Guide to Teaching Ethics in Emergency Medicine
Residency Programs

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SAEM Ethics Committee

Terri A Schmidt (Chair)
Andrew Beckman
Richard Bradley
Natalie DiGioia
Jennifer Girod
Stephanie Hollingsworth
Jason A Hughes
Jayne MacLaughlin
Catherine A Marco
Brian D McBeth
Katie B. McClure
Tammie E Quest
Raquel M. Schears
Drew Watters

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The purpose of this manual is to provide a teaching guide to residency directors and others responsible for teaching ethics to emergency medicine residents. The goal is to provide residents with the information necessary to be able to make a reasoned analysis of ethical conflicts and to allow them to develop the skill to resolve ethical dilemmas.

After the introductory sections, the manual is divided into teaching modules. Each module includes objectives, an illustrative case, a discussion, study questions, and a brief bibliography. The objectives define basic material a resident would be expected to master after each session. The study questions can be used to focus discussion, provide broad understanding of the subject, and stimulate thought. Like all of medicine, biomedical ethics is continually expanding. No effort is made to cover all aspects of each subject, but rather, an attempt is made to offer a short, pertinent analysis for both the instructor and the resident. This is not intended to be a complete text on ethics in emergency medicine. The guide includes modules that can be taught to emergency medicine residents throughout their training.

Before specific ethical issues are discussed, the relationship between ethics and the law must be clarified. Physicians look to the law for guidance, but the law does not provide the answer to many ethical problems. In addition, statutes and regulations may vary substantially between states. Ethical theory should guide physicians toward a universally applicable standard. The law may be ambiguous, so no clear guidance is offered, or it might be very specific, applying only to cases with substantially similar circumstances. The law also neither addresses the breadth of ethical imperatives which oblige emergency physicians nor does it necessarily reflect ethical behavior. While the law is limited in its ability to provide universal guidance and direction, ethical analysis should provide a framework for determining moral duty, obligation and conduct.

Similarly, ethical analysis does not substitute for appropriate legal guidance. When dealing with dilemmas, when initiating policy and protocols, or when updating
existing procedures, informed legal advice is encouraged. An attorney familiar with emergency medicine and well versed in relevant statutory and case law will help to define legally acceptable actions.
I. Introduction: Basic Ethical Foundations of Clinical Medicine

Objectives

1. Discuss the moral principles that underlie the practice of medicine.
2. Define ethics.
3. Define respect for autonomy.
4. Define paternalism.
5. Define beneficence.
6. Define nonmaleficence.
7. Define justice.

Case Study
A 21-year-old woman arrives in the ED with severe blood loss following a car accident. You think she needs a transfusion immediately to survive, but she states that she is a Jehovah’s Witness and does not want blood. She requests a very expensive and rare blood substitute instead.

Ethics is the branch of philosophy concerned with norms of human behavior. In medical ethics, philosophical principles may be used to prescribe and evaluate the behavior of health care professionals as they interact with patients and families, the community at large, and one another.

Four principles have been fundamental in shaping norms for American health care: respect for autonomy, beneficence, nonmaleficence and justice. Most ethical dilemmas arise when two of these principals are in conflict. For example, a conflict arises between respect for autonomy and beneficence when a patient wants to refuse a treatment that seems beneficial. Careful consideration of the circumstances can determine which principle takes precedence in a particular case.

Respect for autonomy in health care means that physicians respect a patient’s ability to choose goals for himself or herself according to his or her own values. It is called paternalism when a physician tries to help a patient in a way that does not agree with the patient’s values. The obligations of informed consent, honesty and
confidentiality arise from respect for autonomy. The need to respect autonomy was highlighted by the abuses of medical research committed by Nazi Germany on concentration camp victims, the U.S. Tuskegee syphilis study, which continued into the 1970s, and the U.S. government-sponsored radiation studies.

The law supports respect for autonomy. New York State Supreme Court Justice Cardoza said in 1914, “any individual of sound mind has the right to determine what shall be done to his body.” However, informed consent does not appear as part of American case law until 1957. Since then, the concept of patient autonomy has proven one of the most important principles in U.S. health care delivery.

Beneficence means “doing good,” and is embodied in the Hippocratic physician’s pledge to act for the good of the patient. There is a specific obligation of beneficence based on the health provider-patient relationship that is a contractual, fiduciary obligation. However, the professional’s obligation to benefit a patient is not solely based on this contract, but is inherent in the role of the physician as healer. Present day ethics codes strongly embody the guiding principle of beneficence. The Declaration of Geneva, sworn by many medical students at graduation, states, “the health of my patient will be my first consideration” (World Medical Association, 1983).

Non-maleficence means “not doing harm.” In the U.S., the duty not to harm is often understood to be more binding than the obligation to help. Negligent medical care violates this principle. Some ethicists do not make a distinction between non-maleficence and beneficence.

Justice is the principle we consider when attempting to make decisions about competing interests, or allocation of resources. Justice is often equated with fairness or non-discrimination based on morally irrelevant qualities. In medicine, justice requires that each patient be treated respectfully and competently, and that the use of resources does not unfairly advantage one group or unduly harm society.
Study Questions:

1. What values conflict for the physician caring for the Jehovah’s Witness patient?

2. What action would be considered paternalistic in this case?

3. Is it just for this patient to request and be given a more expensive treatment than other patients?

Bibliography


II. Applying Ethics to Emergency Medicine

Objectives

1. To describe the challenges of ethical decision-making in the emergency department

2. To be able to use patient scenarios to show the difference between “gut instinct” and ethical analysis

3. To learn some resources available to the emergency medicine physician when facing an emergent ethical concern

4. To be able to present an emergency medicine case that emphasizes ethical concerns; include a discussion of the outcome as well as the decision-making that led to the outcome.

Case Study
A 34-year-old male who was noted to have fevers, diarrhea and oral thrush. He had been imprisoned and had unprotected homosexual activity there, and then he had also been involved with prostitutes. He also has a wife and a one-year-old child. Initially the physician ordered an HIV test after discussing this with the patient. It was cancelled when the patient elected not to have the test; his whereabouts were unknown until he arrived again to the emergency department and he agreed to an admission due to his deteriorating condition. (by Parsa and Walsh)

The emergency department is complex; requiring continued situational awareness. The decisions made can affect lives for years to come. As noted by Dr. Kenneth Iserson many emergency physicians have “uncertain information about their patients” including the inability to know patients’ health histories and possibly even the event that brought them to the emergency department. The rapid need to intervene and make decisions coupled with the need to care for other patients means that resources such as consultation with a hospital ethics committee are rarely an option.

We all have ideas on “the way things should be” but this feeling might not be acting in a patient’s best interests. In fact it could cause a chain reaction of decisions to occur that have no ethical background. Most ethical decision-making should not derive
from this “instinct” but it should derive from careful analysis (even if that analysis is brief). Experience, didactics, and case presentations are possible ways to teach residents to distinguish a “gut reaction” from a rapid, well-reasoned ethical decision.

Realizing that time is of the essence, emergency physicians should know some of the resources available to them including colleague interaction and opinions from ethics teams, hospital legal assistants and experienced nurses. Preparation may be the best resource and this can include ethical case conferences, emergency medicine experience, and reading about prior ethical decision-making and models for making these decisions.

One model for making ethical decisions was developed by Jonsen, Siegler and Winslade. They propose that considering four factors can help make any ethical decision: medical indications, patient preferences, quality of life and contextual features. This model assures that all the salient features are considered but it can be cumbersome to use in the emergency setting.

Iserson has developed another model specifically designed for the emergency setting. The first step in this model is to ask the question, “Is this a type of ethics problem for which you have already worked out a rule or is this at least similar enough so that a rule could reasonably be extended to cover it?” If so, then follow the rule. The second step is to ask the question, “Is there an option which will buy time for deliberation without excessive risk to the patient?” If yes, buy time. Finally, if the first two steps do not yield a solution, then there are three rules to apply:

1. Impartiality—Would you be willing to have this action performed if you were in the patient’s place?
2. Universalizability—Would you be willing to use the same solution in all similar cases?
3. Interpersonal justifiability—Would be willing to defend the decision to others, to share the decision in public?

One potential criticism of Iserson’s decision-making model is that there could easily be different answers to the questions proposed. One physician might see the fact that he or she did not intubate a dying AIDS patient as a justifiable and ethical act. On the other hand, some physicians might believe that they have an obligation to provide more aggressive treatment. In spite of these concerns, the model provides yet one potential model for decision making when time is critical.

A teaching approach to ethical decision making is the “modified essay question”, which emphasizes critical ethical thinking. Residents can be given theoretical cases to work through, developing critical analysis. Preparation for ethical thinking also includes teaching professionalism to residents (see section on Professionalism). Finally, ethical ideals can be brought together through a case conference approach. During such a conference, materials can be used and understood and through careful and ethical dissection, the resident can learn the important features of ethics in the emergency department.

Cases like the one presented above tie together important concepts of emergency medicine. By using similar presentations, academicians may be able to generate the opinions and “gut reactions” of residents vs. the importance of ethical thinking. Models can be used to think through the problem. Experienced faculty members who have seen similar cases and a literature review of these cases may help the resident understand the complexity of a decision that must be made according to the ethical standards in this guide.
Study Questions

1. Use a case scenario that involves an ethical dilemma and use different ideals and models to solve this dilemma.

2. Present a spoken case conference of a difficult ethical concern in the emergency room. Discuss your solution of the concern, and discuss how you came about the solution. Use varying texts and faculty experience to embellish the case.

3. How do “gut feelings and reactions” differ from ethical decision making? What tools can you use to formulate the latter?

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III. Core Competencies relating to Ethics

The Accreditation Council for Graduate Medical Education (ACGME) initiated the Outcome Project, with the goal of improving the quality of graduate medical education. The ACGME Outcome Project stresses the importance of educational outcomes, such as the development and utilization of competencies and learning objectives, the development of methodologies to assess the achievement of objectives, the implementation of continuous quality improvement initiatives, and the development of resources to improve educational processes.

Six general competencies have been identified by the ACGME Outcome Project. These six general competencies (Table 1) and ACGME program requirements relating to ethics and professionalism (Table 2) are listed below.

Table 1.

**Six General Competencies Endorsed by the ACGME**

1. Patient Care
2. Medical Knowledge
3. Professionalism
4. Systems-based Practice
5. Practice-based Learning and Improvement
6. Interpersonal and Communication Skills
Residents should be taught the fundamental qualities of professionalism in emergency medicine including:

1. Provision of compassionate emergency medical care with the best interest of the patient as the focus of decision making;

2. Respect, regard, integrity, and a responsiveness to the needs of patients and society that supersedes self-interest, that assumes responsibility and acts responsibly, and that demonstrates commitment to excellence and ongoing professional development;

3. Commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices; and

4. Sensitivity and responsiveness to cultural differences, including awareness of their own and their patients’ cultural perspectives.

Interpersonal Skills and Communication

Residency programs must ensure that residents develop appropriate communication skills to effectively create a therapeutic relationship with patients, to educate and provide useful information to patients and families, and to work collaboratively in health care teams for the benefit of their patients.

Emergency Medicine Education in Ethics and Professionalism

Graduate medical education related to ethics, professionalism, and interpersonal skills presents a challenge to many physicians, who often teach, both clinically and didactically, such scientific topics as epidemiology, pathophysiology, pharmacology, and evidence-based medicine. Because education in scientific areas of medicine is well established, education in less technical areas of medicine can be challenging. Didactic
teaching is an essential component of teaching professionalism, and should provide both the delivery of information and the opportunity to discuss pertinent issues.

Resources are available for teaching professionalism in emergency medicine including books, and internet resources, such as The Accreditation Council for College of Graduate Medical Education website and American Medical Association website. (See bibliography) Integration of existing resources into a tailored program at each individual residency program should provide the appropriate curriculum of prepared material and individualized teaching ideas and methods.

In addition to traditional lectures, the use of multimedia presentations, role-plays, drama, panel discussions, and other creative educational techniques may be helpful. Multimedia educational presentations have advantages, including improved attention, interaction, test scores, and retention of information in a variety of settings. Multimedia educational approaches have demonstrated effectiveness in many settings, including clinical skills, procedural skills, interpersonal skills, distance learning, quality assurance and peer review of patient encounters, and public education. Another approach studied at one institution is an ED visit program, in which residents act as patients, and experience the patient perspective.

**Mentoring Professionalism**

In academic emergency medicine, faculty and residents function as teams, with shared goals including clinical education, didactic education, research, writing, and other administrative and academic goals.

Effective leadership and mentoring among faculty members is essential to teaching professional skills to residents. The observation of appropriate skills such as
honesty, compassion, and communication, practiced effectively by role models, is crucial to the effective development of those skills by residents.

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IV. The Physician-Patient Relationship

A. Privacy and Confidentiality

Objectives

1. Understand the importance of confidentiality as a foundation for the physician-patient relationship.

2. Define circumstances in which it is ethically appropriate to break patient-physician confidentiality.

3. Differentiate between privacy and confidentiality.

Case Study
An 18-year-old female comes to your emergency room complaining of lower abdominal pain. Her mother is at the patient’s bedside and she does not wish to leave, stating, “Since she is my daughter I have the right to know everything”. After finally enticing the mother to leave for the pelvic exam, the patient reveals that she might be pregnant. Your sonogram done at the bedside reveals free fluid, and the exam is consistent with an ectopic pregnancy.

In Larkin’s review of emergency physician and patient confidentiality, “confidentiality is the keystone of emergency care”. Without this foundation, patients would be less likely to reveal their true concerns; their health and even their lives could easily be at stake without the premise of the confidential relationship. Thus, in most circumstances, physicians are expected to keep the information revealed to them by patients in confidence. However, there may be times when this bond has to be broken. The need for confidentiality may conflict with the need to protect other members of society. For example, a person has AIDS who is unwilling to reveal this to a spouse or a person with tuberculosis who refuses treatment.

One example of a challenge to privacy is filming in the ED. In the age of technology and “reality television” concerns have been raised about filming patients without prior consent. Although filming has occurred in the past and some authors
support it, currently filming without consent would be considered a HIPPA violation. Specifically, although filming a patient is not necessarily a breach of confidentiality, it is a breach of privacy. Privacy issues are a concern throughout the emergency department including patients in hallways and in “rooms” separated only by curtains.
IV. The Physician-Patient Relationship

B. Truth Telling and Communication

Objective

Describe how a physician should communicate the truth in the following situations:

1. When an error has caused worsening of a patient’s condition
2. When a patient is found to have a diagnosis of cancer but family does not want the patient told
3. When family members are told the death of a loved one

Case Studies

1. While teaching a resident how to place a subclavian central line under emergent circumstances, a pneumothorax develops and eventually this becomes a tension pneumothorax. The patient was in a pulseless electrical rhythm before and after chest tube placement.
2. An elderly patient arrives to your emergency room with a large family. The family calls you to the side to let you know she has pancreatic cancer as diagnosed at a neighboring hospital. They are insistent that she should not know her diagnosis during “her final days” and they will seek retribution if you do tell her.
3. A 21-year-old male has died suddenly due to a brain aneurysm. You have been keeping the family informed throughout his deteriorating condition. After his death, the family asks whether or not his 3 and 4-year-old children should see him.

It is of utmost importance that emergency physicians have an ability to communicate in forthright and truthful manner, without mixed signals. For example, a review article concerning medical errors revealed that ED patients desire to know about any errors made in their care. Although this is difficult for physicians, it is imperative to tell the truth in order that the bond between physician and patient continue to be a therapeutic one.

On the other hand, cultures vary in their beliefs about how and when to share information with patients. Some cultures, for example, avoid sharing a terminal diagnosis...
with the patient, preferring that the information be shared with family. Caring ED physicians need to understand and respect these cultural differences while maintaining a trusting bond between the patient and the family. The physician needs to work with the family, while assuring respect for the autonomy of the patient which usually requires disclosure of the truth.

Another area where sensitive communication is critical occurs when informing family of a patient death. Eye contact and non-verbal communication may be more important than verbal communication. Sitting down with the family and discussing the events surrounding the patient’s arrival to the emergency room may help establish rapport with the family. Finally, consider assigning a nurse or social worker whose sole responsibility is to the family will help.
IV. The Physician-Patient Relationship

C. Compassion and Empathy

Objectives

1. Describe the importance of displaying compassion and empathy.

2. Discuss emergency department barriers to compassion and empathy.

Case Study
A 31-year-old female presents to the emergency room in an obvious agitated state. She has been told to “stay in her room” but she becomes more agitated and is now walking around the emergency room, crying and screaming while hitting the employee computer keyboards with her fists. When asked, she states she has been on medication for a mental illness and ran out of it 1 month prior.

The busy emergency department is a disorienting and difficult place for patients and their families. Health care providers must be ever mindful of patients and their feelings as they are examined and treated. The physician must be able to remove personal bias when caring for those who may be intoxicated, angry, mentally ill, or all of the above.

One study placed first year residents in a setting in which they were treated like patients. There appeared to be an overall increase in the concept of empathy for patients as well as their waiting times. This may be a way was to teach empathy.

There are barriers to an emergency physician’s ability to communicate compassion and empathy. The physician may be suffering burnout, home difficulties, financial concerns, or abuse of alcohol or other drugs. The patient may be hostile, have another primary language, they may be intoxicated, in mental or physical anguish, or frightened and confused. In order for truth telling and barrier breaking to occur,
emergency physicians should look inside themselves so that they may appropriately care for their patients with empathy and compassion.

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V. Issues Related to Patient Autonomy

A. Informed Consent

Objectives

1. Define Autonomy
2. Explain why informed consent is obtained for treatment.
3. Define the emergency rule.
4. Define express and implied consent
5. Describe the circumstances under which a physician may treat a patient against his or her will.

Case Study

A 39-year-old patient with HIV presents with a severe headache. The patient has a history of headaches, but this episode is worse than usual. There is no fever, and the patient has a non-focal neurological examination; the patient's sensorium is clear. Head CT scan is normal. The physician feels that a lumbar puncture is indicated.

Autonomy is defined as self-determination and refers to a person’s ability to make his or her own decisions, including those affecting medical care. Respect for autonomy requires us to recognize a person's right to make independent choices, and take actions based on personal values and beliefs. Informed consent takes in to account patient autonomy and is a moral and legal obligation of physicians. The key elements of informed consent include adequate patient decision making capability, disclosure of information about the treatment and risks, patient comprehension of the information and the patient’s voluntary consent without coercion. In the emergency care setting issues of consent frequently arise for procedures, informed refusal of care, treatment of minors, and consent for research protocols.
Obtaining informed consent in the emergency department is challenging. Many of our patients may not be capable of making decisions secondary to their acute life threatening condition, intoxication, language barriers or other impairments. It is the health care provider's responsibility to assure that the patient can meaningfully participate in the decisions. Shared decision making requires that the patient possess correct and complete information, and that the decision promote the patient's goals and life values. When this is not possible the concept of implied consent, surrogate consent and emergency treatment may be invoked.

**Legal support for informed consent**

While informed consent is an ethical imperative, United States’ law also requires that a patient provide informed consent for medical treatment, except under unusual circumstances. This legal principle was recognized in 1914 when the New York State Supreme Court held that, “Every person of adult years and sound mind has the right to determine what shall be done with his own body and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages.” This landmark case cites the fundamental premise upon which our understanding is based. Any time a health care provider touches a patient; the patient must authorize such action. In the absence of such authorization, the intervention could be actionable in tort as a battery. The imminent threat of such a violation constitutes assault. This principle gives the patient with decision-making capacity the legal right to refuse medical care.

In addition, lack of informed consent may result in an action for negligence against the health care provider. A failure to disclose potential complications or alternative treatments may constitute negligence if such information would influence the patient to alter his or her decision. This distinction was made clear in 1972, when the court affirmed that performing an unauthorized procedure is battery, but performing an authorized procedure without appropriately disclosing the risks constitutes negligence.
**The Emergency Rule**

The court has stated that an emergency rule applies when a patient is unable to consent to treatment for reasons such as the patient is unconscious or otherwise incapable of consenting, and harm from a failure to treat is imminent and outweighs any threatened harm by the proposed treatment. When time does not permit informed consent, emergency services operate under the moral imperative of beneficence, acting in the best interests of the patient. The rationale for treatment without consent in such situations is that patients would consent if they could be informed and *thea tharem* would result if care were delayed.

Courts also have held that in time of life threatening crisis, it is the physician's duty to do that which the occasion demands, even without the consent of the patient. However, it is imperative that the condition of the patient be so severe that definitive care could not be delayed until consent is obtained. The emergency rule depends upon the patient's inability to offer consent as well as urgent circumstances. How urgent a situation is depends primarily upon the consequences to the patient of a delay in rendering treatment, or indeed upon the consequences of a failure to render any treatment at all.

**Surrogate Consent**

When the patient is unable to consent due to physical or psychological distress, the nearest relative or designated surrogate is turned to for consent. It is then assumed that surrogate decision makers will make decisions based either on the patient's best interests or the patient's previously expressed wishes.

**Implied Consent**

"Implied consent" is defined as a logical inference from the conduct of the patient. The individual patient's actions would indicate to the health care provider that the treatment was requested. This is described in the case of *O'Brien v. Cunard Steamship Co.* A passenger sued the steamship company for administering an immunization without
his consent. The court held that by the plaintiff’s act of standing in the line where
injections were being administered, rolling up his sleeve and submitting to the injection,
he provided a consent implied by his actions. The typical prehospital or ED encounter
may parallel this situation. The patient or a designee requests help, and care is
administered. The patient implies consent as he or she participates in the care, and
actively submits to treatment. Express consent must be sought for any intervention with
more than remote risks. Information must be freely shared with patients. Implied consent
might extend to that necessary to relieve suffering and preserve and promote the care of
the patient. All such treatment rendered must be well within the scope of accepted
therapy. The emergency rule applies if the patient is unconscious or without decision-
making capacity, the emergency rule applies.

Refusal of Care

Informed consent requires decision-making capacity. It follows that patients with
decision-making capacity have a right not to consent to care. The elements of a valid,
informed refusal are the same as consent: the patient must have decision making capacity,
information including significant risks and magnitude of harm must be provided, the
patient must comprehend the information and the refusal must be voluntary without
coercion or duress. Because refusal of care may conflict with the judgment and
recommendation of the physician, it is prudent for the physician to emphasize the risks
presented by refusing care and outline specific consequences to be expected. The
physician must be careful because both consent and refusal must be made without
coercion or duress.

Study Questions

1. In this case, what must be discussed with the patient in order to obtain her
   consent?
2. How would this change if the patient was encephalopathic and refusing the lumbar puncture?

3. Why does a physician obtain informed consent for treatment?

4. How do the principles of beneficence and autonomy relate to consent issues?

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V. Issues Related to Patient Autonomy

B. Patient Decision Making Capacity

Objectives

1. Define decision-making capacity

2. Contrast medical interpretations of decision-making capacity with the legal definition of competence.

3. List the elements of decision-making capacity

4. List the ways decisions can be made when a patient lacks decision-making capacity.

Case Study
An ambulance brings a patient to your emergency department with a 54-year-old homeless man. They state he was found down on the sidewalk. When you address the patient he is obviously intoxicated and you see signs of a hematoma on his head. The patient tells you he is leaving the emergency department immediately.

When a patient arrives in an emergency department and an evaluation by a physician is begun, a physician-patient relationship is established. This relationship carries certain legal and ethical obligations for both parties. The physician assesses the patient and proposes a plan of evaluation or a course of care. Patients have the ultimate authority to accept or refuse this proposal.

The patient's authority is founded on 1) the ethical principle of respect for autonomy, 2) the legal right of self-determination, and is based on the pivotal assumption that the patient is acting in his or her own best interests. The obligation of physicians to protect patients from harm can conflict with the obligation to respect patient autonomy when the patient makes decisions that seem unwise or harmful. When this conflict occurs, physicians must assess the patient's ability to make a reasoned decision.

Competence and decision-making capacity are two descriptors commonly utilized to characterize this ability. Though competence and decision-making capacity are often used interchangeably they are distinct terms. Competence is a legal term that can only be
determined by a court. Decision-making capacity is a medical concept that is determined by a health care provider.

**The Medical Concept of Decision Making Capacity**

All adult patients are assumed to have appropriate decision-making capacity to accept or refuse a plan of evaluation or course of therapy unless there is evidence obtained by history, behavior, or physical examination that would lead the physician to believe that the patient's decision-making capacity has been significantly compromised. Decision-making capacity is decision-relative; a patient may have the capacity to make a simple medical decision but not a more complex one. The determination of decision-making capacity requires that the patient:

1. Be able to receive information
2. Be able to process and understand information
3. Have the capacity to deliberate
4. Have ability to articulate and defend choices.

The concept of decision-making is a dynamic one that changes throughout a patient’s illness. The degree or level of decision-making capacity a patient must show varies with the degree and probability of risk, the degree and probability of benefit, and the patient's decision to consent or refuse. The greater the risk posed by the patient's decision, the more exacting the standard of decision making capacity needs to be. Thus, a patient might need only a low level of decision making capacity to consent to a procedure with substantial, highly probable benefits and minimal, low probable risks, but a high level of decision making capacity to refuse the same treatment.

**Determining Decision-Making Capacity**

Determining capacity begins when a physician walks into a room and begins taking a history. Most patients will be able to receive and process information in order to
cooperate with a history. If they are not able to do this then questions arise about their decision-making capacity. Patients who are intoxicated, delirious or unconscious clearly are not able to make life or death medical decisions. Standard mental status exams may be helpful but only when patients clearly fail such tests. If a physician believes that a patient does not have sufficient decision-making capacity for a particular decision the physician may need to call upon a third party such as a family member, health-care proxy or psychiatric consultant for assistance.

The Concept of Legal Competence

In the law, competence requires mental capacities sufficient to appreciate the nature and consequences of such legal rights or responsibilities as making a will or contract, standing trial, or rearing a child. The degree of understanding required by the law will vary in relation to the task to be performed. The law assumes that adults are competent until proven otherwise in a formal legal decree. Once the person is formally judged incompetent, a guardian or conservator is appointed by the court to make decisions. Depending on the degree of incompetence, a person may be judged incompetent relative to business or financial affairs, yet competent to consent to or refuse medical evaluation or treatment.

If a conservator is appointed to make medical decisions on behalf of the patient, then the conservator is the individual who must give consent, not the patient or family members. Each state may have slightly different criteria for the determination of competence. However, a person is determined to be incompetent only after a formal legal proceeding.

When a Patient Lacks Decision-Making Capacity

If the physician knows that a patient does not have medical decision-making capacity to give an informed consent, how should medical decisions be made? The
answer to this question depends on the speed with which the decision must be made, and what information about patient preferences is available.

If a decision needs to be made immediately to save a person's life or limb, then legally and ethically, the emergency physician is obligated to provide appropriate care without the need for consent (See Emergency Rule). If time permits and there is a legal decree that the patient is incompetent, then the emergency physician should contact the conservator of the patient who would have legal responsibility for medical decision-making. In addition, patients may have a durable power of attorney for health care, living will or previously expressed wishes to family or others, which should be honored (see section on advance directives). When patients previously expressed wishes are known, based on the principle of respect for autonomy, those wishes should generally be honored.

Historically, there was substantial ethical and legal consensus supporting the concept of surrogate decision-making by family members. Surrogate decision-makers may be acceptable in the emergency setting, but the time required to confirm surrogate identity, explain the medical circumstances and prognosis, and assure sound reasoning, may be prohibitive when there is a medical imperative to intervene. When doubt exists, a conservative course (resuscitation/stabilization) is warranted.

**Study Questions**

1. In the case does the patient have adequate decision-making capacity?
2. What are the key elements to determining decision-making capacity?
3. How would you assess whether the patient possessed adequate decision-making capacity?
4. What are alternatives when a patient doesn’t have decision-making capacity?

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V. Issues Related to Patient Autonomy

C. Treatment of minors

Objectives:

1. Explain how consent for minors is obtained.
2. Explain how EMTALA effects care for minors.
3. Explain how state laws regarding minors and pregnancy, sexually transmitted diseases, substance abuse, and child abuse relate to consent and confidentiality.
4. Explain the concepts of emancipated minors and mature minors.
5. Describe situations when a minor can refuse care.

Case Study
A sixteen year old is brought to the emergency department by his parents who insist on a drug screen to confirm their suspicions that the teenager is using marijuana. The patient refuses to submit to any exam or produce a urine sample.

Respect for autonomy presumes that a person with decision-making capacity has a right to make choices about health care. However, minors are generally presumed not to have decision-making capacity. In general, consent for treatment of minors is obtained from the parent or legal guardian. We assume that parents will make decisions based on the best interests of their child. Thus, with minors we are more likely to base our actions on the principle of beneficence than on the principle of respect for autonomy. However, as children become old enough to express their wishes and reason for themselves, they are entitled to respect for their preferences. In recent policy statement the American Academy of Pediatrics recommends a three-way interaction in which the physician has a responsibility to address the parent who provides informed permission, but the minor gives informed assent (as appropriate for their level of maturity). The ethical task is to weigh the preferences of parents and children and solve the conflicts, which may arise.

In the emergency department it is not uncommon for minors to arrive without a parent. Under the federal law Emergency Medical Treatment and Active Labor Act (EMTALA) a medical screening exam must be performed and if an emergency medical
condition is found it must be treated. This takes precedent over obtaining parental consent for treatment. Therefore, in most cases beginning treatment without the consent of parents is legally mandated. Once an emergency medical condition is ruled out, however, consent needs to be obtained.

In addition, ethical issues surrounding the care of minors in the ED are intertwined with state laws that address consent substance abuse, pregnancy, abortion, and child abuse and neglect. Physicians must know the requirements of the law in the state in which they practice. Many states have laws that allow minors to consent when they seek care for pregnancy, sexually transmitted diseases, substance abuse, or child abuse. In addition, many states by statute or common law allow emancipated minors or mature minors to consent for their own medical care.

Emancipated minors are usually defined as minors who live independently of supporting minors, who are married, have been pregnant, or who are in the armed forces. The mature minor is a young person who the physician believes possesses the requisite decision-making capacity and demonstrates understanding of the nature of treatment. Under most circumstances the mature minor can consent to or refuse treatment that is of low risk and to the minor's benefit. A mature minor is generally 14-15 years or older and is mature enough to understand the risks and benefits of the proposed treatment plan.

Like adult patients, minors have a right to privacy and respect for confidentiality. Ethical dilemmas may arise when a minor is accompanied by a parent who demands to know the nature of the condition or treatment which involves one of the exceptions for which a minor can give consent (pregnancy, child abuse, etc.) and the minor refuses to provide that information to the parent. The physician may feel conflicted when she or he believes that involving the parent is in the child's best interests. However, in general, the wishes of the minor patient should be respected when the minor is allowed by law or ethics to consent. In addition, older minors have a right to privacy and sensitive
information should generally not be shared with parents or others without first discussing disclosure with the minor.

**Study Questions:**

1. How should you resolve the above case? Can you treat this teenager against his will?

2. Describe treatments for which a mature minor may give consent, and treatments for which the mature minor may not give consent.

3. Can an emancipated minor refuse a life saving blood transfusion on religious grounds?

4. Do you need to obtain parental consent to treat a 10 year old trauma patient?

**Bibliography**


VI. End of Life Decisions

A. Honoring Patient Preferences: Advance Directives and Do Not Attempt Resuscitation (DNAR) Orders

Objectives

1. Define advance directives: durable power of attorney for health care and living wills
2. Explain the conditions that make an advance directive applicable
3. Define DNAR orders and the conditions under which they apply
4. Define the difference between DNAR orders and advance directives
5. Explain your state laws regarding advance directives and DNAR orders

Case Study
A 45-year-old male is brought into the emergency department with altered level of consciousness. According to his companion, he has AIDS, but until yesterday was alert and interactive, although confused at times. He has been diagnosed with AIDS dementia. His companion brings along the patient's durable power of attorney for health care naming his companion as his surrogate decision maker.

An advance directive is a written document expressing the future wishes of a patient. It is designed to give patients control over the treatment decisions that will be made when they are unable to participate directly. The two main types of advance directive are living wills and durable powers of attorney for health care. The Patient Self-Determination Act, which became effective in 1991, requires that all hospitals that accept Medicare and Medicaid funds provide information about advance directives and develop policies for implementation of advance directives. Do Not Attempt Resuscitation (DNAR) Orders are physician (or other health care provider) orders withholding cardiopulmonary resuscitation (CPR) and advanced life support (ALS) interventions if a patient is pulseless and apneic.
Living wills express the wishes of patients regarding life-sustaining procedures in the event of terminal illness. They are legally recognized by over 45 states. Living wills have specific restrictions that state that the person would not want resuscitation if he or she is terminally ill, death is imminent and resuscitation would only prolong the dying process. Because of these restrictive phrases, living wills are often of little value in the emergency and prehospital setting. In many cases health care providers do not follow them. When the applicability and circumstances are clear, however, the emergency physician has an obligation to respect the living will. If the physician cannot in good conscious do so, he or she should provide for another physician to care for the patient. Finally, the patient can revoke a living will at any time, even during a time of crisis in the emergency department.

All states have statutes governing durable powers of attorney. In some states, additional statutes explicitly identify that durable powers of attorney may apply to health care decisions. A durable power of attorney gives to another person the authority to make decisions for a patient if he or she becomes incapacitated. The person then becomes a legally recognized proxy decision maker for the patient. When a durable power of attorney exists, the emergency physician should allow the designated person to participate in decisions regarding the patient's medical care. The proxy decision maker should not base requests to initiate or withheld resuscitation on his or her own values, but must make decisions according to the known wishes of the patient. Immunity is generally granted to the physician who carries out the proxy's decision in good faith. Physicians should be aware of state law, federal guidelines and ethical responsibilities that outline policies regarding health care proxies and living wills. Emergency departments should have guidelines regarding advance directives.

Do not attempt resuscitation orders (DNAR) are written orders from a health care provider limiting resuscitation. DNAR orders apply to a patient when he or she is pulseless or apneic but do not provide direction about what treatments to provide to
patients in any other circumstances. Some states and regions have developed more complete physician orders that provide direction about providing or limiting treatment under other circumstances. One such program, Physician Orders for Life-Sustaining Treatment (POLST) developed in Oregon and now used in other states.

If there is doubt regarding the patient's wishes or the validity of a document, resuscitative efforts should be initiated. The decision to resuscitate must be an immediate “yes” or “no” decision. "Slow codes," suboptimal effort, or delayed interventions are never medically or ethically acceptable.

Living wills usually cannot be used to limit prehospital resuscitation since the applicability of the document may not be clear. Emergency Medical Services (EMS) need to honor DNAR orders. Recognizable, standard DNAR orders should identify those patients who wish to have no resuscitation attempts. States have developed various mechanisms to honor out-of-hospital DNAR orders. EMS relies on the personal physician to provide appropriate, written DNR orders that are consistent with patient preferences and medical indications. The form used for DNR orders must be acceptable to EMS and the legal jurisdiction. It must be clear regarding those interventions that are to be implemented and those that are to be withheld. Prehospital DNAR orders need to be portable, so the directive can be honored equally in the hospital, nursing home, private home or public setting. An ideal system would possess DNAR orders with standard communication and authorization procedures that are easily recognizable and do not demand interpretation or cause confusion. The document should be familiar to the EMS, the family, the emergency department, the private physician, and nursing homes.

Study questions

1. What are your state laws as they relate to advance directives and DNAR orders? Which forms of advance directives are allowed?

2. In this case, who has decision-making power for this person?
3. Who would you consult for decisions if the parents also came to the emergency department and requested to make decisions for their son?

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VI. End of Life Decisions

B. Futility

Objectives

1. Be able to offer a definition of futility

2. Consider how futility may play a role in medical decision-making

3. Describe emergency situations in which a fair process approach and case-by-case evaluation, may fail to support patient autonomy and/or the best medical judgment.

Case Study
You provide EMS medical command over the radio and receive a call from the ambulance dispatched to transfer an 82 year-old woman with widely metastatic lung cancer and advanced dementia from your hospital to another. Apparently, the transfer is a result of institutional arbitration between the surrogates and care providers of the patient. Deliberations involved the physicians’ judgment of medical futility, countered by surrogate advocacy for an indefinite continuance of life support. While loading the patient into the ambulance, she grabs at her ET tube and self-extubates. The patient rapidly desaturates, becomes pulseless and cyanotic, despite bag-valve mask ventilation. A unilateral DNR order written by the physicians from your hospital is found among her transfer documents. No prior advance directive from her former Nursing Home records is noted. The paramedics want medical direction on whether re-initiation of CPR is appropriate.

Health care providers are not expected to offer treatments to their patients that are not medically indicated or unwanted. For many clinical conditions, the medical indications and prognosis for resuscitative measures still need to be defined. Yet for some end stage illnesses, the resuscitation imperative sometimes tempts, and at other times inappropriately licenses, individuals and institutions involved in health care to compromise important values. One of which is the public trust placed in the integrity of the standard process of evaluation and treatment provided by the medical profession. Another is that, the doctors do the right thing, and pay a ransom to practice medicine. Namely, to provide comfort to the dying patient, the prospect of prolonging life must be relinquished. Physicians and ethicists continue to discuss how to proceed when it is
believed that attempts at cure, health maintenance, or lifesaving would be unsuccessful. If a medical intervention is of no benefit, then it should not be applied. The American Heart Association suggests the following criteria for medical cutoffs in ACLS:

1. Appropriate BLS and ALS have already been attempted without restoration of circulation.

2. No physiologic benefit can be expected from ALS and BLS because the patient's physiologic functions are deteriorating despite maximum therapy (examples, overwhelming sepsis, cardiogenic shock).

3. No survivors have been reported under the given circumstances in well-designed studies.

Another calculus used to define the ethics of treatment endpoints, involves the predictability of pointlessness. Some intensivists suggest that if in the last 100 cases a medical treatment has not worked, then that treatment is useless. This probability analysis allows for the possibility that 3 successes would occur in the next 100 similar cases. Though the precision of this method may be appealing the call for static treatment and total recall are not easy bedrock in clinical practice. Further, the distinctions made between an effect on one part of the body and a benefit, which improves the person as a whole is not always readily detectable in acute illness.

Others have pointed out the importance of determining treatment goals when defining an absence of benefit. A common example is the patient for which living for a few days may be beneficial because it would allow her to say goodbye to family, or permit timely arrival of distant relatives. Thus, while some have argued that patients and families need not be consulted in determining futility, only those invested in their goals for treatment understand the quality of their care and can help care providers better appreciate the inconveniences of awaiting death in our society. While the decision to forgo prescription of therapy that doesn’t work, may rest with the physician, patient and surrogate dialogue guide the exploration of the desired outcome, the acceptability of
burdens, and the participants’ willingness to gamble on miracles, compress morbidity, or anticipate bereavement. Research into outcomes of resuscitation should help determine more precisely the expected weight of intervention and thereby more clearly demonstrate which interventions are without supporting evidence.

Medical technology and the moment of death are usually knit together, orchestrated by well-intentioned professionals paid and often constrained, to act as if death is avoidable. There is often the fear of blame, which motivates useless hyperactivity at the moment death. There is no moral difference between withdrawing a treatment that is felt to offer no benefit and withholding one that is not indicated. However, the ease with which non-beneficial treatments are withheld or withdrawn once instituted, may be relative to the practice setting, medical provider perceptions’ of litigation risks, and training biases aimed at providing cures.

Prior research has established the medical pointlessness of continued ED resuscitation efforts for patients in cardiac arrest who fail to respond to non-hospital ACLS. Yet, there is continued transport of many patients to hospitals after failed out-of-hospital resuscitation attempts. A few studies have looked at family acceptance of terminating unsuccessful pre-hospital arrests in the field. The findings indicated families did not expect that EMS treatment always include transport to a hospital, and were satisfied with ending unsuccessful arrests at the scene. Jurisdictions differ in whether physician radio backup or even on-site medical doctors are employed to terminate unsuccessful arrests in the field. State law defines who can legally determine that extraordinary procedures not be used to continue life, and who can implement such an order. While the concept of futility may seem grounded by law, order, and common sense, the comfort of hopeless or dying patients and their families, remains the real work of medicine.
Study Questions

1. Discuss situations in which you might justify halting resuscitative treatments in or from the emergency department.

2. What options are available to the paramedics in treating patients without advance directives when death is expected and 911 is called?

3. Discuss the difference between strict medical futility as no possibility of long term survival, and futility as lack of benefit.

4. Should the trained preoccupation with preservation of life be dispensed to all patients regardless of their wish for a natural death at the end-of-life?

5. Does this case fit the definition of medical futility? What efforts toward resuscitation should be attempted?

6. Is there an ethical or medicolegal difference between withholding and withdrawing life sustaining treatment?

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VII. Issues Related to Justice

A. Stewardship of Health Care Resources

Objectives:

1. To understand the meaning of justice
2. To understand stewardship of resources
3. To be able to describe the emergency physician’s relationship to society

Case Study

*It is 11 pm on a Saturday evening. A 22-year-old woman comes into the emergency department stating that her last period was 6 weeks ago and a home pregnancy test was positive. A urine pregnancy test n the ED is positive. She is having no symptoms other than nausea and vomiting but wants you to order an ultrasound to show that everything is okay. If an ultrasound is done now a technician will come from home and the study will be billed as an emergency procedure.*

Since health care resources are not unlimited, emergency physicians have an obligation to use those resources wisely. Justice is the principle that guides our actions in regard to others and is the ethical principle evoked when the interests of individuals or groups compete. When we must make a decision that involves competing interests of individuals or groups, then justice may guide our actions. Thus, justice is the principle generally used in arguments about access to health care and stewardship of resources.

**Definition of Justice**

Justice is related to the idea of human equality. The idea of the equality of all of human beings is found in many traditions. The ancient Greeks saw all humans as equal sparks of Zeus, while in Hindu traditions humans have an equal destiny through the cycles of reincarnation. Christianity is also based on human equality. In secular thought, Thomas Hobbes, Rene Descartes and Karl Marx all consider equality a basic axiom. The American constitution and democratic principles are based on the idea of human equality (although, originally, this equality was limited to white males).
Moral theories apply the principle of justice differently, but all agree on the basic concept that equals must be treated equally. This is called the principle of formal justice. To make the principle of justice meaningful requires defining the relevant characteristics of equals. These characteristics are called material principles. Beauchamp and Childress offer six examples of material principles that could be a part of a theory of justice:

1. To each person an equal share.
2. To each person according to need.
3. To each person according to effort.
4. To each person according to contribution.
5. To each person according to merit.
6. To each person according to free-market exchanges.

A theory of justice can accept any or all of these material principles. The principles are then used to determine the relevant properties that one must have to qualify for inclusion in a group deserving of equal treatment.

Distributive justice fairly determines who actually gets resources. In this regard justice makes a distinction between equal distribution and equitable distribution. Equal distribution implies that equal shares are distributed. Equitable distribution implies that shares are distributed fairly, taking into account need. Emergency physicians must attempt to reconcile the goals of equitable access to health care and just allocation of health care with the scarcity of resources and the need for cost containment.
Stewardship of resources

Emergency physicians have the obligation to ensure that quality care is provided to all patients presenting to the ED for treatment. This means that they must strive to provide care including new technologies, based on individual patient needs and the appropriateness of the therapy as documented by medical literature. Participating in quality assurance activities and peer review; using evidence based guidelines; and attending continuing education are important ways of assuring that high quality care. At the same time, the emergency physician has an obligation to diagnose and treat patients in a cost-effective manner. Emergency physicians must keep the patient's interest as a primary concern while recognizing that inappropriate, marginally beneficial, and futile care is not required and may use scarce resources that could potentially benefit others. Thus, the emergency physician has dual obligations to steward resources prudently while honoring the primacy of patients' best medical interests.

Study Questions

1. What do you think are the relevant characteristics that should be considered when determining who should be considered equal?

2. How should you respond to the patient in the above case?

Bibliography


VII. Issues Related to Justice

B. Duties and Responsibilities

Objectives
1. Define the "Good Samaritan" statute in your state.

2. Explain the applicability of the "Good Samaritan" statute to emergency physicians in the prehospital setting and in the Emergency Department.

3. Define your ethical and legal duty to patients who present to the ED.

Case Study
1. A patient presents to the emergency department with nausea, vomiting, and mild diarrhea. The patient belongs to an HMO that requires pre-approval for emergency care. The HMO denies approval for the patient to be seen in the ED, since the patient has no fever, no significant abdominal pain, and is not dehydrated.

2. An emergency physician is walking down the street when she witnesses an assailant stab another person and run away. The assailant dashes into the street and is struck by an oncoming car and appears to be lying unconscious on the pavement.

As emergency medicine grows and matures, so do the legal and moral obligations required of the specialty. The Code of Ethics for Emergency Physicians of ACEP states, “because of their unique expertise, emergency physicians have an ethical duty to respond to emergencies in the community and offer assistance as a special resource.”

Emergency physicians have both an ethical and legal duty to evaluate and treat any patient who arrives requesting treatment. These patients must at least be screened to ensure that no illness exists that will cause harm to the patient if untreated. This duty is based on the principles of beneficence and nonmaleficence as well as justice. The *Emergency Medical Treatment and Active Labor Act of 1985* (EMTALA) has further defined this obligation. Reimbursement issues do not affect this duty; all patients must be evaluated regardless of ability to pay. If potentially significant illness or injury is present, the patient must be provided with the treatment necessary to stabilize his or her condition.
Health care reform and managed care added new strains to emergency physicians' traditional role of providing universal access. In an effort to control costs, third party payers expected "gatekeepers" to limit access to specialists and other services. At the same time, EMTALA and the principles of emergency medicine require emergency departments to maintain their availability to all patients who seek services, and screen patients to determine the extent of their urgent medical need.

However, there are circumstances that may limit the obligation to treat patients. Although all health care providers assume some personal risk in choosing to treat patients, emergency physicians are not required to place themselves in excessive physical danger. Patients who are threatening physical harm to staff or other patients do not have a right to treatment. Weapons may also be removed from patients as a condition of treatment. We do have an ethical obligation to treat patients despite the risk of exposure to contagious diseases.

In addition to defining responsibility of health care workers on the job, society has an interest in promoting the willingness of people with health care expertise to assist others in need even when the person with expertise is not on the job. "Good Samaritan" statutes have been instituted to serve this end. These laws generally state that law protects a person who has no duty to another and expects no payment for services as long as no gross and willful negligence is committed. The "Good Samaritan" rule does not apply to physicians in the emergency department since a duty is recognized to all patients present, but would apply to a physician who comes upon an automobile accident or witnesses a cardiac arrest, for example.

Some situations have conflicts that must be evaluated by the emergency physician when deciding to act as a Good Samaritan and each situation must be evaluated individually. Some of the conflicts include: uncertainty about whether to stop to give aid vs. summoning for help, existence of compelling personal exigencies, fear for personal
safety, and fear of legal repercussions. Of note, no suit has ever been filed in the US against a physician for providing emergency care outside the hospital.

**Study Questions**

1. What is the duty of the emergency physician to the patient in these cases?

2. Under what circumstances might you refuse treatment to a patient?

3. For the first case, is it acceptable for the emergency physician to look at the patient, briefly examine the abdomen, and provide detailed, written instructions of signs and symptoms that signify an emergency?

**Bibliography**


VII. Issues Related to Justice

C. Moral Issues in Disaster Medicine (Triage/limited resources)

Objectives

1. Discuss the scope and limits of medical effectiveness in disaster situations.
2. Identify the moral principles underlying triage.
3. Discuss criteria for making triage decisions and their ethical justification.

Case Study

Police receive a call that a chemical agent has just been released at a crowded sports event, which the governor was attending. The caller states the agent is lethal, but does not identify it. As the only physician covering that evening in the emergency department, you are notified. Soon, reports of ill spectators are called and multiple ambulances arrive with patient and paramedic complaints of respiratory distress. News channels broadcast the “late-breaking events,” and dozens of civilians begin arriving with complaints of nausea, shortness of breath, and concern that they were recently at or near the stadium.

Disasters, by their nature, overwhelm an emergency department’s normal operating parameters. This may include terrorism, natural events, accidents or exposures, internal disruptions that compromise services, or even isolated events that cause exceptional disruption (eg. infectious diseases, celebrity patients, public concerns…). In a disaster, emergency departments shoulder the brunt of the work, and the corresponding chaos. Preparing for potential disasters and maintaining an organized department are the paramount. Recent disasters have increased global awareness regarding the need for a cohesive infrastructure; an inability to communicate and respond caused loss of lives in both the 9/11 terror attack and the Asian tsunami of 2004.

The ethics of disaster medicine rely on triage. Triage is based on the principle of providing the greatest benefit to the greatest number of patients. All arriving patients should be triaged (after any necessary decontamination) through one area when possible, with all ill and injured being evaluated by a physician if possible. Assessment of status by the triage physician dictates further care. Ultimately, the maximum benefit must be given; this requires that non-
threatening problems be transferred or postponed, and non-survivable patients be relinquished to palliative care.

Patients whose injuries/illness are potentially fatal must be assigned status based on multiple factors: likelihood of benefit, duration of benefit, resources required for treatment, and the “multiplier effect”. The multiplier effect contends that patients who may go on to help others should be given treatment. For example, officers, firefighters, medical personnel, all should be treated if it returns them to duty, thus aiding the effort. Ethically, priority should not be given based on social status. The tendency to give preferential treatment to celebrities, politicians, or acquaintances can be strong, but is not just.

Initial treatments should emphasize maximal benefit, as well. Interventions such as establishing an airway or stopping bleeding should receive priority, as they may prolong the patients’ survival potential. Pain management should be stressed in all patients, even the terminal.

Lastly, management of asymptomatic patients (the “worried well”) must be addressed. At the initiation of a disaster situation, separation must be made for arrivals. Patients who are concerned about exposure should be triaged and placed together for education and observation. Education should stress the nature of the situation, the need for cooperation, and the symptoms of concern. Patients who subsequently develop symptoms may need to be re-evaluated. It should not be assumed that the development of symptoms among the “worried well” constitutes psychosomatic transference.

Remember, an ounce of prevention is worth a pound of cure; being active in the creation and maintenance of disaster plans is ethically and pragmatically imperative, especially in small hospitals where resources are most limited. Proper communication channels, response mechanisms, and resource allocations should be addressed before the need arises. If possible, decontamination and triage areas should be established outside the emergency department before arrival of patients, especially when an unknown exposure is involved.
Study questions

1. How should you proceed to care for patients in this case?
2. Would you give some priority attention to the governor?
3. Could any patient distract you and cause you to pay extra attention or provide longer, more attentive care?

Bibliography


VIII. Education in Emergency Medicine

A. Interpersonal issues

Objectives

1. Discuss and understand how interpersonal conflict with patients and caregivers can adversely affect patient care.

2. Outline techniques for diffusing an interpersonal conflict between physician and patient and between physician and other caregivers.

3. Define appropriate and inappropriate romantic relationships in the context of a residency training program.

Case Study

Early in an academic year, it becomes apparent that a junior faculty member has become romantically involved with one of the new interns. At first there are rumors, and although neither person has publicly admitted the relationship, later it becomes increasingly a source of gossip in the E.D. A few of the other residents have been overheard making comments about “getting special treatment” from the faculty. The intern in question is doing well academically, and the faculty member is not in a designated position of administrative authority (assistant residency director, etc.)

Discussion

Interpersonal relationships are a reality in the emergency department as in almost every work environment. Most often, these interactions are the means of communication with our patients and fellow caregivers and add to the enjoyment of the job. At times, however, these relationships can be a source of conflict, and can adversely affect patient care.

Patient-physician relationships can be a challenge in a busy E.D. A physician has a very brief period of time in which to meet the patient and associated family/friends, establish rapport, take an appropriate history and physical exam, form a differential diagnosis and diagnostic/therapeutic plan, and discuss this adequately with the patient and family, answering all questions in an appropriate manner. In situations where this
line of communication breaks down or is difficult to establish, it is important for the emergency physician to remember that most patients feel powerless and frightened when placed in this environment. Patience and a caring approach will go a long way towards breaking this barrier of fear and distrust in even the most demanding and abrasive patients. In the end, the investment of a few extra minutes to develop the patient-physician relationship may make the difference in a patient’s agreement and compliance with the proposed plan of care.

Professional relationships (physician-physician, physician-nurse, etc.) are another potential source of conflict in the E.D. Limited time and resources, differences in treatment goals (emergency physician vs. consultant or primary care physician), poor communication and personality clashes can all contribute to conflict between caregivers. In these situations, it is important to remain focused on the needs of patient care. One ought to approach these situations with the question, “What is in the best of interests of this patient?” Most of these conflicts can be resolved with a return to this basic premise. All caregivers, though they approach from different perspectives, have the same fundamental goal: high quality medical care for the patient.

Romantic relationships are another potential source of ethical conflict within the emergency department. Clearly, a romantic relationship between a caregiver and patient can lead to exploitation of the patient and can be detrimental to that individual’s physical and mental health. Additionally, in a residency training program, as in any academic hierarchy, there is a potential conflict of interest if two individuals on different levels of the academic ladder establish a romantic relationship. Residents or students in training are vulnerable to coercion in such relationships. Whenever there is a difference in level of
power between participants, whether it be faculty-resident, resident-student, faculty-student, there is potential for conflict or abuse by the individual with greater power. Most academic institutions forbid relationships between teachers and students during periods of active instruction/grading (i.e. while students are taking an instructor’s class). As residency represents an ongoing process of education and evaluation, it is most prudent to avoid any relationship between faculty and resident that may develop into a conflict of interest. However, these relationships sometimes do exist. In those circumstances it is important to assure that the faculty member is not involved on evaluation of the resident and that mechanisms are in place to assure that both the individual resident and all other residents are treated fairly.

**Study Questions**

1. In the above case, if you were the chairman of the department, would you approach the faculty member concerning the relationship? How would you do it?

2. Should residencies have written policies forbidding all romantic relationships between faculty and residents?


**Bibliography**


VIII. Education in Emergency Medicine

B. Student Supervision/Autonomy

Objectives:

1. Describe the role of residents and faculty as educators.

2. Describe appropriate interactions with students.

3. Describe supervision and autonomy in education.

Case Study
A fourth year medical student, interested in emergency medicine, is working alongside a third-year resident in August. On a busy shift, there are simultaneously patients requiring suturing, casting, and chest tube placement. A stable and well-appearing young male also is being brought in on a backboard and in C-collar after a low-speed MVA.

Emergency medicine is increasingly a part of undergraduate medical education, and residents as well as faculty find themselves placed in the role of professor, often unexpectedly. The educational benefits of an emergency medicine rotation include diverse patient and disease presentations, high volume of exposure and subsequently increased learning opportunities, observation and practice of varied procedural skills, and appreciation of presenting symptoms. In order to provide competent healthcare, optimize learning, and promote the specialty, emergency physicians must be prepared to provide appropriate instruction. The goal of an emergency physician as educator is to impart knowledge while maintaining quality of care.

Medical students routinely perceive similar positive and negative aspects of emergency medicine. The procedures, the multi-disciplinary approach, the stabilizing of critically ill patients, the broad spectrum of problems, and the diversity of the patient population in EM are all points of interest to students. Students are concerned about the lack of follow-up, pressure/time constraints, managing multiple patients, lack of prior
knowledge of the patients, and management of difficult patients in EM. Therefore, residents and faculty should encourage participation in or observation of interesting cases, procedures, or learning points. Simple procedures or diseases, which may seem mundane to an ED physician, may be fascinating to a student. Offering to let a student observe -or if appropriate even perform- a procedure encourages the student and reinforces the teacher-learner relationship.

“Pimping” students can be an effective way to teach and to gauge a student’s knowledge base if the goal is student learning. Derogatory interrogations are counterproductive and reflect poorly on the teacher; a preferable approach is to ask students to research the answers they do not know and then present them. In an emergency department setting, this is often complicated by workload and the relative infrequency that a given resident or faculty member will work with a given student. One solution is to ask the student to review the subject briefly on-line in the department. Another approach might be to have the student e-mail his or her findings. Overall, the goal should to educate the learner in a supportive manner.

The primary role of a physician is that of patient advocate and healer. Maintaining optimal patient care in an educational atmosphere is a perennial concern. Debates continue regarding teaching procedures on patients, animals, and the newly deceased. Historically, admission to a teaching hospital required consent by patients to be seen by student physicians. In an emergent situation, however, consent is often not obtainable. The social benefit of educating future physicians competes with concerns for individual patients and emphasis must be placed on supervision and patient safety.

Medical students routinely list performing procedures, stabilizing critical patients, and working with diverse complaints as positive aspects of emergency medicine. Therefore, residents and faculty should encourage participation in or observation of interesting cases and procedures. Mundane tasks to an ED physician may be fascinating to a student. Offering to let a student observe -or if appropriate even perform- a
procedure encourages the student and reinforces the teacher-learner relationship. However, medical students are not qualified to care for patients independently, and procedural competency should be observed. One recent study showed that only half of procedures performed by students were observed by supervising physicians, with few of the unobserved receiving instruction. Initial observation and instruction can reduce the potential risk of performing procedures and increase the educational value. Subsequent independence with support further reinforces learning and confidence.

As part of the Hippocratic Oath physicians promise to help impart knowledge on future generations of physicians, and respect for the student aids successful education. While teaching styles are as varied as the physicians who use them, a standard of professional and respectful behavior should be enforced. Demeaning students in order to educate is counterproductive. “Pimping” students, by asking them questions regarding patients or illnesses, can be an effective way to teach and to gauge a student’s knowledge base. The student should not, however, be isolated and ridiculed for incorrect answers. In addition, while it can be argued that faculty members accept teaching as part of their employment, residents may have no experience or interest in teaching. Residencies should address this concern; brief educational seminars on teaching style and appropriate supervision may be useful in preparing the resident to function as teacher.

As in all relationships, supervision and autonomy vary, and must be shaped by the competence of the student involved. Optimal care and education rely on taking the time to interact with students, gauge their competency, and then give limited autonomy with reinforcement if necessary.
Study Questions

1. In the case presented above, what role by the student would optimize both patient care and learning? What procedures/level of patient care are appropriate?

2. What are students’ limits to practice in your institution?

3. Should consent be obtained from the patient/family if a medical student is involved in care?

4. Should an attending physician evaluate every patient who comes to the emergency department?

5. What are your beliefs about students being taught on animals/models/newly deceased?

6. What is your hospital’s policy on performing procedures on the newly dead?

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IX. Research Ethics

A. Research Design

Objectives:

1. To describe the ethical responsibilities of a principle investigator and his or her role in research design.

2. To describe considerations for when waiver of consent might be considered in study design. (Note that this is in contrast to exemption from consent which is described in a later section)

Case Study
You are a principle investigator researching the use of a novel cardiac ionotropic agent for use in patients with cardiac hypotension in the emergency department who are likely to have altered mental status. The drug appears to be most effective if patients are enrolled within 1 hour of arrival to the emergency department. How will some fundamental principles in ethical research guide your study design?

Sound and professional judgment is at the core of ethical research design. Before undertaking a new study the following questions should be asked:

- What types of subjects will be enrolled? Are there alternatives to human subjects?
- What is the relationship between the subject and the principle investigators? Is the investigator also the treating physician? Is there a power differential between investigator and subject that creates vulnerability?
- Is there a potential for conflict of interest between the subjects and the investigators? Are you so involved with the pressures of science (grant, publishing etc.) that your judgment may be clouded?
- Will you be considering exemption from consent in your research protocol?

Investigators share with research institutions as well as the sponsors of research the responsibility to protect research subjects. The responsibility for the safety and welfare of research subjects ultimately rests with the principle investigator. The principle
investigator must ensure to the highest possible extent that that 1) the dignity and autonomy of subjects are protected - chiefly via the consent process, 2) the research design is intended to maximize benefit while minimizing harm and that, 3) the benefits and burdens of research are shared across the range of potential subjects. Once investigators have asked themselves a series of questions in conjunction with the acceptance of the core responsibilities of the investigator then study design may proceed with detailed consideration of every aspect of the protocol. The investigator is responsible for every aspect of the research including the actions of authorized study personnel.

A particularly difficult and critical issue in study design is when the protocol may have time for patient enrollment as a factor and/or when the patient does not have decision-making capacity. This may be the case in a variety of commonly studied entities in the emergency setting such as cardio-pulmonary resuscitation research and brain injury research. In these cases, waiver of informed consent might be considered for minimal risk research. Investigators should proceed with extreme caution. Patients who are critically ill or injured and unable to provide meaningful prospective informed consent because of their current life-threatening condition are vulnerable and require additional protections beyond those for research subjects who can speak on their own behalf. The general criteria for waived consent are 1) minimal risk to subjects, 2) the waiver will not adversely affect the rights and welfare of the subjects, 3) the research could not be carried out without the waiver, and 4) subjects will be provided information following participation. Waiver of consent is distinct from exemption from consent.

For studies that involve greater than minimal risk, the Final Rule issued by the FDA and DHHS incorporate a number of additional patient safeguards that must occur if
a clinical trial is to proceed with exemption from informed consent. These are described in a later section.

**Study Questions**

1. In this case, what competing pressure might the PI experience in the study design?

2. Can the PI need to invoke waiver of consent in the protocol? What are the options in study design besides waiver of consent?

**Bibliography**


IX. Research Ethics

B. Ethics of Authorship

Objectives

1. Define authorship.

2. Define what substantiates a significant contribution to a work such that a person is listed in the byline.

3. Discuss the implications of granting inappropriate credit to a person on a manuscript.

Case Study

A third-year emergency medicine resident has just finished his research project. He has written a 5-page research paper with the guidance of his faculty advisor. When submitting the work for publication, he adds the name of the Chairman of his department as a final author as an honorary authorship.

Thousands of research manuscripts are submitted each year to medical journals. Through an extensive peer review, the editors of these journals strive to choose only the most relevant and quality work for publication. The integrity of the journal is dependent upon selecting work that is an honest reflection of important intellectual research by those listed as authors. Furthermore, these publications are an important part of the advancement of medicine. Written work serves as a communication of research to other scientists that may then accept, refute or expand on this work to further advance the medical arena. Because of these implications, it is important that the content not be fraudulent; however, it is also imperative that the authors who are taking credit for the work have contributed sufficiently to deserve such recognition.

According to the International Committee of Medical Journal Ethics’ guidelines, there are three criteria authors should meet to be listed in the byline, “1) substantial contributions to conception and decision, or acquisition of data, or analysis and
interpretation of data; 2) drafting the article or revising it critically for important intellectual content; and 3) final approval of the version to be published.”(icmje.org). Of note, directing the department or laboratory where the data was collected and/or attaining funds for the research through grants or other means are not part of these criteria. However, it is all too common that the names of these individuals become a part of the byline as well thus diluting the work of their co-authors.

This misrepresentation occurs for variety of reasons. Pressure exists in the world of academia to publish research. With an increasing competition for grant funding, tenure and promotion, there is strong incentive to be listed as a co-author. This designation is not without consequence. Not only does this give credit where it may not be due, but it also waters down the contribution of the other authors listed on the paper. Furthermore, with the article being cited in other manuscripts for years to come, this effect is intensified.

In the past, authors were held to an honor code to list in the byline only those persons who have made a substantial contribution. However, with the abuse of this trust, and the average number of authors listed per paper increasing through the years, several journals have taken a stand and have instituted new polices. Prominent journals such as JAMA, and the Annals of Internal Medicine now require statements from the authors regarding their involvement in the work that is being submitted. This is published for the readership to see. In addition, other journals have restricted the number of authors that can be listed. Nonetheless, it remains the primary responsibility of the authors to only accept authorship when the right has been earned.
**Study Questions**

1. Should the Chairman be included in the byline in this case?

2. What, if anything, should be done when there is significant disconnect between the contribution and the credit?

3. Should journal editors limit the number of authors on a manuscript?

**Bibliography**


IX. Research Ethics

C. Vulnerable Populations

Objectives

1. Define a vulnerable population in research.

2. Describe the ways to protect vulnerable populations in research study design.

3. Describe situational vulnerability and how this might relate to patients in the emergency setting.

Case Study

You are the principle investigator of an emergency department study that seeks to determine the efficacy of use of a new drug for cocaine related acute coronary syndromes. A patient presents with chest pain after cocaine use. He is alert, clinically stable, pain free and without ECG changes or initial cardiac marker elevation. He is thought to be able to give informed consent and meets the entrance criteria of the study. He is indigent and each participant enrolled will be given free cardiac clinic follow-up visits that will include transportation and costs and an incentive of $150 upon completion of 2 follow-up visits. The emergency medicine residents working in the ED are asked to recruit “any patient they take care of with cocaine chest pain”.

The Code of Conduct, adopted by the Society for Academic Emergency Medicine (SAEM) Board of Directors admonishes members who engage in research to “strive to safeguard the public and protect the vulnerable. As a researcher, one vows competence, compassion, respect, impartiality, integrity and responsibility.” Traditionally, vulnerable populations in research have included children, prisoners, adults with limited capacity to consent to research and non-English speaking patients. The National Bioethics Advisory Commission (NBAC) highlights a subject’s circumstances, which are situational, that create diminished autonomy and therefore make them vulnerable. That said, exclusion of vulnerable participants may constitute unethical research if those persons who are vulnerable are most likely to benefit from the research. The NBAC recommends that
investigators not exclude persons from research, but importantly, “change the design so that it does not create situations in which people are unnecessarily harmed”.

Despite a heightened presence of local and federal oversight, abuses of human research participants still occur especially susceptible are the vulnerable. The responsibility of ethical research firstly lies in the hands of the investigator. A global shift in thinking must occur to incorporate the NBAC model of ‘situation not classification’ into everyday research design and execution. “Vulnerability, in the context of research, should be understood to be a condition, intrinsic or situational, of some individuals that put them at greater risk of being using in ethically inappropriate ways in research. Persons defined here are vulnerable to unethical research either because 1) they have difficulty providing voluntary informed consent arising from limitations in decision-making capacity or, 2) they are especially at risk for exploitation.” Within the recommendations exists a broad array of considerations that might obstruct an otherwise competent subject’s ability to give their voluntary and informed consent. Six core caution areas have been identified where investigators should examine the need for special protections. One or all six of these vulnerabilities might be present in any prospective individual research participant or population of participants. (Table 1) The 2001 NBAC report seeks to not exclude persons from research, but manifests that all persons be incorporated into research such that potential benefits will be enjoyed across a wide range of individuals, not just those more easily accessed.
Table 1: National Bioethics Advisory Commission: Six areas of Vulnerability

<table>
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<tr>
<th>Type of Vulnerability</th>
<th>Definition</th>
<th>Some Possible Examples:</th>
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| Cognitive /Communicative | Persons insufficiently able to comprehend information, deliberate and make decisions about participation in research | • Low literacy  
• Cognitive Impairment not readily detectable  
• Non-English speaking |
| Institutional | Persons participant to the *formal* authority of others who may have independent interests | • Prisoners  
• Patients in Mental Health Facility |
| Deferential | Persons participant to the informal authority of others who may have independent interests | • Student  
• Employee |
| Medical | Persons who have serious medical conditions for which no satisfactory standard treatment exists | • Amyotrophic Lateral Sclerosis, Dementia, Traumatic Brain Injury, terminal cancer |
| Economic | Disadvantages in the distribution of goods and services | • A subject in need of medicine, clothing, food or money |
| Social | Persons belong to undervalued group | • Drug or alcohol addicted |

**Study Questions**

1. Beyond the traditional vulnerable populations defined by research oversight committees such as children, prisoners and the mentally ill, in the case above what types of vulnerabilities might exist?
2. How could the study design account for subject vulnerabilities?

**Bibliography**


IX. Research Ethics

D. Subjects’ Rights and Informed Consent for EM Research

Objectives

1. Define the moral principles for research on human subjects.
2. Describe how to obtain informed consent for research
3. Describe the unique moral challenges relating to research in an emergency setting.
4. Describe using emergency exception to informed consent in resuscitation research

Case Study
A new compound has been developed to replace normal saline in trauma resuscitation. Preliminary studies suggest it to be beneficial over normal saline. Only patients in extremis from blood loss will be eligible to be in the study to test the fluid. An unconscious 25 yr old male suffers a gunshot wound to the abdomen and needs aggressive fluid and blood resuscitation. Should he be entered into the study?

The ethical principles that govern research on human subjects include respect for people as autonomous agents, truth telling, beneficence in maximizing the benefits and minimizing the burdens for research subjects, and justice in equitably distributing the benefits and burdens of research. Use of human subjects in research is necessary to advance current knowledge of disease treatment, but this research may pose risks to those who participate. Historical events such as the Nazi medical experiments have shaped current regulations governing human subjects’ research. In these experiments prisoners were subjected to inhumane and cruel experiments without their consent. The physicians that carried out these experiments were ultimately put on trial. During the trial, expert witnesses provided a code of research ethics, known now as the Nuremberg Code, which established guidelines for the ethical conduct of medical research. The Code begins, “The voluntary consent of the human subject is absolutely essential”, making informed consent the centerpiece of protection of human subjects. The code further stipulates that
the research should be based on animal studies, should be conducted by qualified medical researchers and should avoid mental suffering and exclude death or disabling injury.

It wasn’t until 1979 that the Department of Health, Education, and Welfare charged a National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research with articulating the basic ethical principles that should underlie the conduct of human subjects research. In 1991, the proceedings of this Commission, known as the Belmont Report was used by the Office of Science and Technology Policy, Executive Office of the President, to draft and adopt a Federal Policy for the protection of human subjects, known as the Common Rule (45CFR46). The Belmont Report is a timeless document that contains the guiding ethical principles, justice, respect and beneficence to help solve ethical problems in scientific research.

The overall guiding concept for research on human subjects remains prospective informed consent. What happens when this consent is unable to be obtained secondary to a patient’s acute life-threatening condition? In 1996 the Department of Health and Human Services developed a set of regulations to govern research on subjects unable to consent. The regulations require that the research subject be in a situation that is acutely life threatening for which currently available treatments are untested or believed to be unsatisfactory. In addition, the potential subject must be unable to provide informed consent because of the acute clinical condition without time to contact the legally authorized representative (as defined by the state in which the research is being conducted) to obtain prospective consent. Further, the possibility must exist that the subject will directly benefit from participation in the study and there needs to be no
known harm to the subject. Finally, the regulations require community buy in for proposed research, and therefore, additional protective measures have been mandated.

While this provides a framework for doing research when consent is not possible one further consideration in emergency medicine is whether or not true informed consent the spirit of the Belmont Report can be obtained in the emergency room. In a recent review in *Annals of Emergency Medicine* Young et al recognize the potential for difficulty in obtain informed consent in the emergency department. How can a patient with active chest pain be expected to understand the risk benefit ratio of an experimental drug? They call for a national dialogue to further look at how informed consent can be obtained in the emergency setting. We have a framework for the unconscious patient but we may need further guidance on conscious patients who may not be able to fully understand the process due to their acute medical condition.

**Study Questions**

1. What are the guiding principles of human subjects’ research?
2. How does the emergency setting affect these guiding principles?
3. Can research be performed on unconscious patients?

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IX. Research Ethics

E. Research funding and conflicts of interest

Objectives:

1. To describe ethical issues related to commercial funding of research
2. To understand the importance of delineating data ownership prior to data collection
3. To develop an ethical and scientifically accurate approach to data management and dissemination

Case Study
A researcher in emergency medicine concludes data collection for a large study to compare two pharmaceutical treatments for pneumonia. The study was funded by a pharmaceutical company who produces one of the study drugs. The study did not demonstrate any significant differences in efficacy, yet demonstrated higher adverse event profile for the drug produced by the sponsoring company. The company insists that the data remain in their possession, and not be disseminated until approved by the company. The researcher wishes to publish the results, but is bound by a previous contract stating that the company owns the data and is responsible for dissemination.

Emergency physicians should support the moral and ethical conduct of research. Researchers have a responsibility to the public, the specialty of emergency medicine and to the academic community to utilize funding to conduct meaningful research to improve medical care.

Large studies are often funded by external sources, sometimes by pharmaceutical or other biomedical companies. External funding sources may present a conflict of interest for the researcher, who depends on the external funding source for income and wishes to cooperate with the source company. If research findings are not considered advantageous to the sponsoring company, the company may wish to prevent dissemination of the results. This presents an obvious conflict of interest for the honest researcher, who wishes to disseminate the research findings, whether positive or negative.
To minimize such conflicts of interest, research in emergency medicine should be conducted with emergency researchers directing or assisting in all phases of the research design, data collection, data analysis, and dissemination of results. Emergency physician involvement helps to ensure that research conducted in the emergency department and out-of-hospital settings is reported in a manner that is accurate, unbiased, and contextually appropriate.

Prior to the initiation of data collection, agreements between investigators and industry sponsors should be established in writing. Agreements should clearly identify researchers as being responsible for data collection, analysis, writing, and reporting. These agreements should assure that the researcher controls the final content of the manuscripts published. While financial support to researchers and assistants is certainly fair, remunerations should not be unduly generous, coercive, or dependent on research findings.

Researchers also have a responsibility to disseminate data through peer-reviewed scientific journals. Research results should be reported in a timely, accurate, and complete manner. Data should be presented in an unbiased, scientifically sound approach, and should be free of commercial or individual bias that may adversely affect the complete and accurate presentation of research findings.

All potential conflicts of interest, including external funding sources, should be disclosed. This may include disclosure to the investigator's institution, and in any reporting venues, including presentations, lectures, and publications.
Study Questions

1. Should emergency medicine researchers participate in research that is funded by pharmaceutical companies?

2. If so, under what conditions?

3. How can researchers avoid conflicts of interest that may affect data collection or reporting?

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X. Professionalism

A. Emergency physician relationships with other health care providers

Objectives:

1. Understand the aspects of EM that are unique in conflict generation.
2. Recognize the importance of conflict resolution skills in EM.
3. Understand the use of a conflict resolution skill set as it applies to EM.
4. Gain a framework for resolving disagreements and conflicts in the ED.

Case Study
A 24-year-old female presents to the Emergency Department with RLQ abdominal pain. After ordering routine labs you consult with a general surgeon to request an evaluation. The surgeon tells you, “I’ll be there in 2 hours, and don’t give the patient any pain medicine, I need to get a good exam.” After informing him that the literature indicates that pain medication is indicated and has not been shown to interfere with clinical exam, you are told, “I am the only one who will have to take the patient to the operating room and I don’t want my exam messed up.”

The specialty of emergency medicine involves multiple interpersonal and interdisciplinary interactions. Perhaps no other specialty forces the physician to interface directly with such a wide spectrum of professionals with various levels of training. During a shift, an EM physician may need to cooperate with police, social workers, EMTs, nurses, respiratory therapists and a variety of medical specialty physicians. All of these professionals bring diverse training and perspectives to their contribution to patient care. With such a wide array of personnel interaction in patient care, conflicts can be anticipated.

Because Emergency Medicine involves constant interaction with others, EM physicians must be skilled mediators and problem solvers. Traditional problem solving
involves both partners expressing their perspectives and coming to a face to face mutual agreement. This is not always possible in the fast paced environment of the ED.

Resolving conflicts in the ED involves specific skills, the most important of which is understanding the perspective, values and training of the person with whom one disagrees. The explanation of one’s rationale in resolving conflicts with members of each of these professions should be different. EM physicians should have developed the skill of communicating with patients and family members of various educational and socioeconomic backgrounds. Those skills can be used in conflict resolution.

The practice of EM creates opportunities for conflict with medical specialists. The inconvenience, reimbursement issues and unpleasant nature of some ED patients can serve to heighten the conflict. In working on conflict issues with other physicians it is paramount to keep the patient’s best interest at the forefront of any decision-making. EPs must also strive to avoid ‘specialty bashing’ by implying that certain specialties are deficient in specific areas. The best way to do this is to gain an appreciation of the knowledge base, practice patterns, and decision making of consultants of various specialties. If one understands the knowledge base and perspective of other professionals it is possible to frame a patient-centered discussion to resolve conflicts.

Patient management differences may result in physicians from different services acting in a hostile manner to those working in the ED, particularly nurses and medical residents. Procedures exist for addressing these clinical management differences, such as writing letters describing points of dispute to the chairperson or medical director. When those procedures are ignored, and other physicians attempt to use intimidation to express their anger, staff physicians and nursing administration in the ED should feel a
proprietary interest in their staff and should zealously advocate for those in their department. The most senior person present should deal with these kinds of breaches of procedure or human decency on an immediate basis.

Emergency medicine faces many challenges and opportunities with respect to interpersonal and professional conflicts. By keeping the patient’s best interest first, understanding the perspectives of co-workers and consultants, and maintaining the ability to compromise, the EP can lead the conflict resolution process.

**Study Questions:**

1. What aspects of EM make it likely to generate conflict?
2. What are the strategies for avoiding conflicts with specialist consultants?
3. How would you resolve the conflict in the case?


XI. Professionalism

B Physician Relationships with the Biomedical Industry

Objectives

1. Discuss promotional offerings that are clearly not to be accepted by physicians.

2. Explain circumstances when gifts of nominal value can be accepted.

3. Explain why the relationship with industry must remain ethically appropriate.

4. Explain the current level of knowledge residents and faculty have regarding the pharmaceutical industry.

Case Study
A drug company representative in the emergency department asks to speak with the senior resident. The senior resident sits with the representative in the charting area, and they discuss the value of his company's new antibiotic for an emergency department use, versus other products on the market. The representative distributes promotional material on the antibiotic to the resident and other residents in the area. The representative then reaches into his shoulder bag and passes out company pens, note pads, and penlights to the residents, and presents a "textbook" on infectious diseases for the resident's ED library. The resident thanks the representative for his gratuities. The representative passes out his card and offers to bring food to one of the future resident conferences, or pay for a noted emergency medicine speaker to come and present a grand rounds on infectious diseases in the emergency department.

The interaction between emergency medicine residents and the biomedical industry has been a matter of concern by organizations within emergency medicine for over a decade. As the biomedical industry must compete in a free enterprise market system, they must advertise products to physician consumers. Nevertheless, physicians must base their pharmacotherapy on the scientific literature. Promotional materials developed by the biomedical industry may not be designed to give physicians objective scientific data regarding a product. Physicians may not be aware of how undue influence, promotional materials and gift giving impacts their clinical decisions. In fact, residents and faculty knowledge about formal position statements or literature concerning the influence of marketing strategies, drug marketing costs, prescribing patterns and how
pharmaceutical representatives are trained to interact with physicians was found to be very limited. Furthermore, biomedical industry representatives are fundamentally motivated to promote only their product, and therefore, a presentation from them is inherently biased.

Speakers who receive excessive compensation may also have a conflict of interest. Invitations to speak at residency or CME conferences should come from the residency organization itself and not from the biomedical company. When examining the beliefs and practices of emergency medicine program directors regarding interactions with the pharmaceutical industry a wide range of practices were found to exist. When surveyed only about half said they “never” or “very rarely” allowed pharmaceutical representatives to teach residents. The majority of program directors desired CORD (The Board of the Council of EM Residency Directors) organizational guidelines regarding interactions with the pharmaceutical industry. A prospective CORD outline in addition to the ethics and research committee guidelines put forth by SAEM can help ensure a balanced and unbiased view of the scientific data presented.

A gift accepted by a resident physician should provide an education to the physician, or a direct benefit to the physician's patients. Residents of a program may accept textbooks of reasonable value, provided they are publications not specifically produced by the biomedical company. It is common for physicians to accept gifts of nominal value such as pens, penlights, and note pads. Gifts of significant value such as tickets to sporting functions, expensive dinners, or hospitality suite parties should be avoided. One standard to judge whether the gift is appropriate is to ask the question, "Would I be willing to defend this gift to my patients?" In addition, to help decrease the overall exposure to gifts, policies that have been implemented to restrict pharmaceutical representatives in the ED are associated with significant reduction in pharmaceutical advertising. Lastly, no gift should be accepted if it is given to reward a specific prescribing pattern or other physician behavior.
A healthy ethical relationship with the biomedical industry can exist. Scholarships, residency program support, monies to stimulate resident research or education could be directed to the residency organization itself, bypassing individual physician influence. Both the ethics committee and the research committee of the Society for Academic Emergency Medicine have developed guidelines for interaction with biomedical companies. These papers describe potential ethical conflicts in the relationship between physicians and the biomedical industry and suggest ethical guidelines for physicians and researchers. Emergency medicine residents and faculty should be conversant with these guidelines.

**Study Questions**

1. Why do biomedical promotional activities, such as gift giving, present potential ethical conflicts to the emergency physician?

2. What aspects of promotional materials and presentations by company-sponsored speakers could subvert a balanced, unbiased medical education?

3. How can physicians and residency programs interact to promote ethical relationships with the biomedical industry?

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X. Professionalism
   C. Mentoring

Objectives

1. Describe the significance of mentorship in academic emergency medicine.

2. Identify tasks appropriately undertaken by effective mentors.

Case Study
A third year medical student was contemplating the selection of a specialty. As he rotated through several specialties, he was drawn to the specialty of emergency medicine, in part due to the clinical environment and patient mix, but was also heavily influenced by the friendly environment, and effective teachers and mentors in emergency medicine.

Effective mentorship in academic emergency medicine is crucial to the advancement of emergency medicine as a specialty, as well as to the individuals involved in each mentorship relationship. Most academic emergency physicians aspire to be mentors for a variety of adult learners, including emergency medicine residents, other specialty residents, medical students, and numerous other adult learners.

During undergraduate and graduate medical training, clinical skills are taught utilizing a variety of approaches, which often include didactic teaching, bedside teaching, leadership, evaluation, and individualized mentorship. For example, if a weakness is identified in the management of respiratory failure, the faculty may utilize additional didactic sessions on respiratory failure and its emergency management, make special efforts to teach at the bedside of patients with respiratory failure, provide role models of how to manage respiratory failure, evaluate residents on their knowledge of respiratory failure, and individually counsel residents who are found to be deficient in their knowledge of respiratory failure. The same multifaceted approach should be utilized for other professional skills in medicine, including communication, compassion, honesty,
integrity, altruism, service, commitment, suspension of self-interest, commitment to excellence, authority, and accountability. Residency programs should include didactic teaching, bedside teaching, evaluation of residents, role models, and individualized mentorship as important approaches to teaching these skills. The observation of appropriate skills such as honesty, compassion, and communication, practiced effectively by role models, is crucial to the effective development of those skills by residents.

Effective leadership among faculty members provides an essential function in teaching professional skills to residents. The observation of appropriate skills such as honesty, compassion, and communication, practiced effectively by role models, is crucial to the effective development of those skills by residents.

Students with good mentors are more successful and satisfied with their medical careers. The current status of mentorship in emergency medicine varies greatly by institution and individuals involved. In the United States, there is a paucity of mentors to advise females and minorities. Some institutions have formal advisor programs, where faculty are paired with students or residents. At other institutions, mentors seek out learners to work with, or learners seek out mentors. Relationships may be structured and documented, or in many cases, relationships are flexible to accommodate individual needs and interests. Mentors may assist learners with such tasks as career guidance, problem solving, interpersonal skill development, residency selection, research interests, academic productivity, and ultimately, job selection.

**Study questions**

1. Should faculty mentors be held to a higher standard of professionalism than students or residents?
2. How much time and effort should mentors devote to their students?
3. Who should initiate mentor relationships: the mentor, the student, the institution, or a professional organization?

4. How can skills such as interpersonal communications and professionalism be effectively taught by mentors?

Bibliography


X. Professionalism

D. Physician impairment

Objectives

1. Define physician impairment.
2. Discuss the various types of physician impairment.
3. Discuss the causation, risks, treatments, and solutions of physician impairment.

Case Study

A 35-year-old emergency medicine physician is halfway through her third consecutive night shift in a busy urban emergency department. By 3:30 a.m., the boost from several sodas and a large cup of espresso have long since worn off. In a scene that takes place all too frequently, the physician downs a few caffeine pills to aid her through the remainder of the night.

The above situation is a myopic view of physician impairment that overlooks several key aspects of the topic. Physician impairment is defined as any condition that adversely affects a physician’s professional performance. This includes substance abuse disorders, but also psychiatric disorders, incompetence, physical or mental disabilities, inappropriate prescribing, and unprofessional conduct. When viewed from this larger perspective physician impairment is encountered with more frequency than we may think.

A 1992 JAMA article reports that as many as 10% of US physicians use alcohol daily. Physicians also abuse drugs, including benzodiazepines and opiates that are often self-prescribed. Unfortunately, most physicians with an abuse problem rarely recognize their addiction as a problem until secondary consequences occur in their professional or private lives.

According to a report to the Georgia Composite State Board of Medical Examiners, approximately 4% to 10% of physicians are brought to the attention of
licensing boards because of impairment related to major psychiatric disorders. In addition, some states report that 12% of referrals to physician well-being programs can be classified as “disruptive” physicians that exhibit compulsive behavior or excessive rage. Add to these statistics unreported cases of sexual misconduct, physical disabilities, and age-related impairments and the issue of physician impairment takes on a larger scale.

Not all examples of physician impairment are related to substance abuse, mental disorders, or other disruptive behaviors. The issue of clinical incompetence is one that is difficult to detect but has significant implications. Poor communication, lack of cognitive reasoning, or deficient knowledge base can all have negative impacts on a physician's patients and hospital environment. As with other forms of physician impairment, incompetence needs to be confronted and addressed to reduce risks and find solutions.

Hospital and department administrators need to work with physicians to develop effective ways to deal with impairment. Policies should be developed that are directed toward both prevention and management of these problems. The ability to detect and treat physician impairment in a non-threatening environment is of paramount importance. Instances of physician impairment should be addressed with minimal delay but with the utmost fairness and respect for fellow physicians.

Access to mental health counselors, regular reviews of the work environment, and open communication among colleagues are just a few ways to prevent physician impairment. The lives of patients, the quality of hospital care, and the well-being of physicians and their families all hang in the balance.
Study Questions

1. How common is the above scenario? Should excessive fatigue be considered physician impairment?

2. If one of your colleagues were impaired by alcohol or drugs, how would you handle it? To whom (if anyone) should the person be reported?

3. What if your colleague was cognitively impaired/incompetent? Should that situation be handled differently?

Bibliography


