

Ethics in the trenches: preparing for ethical challenges in the emergency department

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ABSTRACT

Ethical issues can be more difficult to address in the emergency department than in other settings. We present two cases, with the goal of stimulating moral reflection and encouraging emergency physicians to gain a better understanding of two important ethical issues: advance directives and resource allocation decisions.

Understanding the legal and ethical basis for advance directives allows emergency physicians to determine when the directives should be followed and when they should be questioned. Resource allocation decisions are among the toughest decisions emergency physicians make. Although patients or substitute decision-makers define the value of a treatment goal, emergency physicians must ensure that this goal does indeed represent the patient's wishes, that it is achievable, and that competing claims for the same resource are considered.

Learning from others' experiences and preparing for ethical problems in advance will help physicians feel more comfortable in dealing with ethical issues.

RÉSUMÉ

Il peut être plus difficile d'aborder des questions d'éthique au département d'urgence que dans d'autres contextes. Dans le but de stimuler la réflexion et d'encourager les médecins d'urgence à atteindre une meilleure compréhension de deux questions éthiques importantes, soit les directives pré-établies et les décisions d'allocation des ressources, nous présentons deux cas où ces questions sont en cause.

La compréhension du fondement légal et éthique entourant les directives pré-établies permet aux médecins d'urgence de déterminer quand celles-ci devraient être observées et quand elles devraient être remises en question. Les décisions d'allocation des ressources sont parmi les décisions les plus difficiles à prendre pour un urgentologue. Bien que les patients ou leurs porte-parole définissent la valeur de l'objectif d'un traitement, les urgentologues doivent s'assurer que cet objectif reflète les vœux du patient, qu'il soit atteignable et que les autres demandes pour la même ressource soient prises en considération.

En apprenant de l'expérience des autres et en se préparant à faire face aux problèmes éthiques, les médecins se sentiront plus à l'aise lorsque de telles situations se présenteront.

Key words: bioethics, emergency medicine, advance directive, resource allocation

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Introduction

An emergency department (ED) is a difficult environment to work in. Physicians know little about their patients, many of whom are anxious and in pain. The workload is unpredictable. Decisions must be made quickly. Good emergency physicians will rise to the challenge, making the best possible diagnostic and treatment decisions under these circumstances. They will also rise to the challenge of making the best possible ethical decisions. Unique ethical issues arise in this environment, and common ethical problems may be more difficult to address in the ED than in other medical settings.

Our goal in presenting these cases is to encourage emergency physicians to reflect upon important ethical issues they may face. A basic understanding of issues such as advance directives and resource allocation decisions is necessary for emergency physicians to provide the quality of care their patients need and deserve. Learning from others' experiences and preparing for ethical problems in advance will help physicians feel more comfortable managing these often complex problems. They will be more likely to employ a right process and come to a right conclusion when faced with ethical issues in their everyday practice.

Case 1: To tube or not to tube

A 75-year-old healthy male was working on the roof of his house when he slipped and fell 10 ft. to the ground. He was knocked unconscious. When the paramedics arrived he was awake but confused. His vital signs were stable (e.g., Glasgow Coma Scale [GCS] score of 14). He was immobilized with a C-collar and backboard and taken to the ED. Shortly after arrival in the ED he became more confused, then somnolent. His GCS score decreased from 14 to 10. The attending emergency physician was concerned that perhaps the patient had a significant head injury and was in the process of arranging for a CT scan when the patient's wife arrived. The patient's condition continued to deteriorate, to a GCS score of 8. The emergency physician prepared to intubate him, but when she discussed this with the patient's wife, the wife becomes upset and stated that her husband had a "living will," which specifies that, if he became critically ill, he would not want any resuscitative interventions, including intubation.

Ethical considerations

This case raises the issue of interpretation of advance directives and highlights some of the limitations of these

documents, particularly in the emergency setting. An advance directive (AD) is a statement that competent people make about their desired future medical care. It identifies the person they want to make decisions for them (proxy directive) or gives instructions as to the care they want (instruction directive) should they become incompetent or unable to speak for themselves. The ethical basis for following an AD is grounded in the principle of respect for patient autonomy. ADs are recognized law in all Canadian provinces, which means that treating someone against their wishes expressed in their AD is the same as treating someone without their consent. In 1987, an emergency physician gave a life-saving blood transfusion to a woman involved in a motor vehicle collision. He knew that she had an AD stating she did not want blood products *under any circumstances*. She subsequently sued him, and he was found guilty of battery.

An important difference in this case is that it was not clear if this elderly man wanted his directive to apply in every circumstance. People may complete an instruction directive to avoid "heroic measures" at the end of their life, without anticipating the constraints the directive will place on health care providers if the person suffers an acute but potentially reversible event, such as an allergic reaction or a motor vehicle collision. If a physician has evidence to suggest that the patient would want treatment in these situations, then it is legally and ethically appropriate to intervene despite an AD that states otherwise.

Emergency physicians should focus on the intent of a directive and not just the specific instructions. When possible, gathering information from family, friends and old charts can aid in the interpretation of an instruction directive.

Outcome

In this case, the physician suspected that the patient had written his AD with an irreversible process in mind. She questioned the patient's wife further and determined that the patient wanted to avoid resuscitation if he had a terminal illness, but had not discussed other scenarios with his wife. The physician explained that the problem might be a subdural or epidural hematoma — reversible with treatment — but the wife remained uncertain and wanted to discuss it with their son. The physician explained that there was a reasonable chance of recovery if she intubated the patient immediately and obtained an urgent CT scan, and that unnecessary delays could worsen the outcome. The wife consented, and the patient was intubated. The CT scan showed a large epidural hematoma that was subsequently evacuated. The patient made a good recovery.

Case 2: One final request

An 80-year-old woman was brought to the ED by ambulance. She had been well earlier in the day, but was found unresponsive that evening by a family member. On arrival in the ED her GCS score was 6; she was intubated. A CT scan revealed a massive intracerebral hemorrhage. The neurosurgical service felt there was no surgical option and a very poor prognosis. It was then noted that the patient was not triggering the ventilator and that she would likely die once ventilatory support was removed. The usual approach in this institution is to give the family time to accept the diagnosis and prognosis, then remove ventilatory support and provide palliative care.

The son, who had power of attorney for his mother, explained to the attending emergency physician that his mother had assets she wanted to transfer to her children. He expressed concern that if she were to die immediately, most of these assets would be taken by the government in the form of taxes. He indicated it would take 12 hours to arrange the transfer of assets and asked if she could be maintained on ventilatory support until the morning.

Ethical considerations

Are the family's financial concerns reason enough to continue active treatment, particularly when it involves limited and expensive resources? Ethically, medical treatments should be directed toward a valid and appropriate goal, and resources (particularly scarce or expensive resources) should be used in a way that is fair and just for all patients who may need them.

Some may question the validity of the goal in this case, arguing that the ventilator offers no possible benefit to the patient and may even be harmful if she is feeling pain or had expressed a wish not to be ventilated. It is also possible that the family is acting out of self-interest rather than in the patient's best interest.

The opposing argument is that prolonging ventilation would benefit the patient by allowing for the fulfillment of a goal that was important to her and her family. The value of a treatment goal should be determined by the patient or their substitute decision-maker (SDM), not by the physician. It is the physician's responsibility to ensure the SDM is acting in the patient's interest, and determine if the interventions considered can achieve the identified goals.

The next important question is whether ongoing ventilation is a fair and appropriate use of resources. Ventilated patients require expensive equipment, multiple health care providers and a bed in the intensive care unit. Might other

people be affected by this decision? Will another critically ill patient be transferred elsewhere or managed in a sub-optimal fashion because a ventilator is being used for this patient? Claims for the same resources should be weighed based on each claimant's need and on the likelihood that they will benefit from the resource. While the goals of this patient and her family have value, and an ICU bed may be appropriate if it is available, it would be hard to argue that another sick patient with a greater chance of survival should be displaced.

Outcome

The physician managed this case creatively. It was midnight, and he could not ascertain whether the son would be able to carry out his mother's wishes in a timely fashion. He had a lengthy discussion with the family to ensure that they understood the prognosis and were expressing their mother's wishes rather than their own. He believed the patient was not in pain. He negotiated with the nursing staff to move the patient to an unmonitored bed in the ED. The family agreed that treatment would be limited to comfort care and symptom control, and that if another patient needed the ventilator, it would be discontinued. The patient was ventilated until the morning, when her son went to the bank. It is unknown if the assets were successfully transferred.

Conclusions

Understanding the legal and ethical basis for ADs allows one to determine when they should be followed and when they should be questioned. Resource allocation decisions are some of the toughest decisions emergency physicians make. While patients or their SDM define the value of a treatment goal, emergency physicians must ensure that the goal represents a patient's wishes, that it is achievable, and that competing claims for the same resource are considered. Complex ethical issues can arise unexpectedly in the emergency department. A sound knowledge base and a creative approach will allow emergency physicians to find satisfactory solutions to difficult ethical problems.

Further reading

Case 1

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