basis of firmly held religious beliefs, as in the case of a Jehovah's Witness patient who refuses a blood transfusion.

Surrogates

If patients lack capacity to participate in some decisions about their care, surrogate decision makers must become involved. In most locales, the patient's advance directive may designate surrogates, or such persons or agencies may be detailed in institutional policy or law. Surrogates often include spouses, adult children, parents (of adults), and others, including the attending physician. On occasion, bioethics committees or the courts will need to intervene to help determine the decision maker.

Children represent a special case. Persons younger than the age of majority (or unemancipated) usually are deemed incapable of making independent medical decisions, although they often are asked to give their assent to the decision, allowing them to "buy in" to their medical treatment plan. In many cases, when determining whether a child has decision-making capacity, the same rules as those that apply to adult capacity are used. The more serious the consequences, the more the capacity to understand the options, consequences, and values involved is required of children to make a decision.⁹

In the relatively rare case in which a patient has a court-appointed guardian for health care decisions, the guardian's decisions supersede those of both the patient and any other surrogates. Even if a parent is present, it is not always clear that the adult is acting in the best interest of the child. In such cases, child protective services may need to become involved. Disagreements between parents may, in extreme cases, require the involvement of bioethics committees or the courts.

Family

Traditionally, and usually in practice, the family, in particular the spouse, acts as a surrogate decision maker when the patient does not have the capacity to make medical decisions. Yet even when there is a strong family tie, emotional or fiscal costs may sway the surrogate decision maker from certain courses of action the patient would wish taken.

Surrogates make decisions based on two distinct patterns: substituted judgment and best interests. *Substituted judgment* is used when there is an assumption that the surrogate knows enough about the patient's values to make a decision similar to that which the patient would make. It is not clear that anyone knows that much about a person to make decisions in every situation.^{52,53} Surrogates use the *best interest* standard when they do not know what the patient would want done in a particular situation but, as in the case of Karen Ann Quinlan, they can use earlier statements and behavior to document the patient's values and then make a decision.⁵⁴ Some states may require explicit written directives for surrogates to follow.^{55,56} The best interest standard also applies, as in the Saikewicz case, when the patient has never had adequate decision-making capacity.⁵⁷ Unless there is already a court-appointed guardian, these situations often end up in court.

Surrogate Lists

If a patient lacks decision-making capacity and has no advance directive, many states provide that another person may automatically become the person's surrogate. In practice, this almost always means that the patient's spouse may act in that capacity. Some states now have a statutory surrogate list to simplify the process. The most extensive of such lists, which has worked well for nearly 2 decades, specifies surrogates in the following order: spouse (not divorced or legally separated), a majority of the adult children who can be reasonably contacted, parents (of an adult), domestic partner, sibling, close friend, and attending physician in consultation with a bioethics committee.³⁷

Bioethics Committees and Consultants

Multidisciplinary committees have been developed in most large hospitals to consult on cases with bioethical dilemmas and also may participate in surrogate decision making.³⁷ These committees usually have four main functions. First, they coordinate education on bioethical issues involving clinical care for the committee members, hospital physicians and staff, patients, families, and the local community. Second, they help institute mandatory or suggested policies or guidelines for health care professionals regarding decision-making processes in problematic cases and resource allocation. Third, they consult prospectively and retrospectively on clinical cases and offer advice and conclusions to those directly involved, most often concerning the treatment or nontreatment of patients who lack decision-making capacity. Ethics committees usually do not act as the primary decision makers. Rather, its members serve as consultants, providing information, advising, and supporting the primary decision-making role of the patient-family-physician triad. A common consultation relates to urgent decisions about withholding, withdrawing, or continuing life-sustaining medical care. A large part of ethics committee work consists of clarifying the facts and fostering communication.⁵⁸ Some smaller hospitals have bioethics consultants rather than committees to perform many of the same functions. In 1995, The Joint Commission (formerly the Joint Commission for the Accreditation of Healthcare Organizations [JCAHO]) began requiring that hospitals ensure that ethics committees' functions are accomplished.⁵⁹

Physicians

In the past, physicians made unilateral decisions for their patients, regardless of whether the patients had the capacity to decide for themselves. This still occurs, of course—especially

for the acute illnesses and unexpected injuries seen in EDs. There is a tendency for physicians to determine that a patient does not have the capacity to make medical decisions simply because the patient disagrees with the clinician. If the patient's decision-making capacity is questioned in the ED, the clinician often is forced to make a decision without assistance. But when it is possible to "buy time," clinicians should consult with colleagues and, if possible, the hospital's bioethics committee (see Box 200-3). When making unilateral decisions, physicians should recognize that they are not omniscient. Prognoses often are incorrect and medical knowledge is finite.

Courts

The courts often act as the final adjudicators of disagreements over medical care. They appoint legal guardians and, in a few select cases, set precedent that is followed as health law. The courts, however, usually are neither expeditious nor necessarily cognizant of bioethical principles. They are instructed only to follow the societal values codified in the law. Many courts have suggested that, whenever possible, health care decisions should remain at the bedside rather than in legal chambers.⁵⁴⁻⁵⁶

■ RESUSCITATION ETHICS

The most time-dependent of all activities and arguably the best training periods in the ED occur during resuscitations. The patients who require this care have implicitly been guaranteed that all appropriate medical knowledge and skill will be brought to bear to attempt to save their lives. This implied promise leads to a dilemma. If the most proficient ED professional always leads the resuscitations and performs procedures, the patient will receive the maximum beneficence, as well as nonmaleficence, as expected. Yet restricting ED practice in this manner also deprives future patients of trained clinicians who could bestow the same beneficence.

This controversy has raged for many years. The appropriate balance seems to be that training in EDs can ethically proceed, as it does in other areas of medicine, if safeguards are provided in the form of on-site supervision by experienced clinicians to ascertain that the patients do receive the best possible and appropriate care. It also has been suggested that medical students and residents could be certified for cognitive and procedural skills in a manner similar to that for other hospital physicians. This certification would enable faculty to know when trainees are capable of performing resuscitations, as well as other medical procedures, on their own.⁶⁰

Rarely discussed, but a common practice in some teaching hospitals, has been the custom of allowing trainees with little skill or knowledge to learn and practice procedures on those undergoing resuscitation only when a patient is deemed "unsalvageable."⁶¹ This practice does a disservice to the patient, because prolonging resuscitative attempts solely for this purpose may lead to a clinical state that prolongs dying. It also harms the family and society by making them pay for unnecessary procedures.

Futility⁴⁶

Emergency physicians, nurses, and emergency medical system (EMS) personnel may, in some circumstances, feel that further medical interventions are "futile." Yet only three situations meet the most commonly accepted definition.⁶² The first such situation, which clinicians can identify only in a very limited set of circumstances, is that in which the intervention is effec-

tive in less than 1% of identical cases, based on the medical literature. ED thoracotomy for blunt trauma is a well-documented example. Another common scenario with survival rates approaching zero is that of the out-of-hospital cardiac arrest, either unwitnessed or in a patient who arrives from a long-term care facility.⁶³ Individual clinicians should not rely on their own experiences to make such decisions, however, because they often are skewed owing to selective memory, limited numbers of similar cases, and other biases.

The second futile situation is physiologic futility, in which known anatomic or biochemical abnormalities will not permit successful medical interventions. Examples of such abnormalities generally accepted by EMS systems as reasons not to intervene or provide transport to hospitals are rigor mortis, algor mortis, burns so severe that the victim is beyond recognition, and injuries incompatible with life (e.g., decapitation). These, along with prolonged normothermic resuscitative attempts without success or prolonged “down time” with an isoelectric ECG, and pulseless electrical activity (PEA) are the criteria often used to help determine whether EMS personnel can pronounce death on the scene. In these instances, EMS need not expend valuable resources in a futile resuscitative effort.

The third situation is that in which the proposed intervention will not achieve the patient’s goals for medical therapy in accordance with the patient’s values. Recognizing this instance, the American College of Emergency Physicians asserted, “Physicians are under no ethical obligation to render treatments that they judge have no realistic likelihood of medical benefit to the patient.”⁶⁴ Because this course of action is based on knowing the patient’s values related to medical treatment, it is necessary to have talked with the patient in advance (rare in the ED setting), to have received surrogate-supplied information or decisions, or to have access to the medical record. The danger is that differences in values between caregivers and patients may lead to over- or undertreatment. Communication, if necessary using a third party, may help to resolve these issues.

The futility concept should never be used to deny care to dying patients. Even terminal patients experience medical emergencies that require intervention. The goal is to ease pain and suffering. How that is accomplished depends on the patient, the medical condition causing discomfort, and their value system.

Withholding versus Withdrawing Treatments³⁸

In emergency medicine, a significant difference *rightfully* exists between the withholding and the withdrawal of life-sustaining medical treatment. The justification for this distinction stems, in part, from the nature of the practice of emergency medicine and the unique manner in which emergency medicine clinicians apply many ethical principles. Because EPs often lack vital information about their patients’ identities, medical conditions, and goals for medical treatment, withholding emergency medical treatment is more problematic than is later withdrawing unwanted or useless interventions. Owing to the nature of emergency medicine, in both out-of-hospital and ED settings, higher standards are required to withhold medical treatment than to withdraw it.⁶⁵

Physicians should begin or continue resuscitation on those patients who arrive at the ED without sufficient evidence to determine that the resuscitation effort will be unsuccessful. The only reason to *withhold* CPR is the availability of clear evidence, such as a standard advance directive, that the patient did not wish to have this done, or of clinical evidence that

further efforts would be futile.³⁸ Without such information, the presumption must be to intervene.

Once the EP obtains information confirming a patient’s wish not to be resuscitated or indicating a medical condition not amenable to resuscitation, resuscitative efforts and other medical treatment may appropriately be withdrawn. This information may be obtained from an advance directive, a patient surrogate, recent documentation in the medical chart, or EMS communication detailing the failed results of the ongoing resuscitative effort. With rare exceptions, such as after failed suicide attempts, resuscitative efforts should be withdrawn when information is provided either that the patient did not want such efforts or that the patient’s medical condition precludes success.^{66,67}

Many factors influence the potential success of resuscitative efforts, including time to CPR; time to defibrillation, placement of an intravenous line, and first epinephrine dose; time to insertion of first advanced airway device; presence of comorbid illness; prearrest clinical status; and initial arrest rhythm. No combination of these factors, however, clearly predicts the outcome.^{68,69} The most important factor associated with poor outcomes is the *duration* of unsuccessful resuscitative efforts.

The possibility of a successful resuscitation becomes clearer as time progresses: A patient’s chance of being discharged from the hospital alive and neurologically intact diminishes if spontaneous circulation does not return after 10 minutes of intensive resuscitative efforts.^{30,70-72} Malpractice concerns have led some physicians to prolong all resuscitation attempts until they reach the point at which there have been no survivors.⁶⁸ In reality, cardiac resuscitation with properly executed advanced cardiac life support (ACLS) interventions and documented asystole should not last more than 30 minutes and usually should end much sooner, except in unusual circumstances such as with prearrest hypothermia, after some drug-induced events, following lightning or electrical shocks, or in infants or children with refractory ventricular fibrillation or tachycardia.^{68,72-77} Without these mitigating factors, prolonged resuscitative efforts are unlikely to be successful.⁴⁶

Three special situations should be noted: (1) Cardiac arrest from blunt trauma is nearly uniformly fatal, so little benefit derives from doing chest compressions for any extended period after the airway is secured.⁷⁸ (2) When health care resources are limited, such as during disasters, available resources, such as time, personnel, and equipment, should be devoted to treating those patients with the greatest chance of benefiting. This principle may lead to withholding or more rapid discontinuation of resuscitative efforts than is standard in normal practice. (3) It is unethical to prolong resuscitative efforts to practice or teach procedures or to complete research protocols.⁶⁷

Palliative Care

Although lifesaving medical interventions may not be appropriate in all cases, EPs, whenever possible, should provide patients with palliative care. Terminally ill and fatally injured patients have the right to receive state-of-the-art palliative care.⁷⁹ Palliation often includes analgesics and may include diuretics, sedation, oxygen, paracentesis or thoracentesis, and other medications or procedures to alleviate suffering. Medical personnel should never withdraw or withhold care; only treatment should be withheld when appropriate. Although medical practitioners, surrogate decision makers, and sometimes patients find it emotionally easier to forgo new interventions than to withdraw ongoing treatment, no orders, policies, or directives should ever prevent EPs from alleviating discomfort.¹

The purpose of palliative interventions is not to prolong the dying process but rather, when death is inevitable, to make it as comfortable as possible for the patient. As patient advocates, EPs may need to “push” to have the patient admitted to a hospital, hospice, or nursing home, or to get ancillary personnel (e.g., social workers, home health nurses) to intervene for the patient.¹

Notifying Survivors

Death, especially when it is sudden and unexpected, shocks and devastates family and friends. For them, it is a life-changing event, with every nuance burned into their memories. Moreover, although they may not consciously acknowledge it, such losses also may deeply affect ED personnel, despite their almost constant exposure to life’s disasters. This makes death notifications and dealing with the survivors both vitally important and extremely difficult. EPs, who deal with sudden death on a daily basis, are in a position to gain considerable knowledge of and to hone their skills in how to care for the survivors, their newest patients.⁸⁰

Even though notifying survivors of a sudden, unexpected death is one of the most difficult parts of the EP’s job, they and other professionals whose job includes delivering news about sudden, unexpected deaths rarely are taught the skills necessary to perform this task. Notifying survivors is emotionally draining—70% of EPs find death notifications to be personally difficult. Perhaps this is because only one half received any type of death-notification education in medical school and only one third received any such training during residency.⁸¹ Moreover, most medical “short courses” dealing with resuscitation, such as those on ACLS, advanced trauma life support (ATLS), and pediatric advanced life support (PALS), have not incorporated death notification into their training programs or manuals. This serious omission continues despite the occurrence of approximately 325,000 cardiac disease–related deaths annually in out-of-hospital settings and EDs in the United States.^{80,82}

Occasionally, physicians give the job of death notification to residents, medical students, or nurses. Although all three groups should be present to learn the techniques involved, to have an opportunity to hear what is said, and to observe an attending physician showing sensitivity, they should not be left to do death notifications on their own. That is a form of professional abandonment and, in a teaching hospital, the worst form of student abuse.⁸³

Viewing Resuscitations

Traditionally, survivors have not been permitted to view resuscitation attempts.⁸⁰ That attitude, however, is gradually giving way to a more enlightened view based, in part, on recognizing that families gain enormous psychosocial benefits from being present and that they are also patients in need of appropriate support.

The argument against allowing survivor onlookers has been that resuscitations often involve large teams, unclear communications, and team leaders who are unwilling or unable to make firm, timely, and rational decisions.⁸⁴ Having family members present, the argument goes, introduces the possibility of an onlooker’s fainting or otherwise becoming another patient. Survivors also frequently misinterpret the team’s discussions or actions. Team members may also feel uncomfortable having family members judging their actions.

Yet studies in both the United States and Britain have shown that nearly all survivors who witnessed ED resuscitative efforts found the experience helpful. Seventy-six percent

of survivors responded that their grieving was facilitated by having witnessed the resuscitation, and 64% felt that their presence was helpful to their dying family member.⁸⁵ Psychological tests of survivors who witness resuscitation attempts, performed at 3 and 9 months after the event, showed that this group experienced fewer episodes of “intrusive imagery,” such as flashbacks of the events leading to the death, compared with survivors not present at the resuscitation (relatives in the control group). They also had lower levels of anxiety, depression, post-traumatic avoidance behavior, and grief.⁸⁶

The American Heart Association now endorses giving family members the opportunity to be present so long as the patient has not previously objected. This position stems from the benefit families can derive from their presence during resuscitation attempts, the lack of harmful effects on them from viewing these resuscitations, and their quasi-right to be there based on the nature of their relationship to the patient.^{68,87}

The presence of these survivors does not hinder the resuscitative efforts and often leads to quieter, more effective team efforts. Experience has shown that survivors who witness ED resuscitative attempts never question whether the team “tried hard enough,” do not ask whether the person is *really* dead, and spend less time in the ED trying to come to terms with the death. In addition, survivors may actually thank the ED team for their efforts, a situation that rarely occurs under other circumstances, and the ED staff never has to “notify” survivors of the death.

The general procedure is as follows:

1. Ask survivors if they want to view resuscitative efforts.
2. If they do, give them a quick briefing about what they will see, and have a knowledgeable staff member, usually a chaplain, social worker, or ED nurse who can answer their questions, accompany them.
3. Provide a chair for any elderly persons and allow survivors to leave and reenter as they wish.
4. Staff should attempt to cover as much of the patient as is compatible with effective resuscitative efforts.
5. Team members should be advised that family is in the room.
6. The survivors should be encouraged to talk to and touch the patient.
7. Decisions to pronounce the patient dead, although often discussed with the family, generally are communicated in the format of advising them that “we must stop now.” They should never be asked whether to stop the resuscitative effort; this is a medical decision.

Experience shows that the process of having key survivors view resuscitations often works best if EMS personnel notify the receiving hospital in advance of this request. This allows the ED staff to decide whether they will permit it (if it is not policy), to advise team members, and to be ready to provide an escort for the relative to the resuscitation room at the appropriate time.

If the family is present when it is clear that resuscitative efforts should cease, this should be explained to the family before supportive measures are discontinued. This provides them with a chance to “say good-bye” before death is pronounced. Dedicated pediatric EDs and pediatric resuscitation units in general EDs have adopted these procedures more often than others.

Postmortem Teaching

A less commonly discussed aspect of emergency medicine education programs is the use of recently deceased patients to

teach or practice emergency techniques, such as intubations and central line placement. Although whether this practice is ethical is a matter of controversy, a reasonable argument might be that if medical treatment could not save the patient, then the EP's responsibility is to hone skills for the next patient in need of expertise in resuscitative techniques. This is not to condone the desecration of a body. Rather, it suggests that because clinicians learned the techniques used during the attempted resuscitation on other dead or living patients, this (now dead) patient owes the next patient the same courtesy. No one would advocate practicing unneeded procedures on living patients, and many people argue against using experimental animals. The religious or ethical beliefs of some ED personnel may make practicing or teaching these procedures in such circumstances problematic.⁸⁸⁻⁹¹

Resuscitation Research

Physicians in a new and advancing specialty have an obligation to advance the knowledge base from which they practice. This can be done only through research, a significant component of which must necessarily be clinically based. In the United States, federally mandated institutional review boards (IRBs) must approve any research involving human subjects, including research in EDs and, possibly, in prehospital care.⁹² Increasingly, research ethics committees are being used to approve human-subject research throughout the world. The IRBs try to guarantee that patients who are asked to participate in research review and sign an adequate informed-consent document. Yet even if the patient is conscious, it is unclear whether truly free and informed consent can be given in the midst of a medical emergency.⁹³ In both trauma and cardiac resuscitation research, informed consent is, of course, not feasible. It usually is difficult, if not impossible, to obtain retrospective patient or, if appropriate, prospective surrogate consent. So as not to deny critically ill and injured patients the opportunity to participate in possibly beneficial research trials, the U.S. Food and Drug Administration and the Department of Health and Human Services issued regulations, which became effective in 1996, that allow "emergency research" without informed consent. These regulations contain extensive patient safeguards, including community consultation, public disclosure, and intensive oversight.⁹⁴

The ethical and legal basis for these regulations is "presumed consent": If the research is not harmful, and especially if it is potentially helpful, most "reasonable" patients would acquiesce to the research, given the basic values of good and evil (see [Box 200-1](#)).⁹⁵⁻⁹⁷ As routinely occurs in emergency medical practice, persons suffering unexpected adverse events with a high probability of rapid death or serious morbidity generally demand that the physician deliver acute care interventions—immediately and without discourse. If there is a chance that the patient could benefit from a therapeutic course of action in such circumstances, most people would demand that it be used. Similar logic applies with acute care research, especially when accepted or standard therapy is futile, and possibly when the investigators believe that equipoise (therapeutic equality) exists between the two tested forms of therapy. Protection for the patient in these cases rests with IRBs, which among other considerations must guard against the possibility of organ-specific success but failure to benefit the entire person, such as producing a patient in a persistent vegetative state after "successful" CPR.

Beyond IRB authorization for research is a moral responsibility for the individual researcher to ensure that the research protocol and its execution are ethical. This responsibility extends to the journals in which the research is published.⁹⁸

In the main, emergency medicine has an excellent record of ethical research.⁹⁹

■ PUBLIC POLICY AND BIOETHICS

Restricted Access to Emergency Medical Care

Society has acknowledged its moral obligation to ensure that everyone has reasonable access to adequate health care.¹⁰⁰ People's need for health care is unequally distributed and highly unpredictable. Few could afford this care if left to their own devices, so mechanisms are in place to share the risk.¹⁰¹

The ethical dilemma for EPs comes in basically two forms: one precipitated by the institution in which the ED is housed and one by outside third-party payers. Some institutions have refused care to patients coming to the ED, sending some away for clinic appointments at a later time.¹⁰² Institutions also have pressured EPs to limit treatment, ancillary tests, or hospital admission for patients without the ability to pay. Although such limitation may seem patently immoral, another question must be asked: Is there a moral obligation to the community to keep the health care institution financially viable? Hospitals have closed their doors because of financial losses, and many hospitals, especially in inner-city areas, are on the verge of bankruptcy.

Some prepaid health maintenance organizations (HMOs) use "gatekeepers" to keep patients in need of emergency medical care away from immediate assistance at institutions other than the HMO parent hospital. Moreover, the HMO's income may depend on *not* hospitalizing patients, *not* using ancillary tests, and *not* permitting ED visits. Nevertheless, it is prudent and ethical for EPs to err on the side of providing for the patient's needs.

Morality of Triage Decisions

In the aftermath of a massive natural or man-made disaster, triage officers face difficult decisions about who will receive scarce life-saving treatment and who will be left to die without treatment. Even in "routine" ED triage, decisions about who should receive treatment priority and who can wait for treatment may, at least occasionally, have life-and-death consequences.^{103,104}

Triage provides a method to distribute health care resources when patient needs exceed available resources. Triage operates along a continuum of decreasing resources, social order, and the resource-to-patient ratio. Arrival patterns, triage methods, and the applicable ethical basis for triage vary along this continuum.

Most triage systems are designed to serve the values of human life, human health, efficient use of resources, and fairness. Nevertheless, because of the variety of specific triage settings and goals, no single "correct" way to perform or to justify triage can be identified. Routine triage in the relatively resource-rich setting of the modern hospital ED, for example, focuses appropriately on maximizing benefits for each individual patient, giving treatment priority to patients whose needs are most urgent. In triage following a massive disaster, when not all individual needs for lifesaving care can be met, the focus may shift from an individual to a group perspective, and triage officers may seek to save as many lives as possible with the limited resources at their disposal. In special circumstances such as times of war, military commanders may direct that triage systems devote scarce medical resources to achieving a nonmedical goal—namely, military victory. In situations

of complete devastation, the lack of social order and minimal resources may make triage impossible.

Whether the choice of a triage system is justifiable will depend on an evaluation of the specific system itself, its underlying values and principles, and the setting in which it is applied.

Physician Response to Risky Situations

Over the millennia, personal values have dictated whether a physician would remain with his or her patients during extreme or catastrophic circumstances.¹⁰⁵ Physicians, even legends of medicine such as Galen, often fled to save their own lives. In the era of modern epidemics of unknown virulence and etiology, it remains a personal moral decision, especially for EPs who are on the frontline of these medical assaults.

How will physicians respond when a catastrophe involving personal risk strikes? The moral backbone of medical professionals may be tested as health care providers weigh multiple factors to determine whether to stay and carry out their professional roles or to step back and decrease their personal risk.

With incomplete information, providers may make decisions based on heated emotions and panic, rather than an accurate perception of risk. The decision to stay or leave will ultimately depend on the individual practitioner's risk assessment and value system. Professional ethical statements about expected conduct establish important professional standards and norms, but each practitioner will interpret and apply them based on his or her own situation and values. Recent historical precedent suggests that many physicians and other health care providers will dutifully care for the sick and needy, even at great risk to themselves. Although some EPs have worked in dangerous situations, most have not: Nothing in day-to-day emergency medical practice prepares EPs for the great opportunities and challenges that will accompany a pandemic. EPs can, however, reflect on their professional and personal respon-

sibilities in crisis situations, and public and private institutions can create plans for effective communication and care when a disaster strikes. If this can be achieved before the next pandemic or disaster that includes personal risk to clinicians, EPs, who are inevitably among those at highest risk, can be encouraged to “stay and fight.”¹⁰⁵

“Proactive Ethics”: How Can Emergency Physicians Change the Rules?

In every medical system, practitioners find that they repeatedly face identical ethical dilemmas. The normal outcome is an incomplete and often unsatisfactory solution made by administrators, lawyers, bioethics committees, or others. “Proactive ethics” involves changing the rules under which we operate. Easier done in some settings than in others, the process requires that all “stakeholders,” those with a vested interest in an equitable solution, first come to the table and reach a compromise. Such groups often will include physicians, nurses, EMS personnel, lawyers, religious authorities, and representatives of affected groups (e.g., an organization of elderly persons in the case of issues about the aged). Armed with this agreement or even sample legislation that they can present to politicians, it becomes easier to change laws or administrative rules to address recurrent ethical dilemmas. One such process led to a landmark out-of-hospital advance directive law, which markedly lessened unwanted EMS resuscitation attempts.³⁷ It also led to an extensive statutory surrogate list and a simplified set of advance directives. Proactive ethics lies in the role of public policy—an arena in which EPs are well suited to play a large role.

The references for this chapter can be found online by accessing the accompanying Expert Consult website.