

2012 SAEM ETHICS CURRICULUM

Module 8: Professional Responsibilities

SAEM Ethics Committee, 2011-2

Primary Author: Jean Abbott, MD, FACEP, MH; Denver Health Emergency Medicine Residency

ACGME EM Milestones:

- *ICS1 (Patient centered communication)*
- *PROF1: (Professional values)*

Review date: May, 2012

- 8.1 Code of Ethics for Emergency Physicians
- 8.2 Conflicts between personal and professional values
- 8.3 Cultural Differences and Cultural Humility

8.1. Code of Ethics for Emergency Physicians

Objectives:

1. Become aware of the code of ethics promulgated by our Professional Society, and also the general Code of the AMA.
2. Recognize priorities that may surprise providers and not be intuitively obvious.
3. Consider cases in which basic principles conflict in the delivery of patient care.

Questions pertinent to the ACEP Code of Ethics for Emergency Physicians:

1. Is there a limit to the primary responsibility, also expressed in the AMA Code of Ethics, to put the patient's welfare above your own?
2. What "prejudice or partiality" threatened your response to patient needs for emergency medical care?
3. Is truth-telling always in the benefit of patient "welfare"? Can you think of some exceptions? (#4)
4. What are the exceptions to confidentiality that are encompassed in "the duty to protect others or to obey the law"? (#5)
5. How do you experience conflicts between stewardship of health care resources and your relationship to an individual patient? (#9)
6. Is patient advocacy and political involvement mandated by principle #10?

Case 8.1.1 – request for confidentiality:

A 20s man presents with severe tachycardia, tremors, a history of alcoholism, and signs of significant alcohol withdrawal. He doesn't respond adequately to ED interventions. As you prepare to admit him, he asks you not to tell his mother and grandmother, with whom he lives. He is in AA, has had a DUI and is being monitored by the courts, and doesn't want to "get into trouble."

Case 8.1.1: Questions:

1. Should you agree to the patient's request?
 2. What should you say to the family if they ask if this is related to alcoholism?
 3. Is there a conflicting obligation to the public?
-

Case 8.1.2 – colleague requesting special treatment:

One of the Internal Medicine residents just came into the ED through the back door hobbling and in a splint after twisting her ankle snowboarding. The ED is packed, with a 3-hour wait. She asks if you can just get her through for an Xray.

Case 8.1.2: Questions:

1. Does the Code of Conduct, requiring you to see patients without "partiality", come into play here?
 2. What would you expect if you were in her shoes (or boots)?
-

Case 8.1.3:

You are up skiing when you notice a sign posted on several doors to base hotels, restrooms, ski shops, that states "Continuing Education Opportunities". The poster states that dentists, doctors and lawyers can pay and register for a seminar in a local hotel, with registration at 7:30 AM each day and a seminar offered from 7:30 – 9 am, and again 4:30 – 6 pm.

Case 8.1.3: Questions:

1. Does the "Principle of Ethics" in EM state anything about this practice?
 2. There are state licensing mandates and recertification requirements for CME that are sometime onerous to meet – here is an easy way.
-

Background Information

A profession is characterized by several features that distinguish it from a "job":

- 1) Practitioners have a specialized body of knowledge and special skills
- 2) Their specialized field has a social benefit
- 3) Members are granted extensive independence by society in matters pertaining to those areas
- 4) In exchange for significant autonomy, members have special obligations to society.

The general code of the AMA and the more specific Code of Ethics for Emergency Physicians outline the special obligations that emergency physicians have towards patients, colleagues, themselves and society.

One area where the Code of Ethics may be less than helpful is in areas of confidentiality and truth telling. Both of these are important values described in all codes. Some exceptions are clear: when a patient is an imminent threat to him/herself or others, beneficence and public safety warrant overriding patient confidentiality. But cases where the patient asks you not to disclose intoxication, or to not reveal HIV status, or an unexplained pregnancy are not as clear-cut. Likewise, the related important value of truth-telling can sometimes conflict with respect for patient, the family unit or traditions in some cultures. Balancing short-term good will vs. long-term beneficence for the patient, non-imminent but real risks to family, friends and the rest of society, make these difficult ethical choices for the professional.

It is useful to distinguish between genuine ethical dilemmas that we face as people and professionals on a daily basis from ethical “temptations” – i.e. situations in which we choose not to make the ethical choice. Does giving special treatment to your colleague feel a bit like an ethical temptation? Dr. Kellerman, in “Mommas’s Rules” essay in *Annals of Emergency Medicine*, uses the test of whether you are OK describing your actions to your mother. Others have used a “universalizability” test – would it be OK to treat everybody this way? Or the headline test: would it be OK to read this in a newspaper (on line, of course, these days). Indeed many of the pharmaceutical interactions that are currently being discouraged can have some good rationales, but the appearance of impropriety in a professional interaction makes them suspect to the society that has granted us such autonomy.

The difference between law and ethics has been described in several ways. The law usually reflects an ethical consensus of the society, but more often describes unacceptable actions or defines minimally acceptable standards of conducts. Lord Moulton, writing in the 1920s, described three domains of human action: those acts that are prescribed by laws which we must obey, those in which we have total freedom, and those which require “obedience to the unenforceable.” Many before and since then have described the realm of ethical behavior by this phrase. Codes of Conduct such as that of ACEP describe the “shoulds” of professional life. While registering for a course that give automatic CME and allows you to deduct a vacation is legal, it violates the unenforceable obligation you have to patients and yourself to engage in real education rather than racking up empty credit hours. In addition, as a member of society granted special privileges and reimbursed generously compared to most of your patients, is it appropriate to “game” the tax system by deducting what is otherwise a vacation?

One of the primary principles of both the AMA Code of Ethics and the ACEP formulation is the primacy of the patient's interest above the provider's. This "fiduciary" relationship protects the patient, who is seeking expertise, is ill and intrinsically vulnerable. The principle of putting the patient first is an effort to correct, to some extent, this intrinsically unequal interaction.

Bibliography

ACEP. Code of Ethics for Emergency Physicians. 2011 –most recent update. Available at: <http://www.acep.org/content.aspx?id=29144>. Accessed 3.30.12.

AMA. Code of Ethics, 2011, available at: <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page>. Accessed 3.30.12.

Kellermann AL. Mama's rules. *Ann Emerg Med*. 2009 May;53(5):688-9.

Moulton JF. Law and manners. *Atlantic Monthly*. 1924, <http://www2.econ.iastate.edu/classes/econ362/hallam/NewspaperArticles/LawAndManners.pdf>. Accessed 3.30.12.

8.2 Conflicts between personal and professional values

Objectives:

1. Recognize instances in which your professional obligations may conflict with your personal values.
2. Identify some processes for resolving these conflicts.
3. Recognize the complexity of values that allow you to treat patients with whom you disagree.

Case 8.2.1 – patient request for Viagra:

You have just completed evaluation of a 24 year old man who presented with acute bronchitis and mild asthma, which he has had since childhood. He lacks health insurance and you have written prescriptions to renew his asthma inhaler and a rescue prescription for prednisone for subsequent flares, recognizing that he has not access to ongoing care. He asks for a prescription for Viagra also, stating he has an interview for a movie job that would require the benefits of Viagra to better assure this job.

Questions for Case 8.2.1:

1. Would you write for this additional prescription?
2. If you were this patient's PCP, would you write for it?
3. How would you justify your answer according to your professional code?

Case 8.2.2 – Emergency contraception:

A 19 year old college student presents on Sunday morning at 10 am, stating that she and her boyfriend were fooling around last night and his condom broke. She has heard there is an emergency “morning after pill” and asks for this. You are a religious person who doesn't believe in abortion, and haven't sorted out what you believe about contraception in general.

Questions for Case 8.2.2:

1. What is your professional obligation to this patient?
2. Is your obligation different in an ED setting that it would be if she were not your patient, but just presented as a new patient in your primary care office?
3. Is your decision affected by the fact that she is a college student? Would it be different if she were a single G2, P2 woman who was uninsured and on Medicaid?
4. Would your decision be different if this woman was a rape victim, rather than the narrative that she was having consensual sex gone wrong?

5. Are there other personal values that you could embrace, even if the value of emergency contraception were one that you could not support?
-

Case 8.2.3 – trauma with culpable patient:

You are working in a small rural ED when two patients come in who are critical from a head-on crash on a county road. One is a 18 year old high school senior male with airway compromise, flail chest and hypotension and the other driver is a grossly intoxicated female in her 50s with poor level of consciousness, snoring breathing,, not moving her lower extremities, also hypotensive.

Questions for Case 8.2.3:

1. How do your personal values and feeling enter into your first few minutes of decision making in this situation?
 2. Who do you care for first?
 3. Can you or should you bracket personal values in favor of professional values, and how would you do that?
 4. What patient do you hesitate to treat or feel are morally problematic for you?
-

Background Information

It is admirable to say in theory that personal values need to be subordinated to professional commitments to treat the patient with respect and put their interests above your own, but the issues are more difficult in real life. We all live and have come to medicine because of our personal values and can't leave them at the door when we enter the ED. Indeed, our commitment to professionalism in our work is a reflection of deeply held values. On the other hand, society has granted physicians a "guild" or monopoly on writing prescriptions and treating persons, so to withhold treatments or medications on the basis of personal beliefs of the provider has to be done rarely and with good reason.

Conscience clauses for many professions allow providers to step aside, but not in the way of patient requests. This is true, for instance, for pharmacists who don't want to dispense contraceptives of RU-486, and who need to develop a plan prospectively for how to deal with this in the work situation. In a rural area they may be the only alternative for patients seeking a legally-accepted method of preventing pregnancy. In a big city or at a pharmacy where several providers are available, it may be possible to transfer the request to another provider on duty. There are studies that demonstrate that our treatments are influenced by our values – in one study, Emergency medicine practitioners were more likely to offer emergency contraception after sexual assault than after consensual sex, though $\frac{3}{4}$ of practitioners offered it regardless of the "event" precipitating the request. (Keshavarz)

The choice of specialty and situation may require different standards for exercise of conscientious refusal for physicians. If a physician goes into obstetrics and gynecology, he or she is not usually required to perform elective abortions because there is not a serious harm to a delay of a day or more from the patient's perspective and because patients are free to seek out other practitioners. Also, there is a wide societal disagreement on the acceptability of abortion.

For the EM physician, the bar as to what we need to respect in the way of autonomous patient requests is influenced by the nature of our specialty. Since patients often don't have the choice of which ED or ED physician, the onus is much more on the EM physician to allow the patient to expect that reasonable, medically indicated requests will be honored. This would, in most instances, include emergency contraception, treating alcoholic or drug-intoxicated patients, prisoners who have committed offensive crimes, and caring for people who have caused injury to others. It would include honoring end-of-life choices made by patients or authorized persons who wish to withdraw unwanted interventions, even if this causes the patient's death.

On the other hand, saying "no" may be part of the best practices for a borderline personality patient with unrealistic demands and non-medical needs. And is an EM physician required to write prescriptions for Viagra when it is not medically indicated? One could argue that this is not in the scope of EM practice, even for a medical indication like impotence. Nor is refilling large narcotic prescriptions for chronic pain from the ED part of best practices if the EM physician believes that the proper treatment of chronic pain requires multidisciplinary program over time, rather than ED rescue intervention that provides a one-time "quick fix."

Another way to approach the ethical dilemma of treating a patient against your personal values is to remember that each of us has multiple values, and that these are often in tension (see Module 7: Ethical Theory). Instead of feeling like we as providers have had our autonomous values hijacked when we are supposed to acquiesce to caring for a patient with very different values or life expressions, it may be helpful to emphasize the alternative values that we also hold to be important: such as, emphasizing our humility (in not knowing the whole story), respect for persons, compassion and suspension of judgment.

Bibliography

Cantor J, Baum K. The limits of conscientious objection – may pharmacists refuse to fill prescriptions for emergency contraception? *New Engl J Med.* 2004; 351: 2008-12.

Cassell EJ. Consent or obedience? Power and authority in medicine. *New Eng J Med.* 2005; 352: 328-330.

Charo RA. The celestial fire of conscience – refusing to deliver medical care. *New Eng J Med.* 2005; 352: 2471-3.

De Melo-Martin, Inmanulada. Should professional associations sanction conscientious refusals? *Am J Bioeth.* 2007; 7 (6): 23-4.

Kalvemark S, Hoglund AT, Hansson MG, Westerholm P, Arnetz B. Living with conflicts – ethical dilemmas and moral distress in the health care system. *Soc Sci Med.* 2004; 58: 1075-84.

Keshavarz R, Merchant RC, McGreal J. Emergency contraception provision: a survey of emergency department practitioners. *Acad Emerg Med.* 2002; 9: 69-74.

8.3 Cultural Differences and Cultural Humility

Objectives:

1. To recognize different customs or ways of decision-making that may affect the way you get or give information in the ED.
 2. To consider dilemmas involved in using translators in the ED.
 3. To become more aware of disparities that occur when patients have different emphases on values and these class with the more biomedical values of medical professionals.
-

Case 8.3.1 – Muslim woman refusing pelvic:

You are evaluating a 23-year-old Muslim woman for lower abdominal pain of unclear etiology. You need to do a pelvic exam, but she refuses, as does her fiancé, who states that they can no longer marry (which they are planning to do in 2 weeks) if she is not a virgin.

Case 8.3.1 Questions:

1. What are your choices?
 2. How much are you willing to compromise your standard work-up to accommodate this patient and her beliefs?
 3. What do you decide?
-

Case 8.3.2 – family doesn't want patient told:

A 94 year old Korean woman presents with abdominal pain and hypotension. She stabilizes with IV fluids, but a rapid ultrasound of her abdomen demonstrates a 10 cm abdominal aortic aneurysm. You order a CT scan of the abdomen. As you start to tell the patient what you are concerned about, her son steps forward and states that he wants to talk to you alone. He states that it is his role to understand the diagnosis and to make decisions, and that you should not be talking about these matters with her.

Case 8.3.2b Questions:

1. What are your options?
 2. What do you tell the patient when she asks what you are doing?
-

Case 8.3.3

A Navajo elder presents with progressive respiratory distress that has worsened over the last 2 days. He has known Stage IV Lung Cancer and is followed in your healthcare system. He appears to have a large pneumonia and is septic. You want to discuss the fact that he will die without intubation and understand his goals of care and understanding of his disease better, but you are aware that the use of the word “death” or “dying” is not acceptable to many Navajos, and will bring on the death itself.

Case 8.3.3 Questions

1. How do you proceed?
2. Would you intubate this patient since the conversation is so difficult?

Case 8.3.4 – communication with non-English speaking patients:

A 35 year old Somalian woman comes in with weight loss, abdominal pain and decreased activity over the past 2 months since she arrived from a refugee camp elsewhere in Africa, where she had been living for the past 10 years. All labs are normal, as is the patient’s examination.

Case 8.3.4 Questions

1. When do you use the translator phone and how? What are the problems with this?
2. What parts of the differential diagnosis are hardest to clarify in this patient with whom you can’t communicate directly?
3. How do you incorporate or exclude the family (several of whom are here with the patient) in the evaluation of this patient?
4. What resources do you advise and how do you give discharge instructions to her and her family.

Background Information

The term “cultural competency” has become popular in recent years to describe the professional skills need to interact with people of many different cultures effectively on behalf of their health. ACEP uses the term “cultural awareness” and may prefer to think of this as cultural curiosity or humility in order to emphasize the lack of a “one size fits all” body of knowledge that assures that the physician knows how to conduct him or herself with patients from different cultures. Residents often do not feel prepared to provide care for patients of other cultures, though these are often the very patients whose access to healthcare is limited and who may disproportionately seek care in EDs. (Weissman)

Awareness of the some of the potential culturally-based taboos should be part of resident education. (Sheridan) It is important, however, not to assume that providers can predict what persons of particular backgrounds will perceive as a taboo or a cultural norm

– how predictable are the social norms of us in this country?? For some Arabic persons, a man should not examine or do a pelvic exam on women, as in case 8.3.1. In this particular case, the physician negotiated with the family, did a trans-abdominal ultrasound, and abdominal pain recheck without doing the pelvic exam. When this is documented as the diagnostic plan, and recognized as a compromise of usual practice, it is supportable. In addition, it maintains the trust that will hopefully encourage the patient return if she gets sicker.

In several cultures, using the word “death” can bring that outcome about, and informed consent discussions must take that into account. Language must be carefully chosen, and it is helpful to ask a family member or cultural authority figure how best to approach the conversation, as in case 8.3.3. Likewise, in some cultures, burdening an older patient with end-of-life or important medical decisions is a sign of disrespect. This is the role of the adult children and is understood to relieve an honored elder of unnecessary concern. While Western culture may emphasize the ethical importance of “truthtelling”, the provider’s obligation is not necessarily forcing disclosure on a patient such as the one in case 8.3.2, but of asking the patient in a non-coercive setting how she would like the information to be conveyed, or how decisions get made in her family. The curious physician can then decide with the patient how to best respect her and her family. He or she also has a better chance of pushing back if concerns exist that the decision-making style first asserted by the family may jeopardize the patient.

Inability to communicate with patients because of “language discordance” is the most obvious barrier to quality care of patients from other countries. (Sheridan) Use of translator phones, though an improvement over translation by family members or children, is problematic. Even when professional interpreters are mandated, they are not uniformly used, friends or family members often serve well in this role, and the give-and-take of periodic explanations and checking-in on patients is much more difficult with a language barrier. (Ginde)

Health care disparities related to racial, ethnic and cultural differences were highlighted by the Institutes of Medicine in 2002, and multiple studies emphasize the difficulties in diagnosis, management and decision making that interfere with achieving the best healthcare outcomes for all patients. The ED particularly is a site where patients and physicians struggle – everything from need for rapid turnaround of patients, lack of records or ongoing relationship with the patient, different understandings of disease, stresses of immigration and inability of the patient to choose a practitioner who shares their world-view. Cultural difference is certainly a component of health care disparities, and awareness of the implications of these for treatment choices, access to follow-up, ability to follow instructions helps the ED physician avoid pitfalls that may make the encounter fail.

Discussion of cultural differences is actually a useful window into the potential “blind spots” that occur when physicians assume that their values and manners are universal. As the US becomes more diverse, awareness of differences in understanding of disease, decision-making processes in families, taboos that are culturally based is important. It also reminds the physician that even for those who “look like us” it is

compassionate and sensitive to ask patients as physicians engage them in decision making.

Bibliography

ACEP Policy Statement. Cultural Awareness and Emergency Care. *Ann Intern Med.* 2008; 52: 189.

Ginde AA, Clark S, Camargo CA. Language barriers among patients in Boston emergency departments: use of medical interpreters after passage of interpreter legislation. *J Immigrant Minority Health.* 2009; 11: 527-530.

Hobgood C, Sawning S, Bowen J, Savage K. Teaching culturally appropriate care: a review of educational models and methods. *Acad Emerg Med.* 2006; 13:1288-95.

Padela AI, Punekar IRA. Emergency medical practice: advancing cultural competence and reducing health care disparities. *Acad Emerg Med.* 2009; 16:69-75.

Richardson LD, Irvin CB, Tamayo-Sarver JH. Racial and ethnic disparities in the clinical practice of emergency medicine. *Acad Emerg Med.* 2003; 10:1184-1188.

Sheridan I. Treating the world without leaving your ED: opportunities to deliver culturally competent care. *Acad Emerg Med.* 2006;13:896-903.

Weissman JS, Betancourt J, Campbell EG, et al. Resident physicians' preparedness to provide cross-cultural care. *JAMA.* 2005; 294:1058-1067.