

2012 SAEM ETHICS CURRICULUM

Module 10: Issues Related to Justice

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ACGME EM Milestones:

- *PROF1: (Professional values)*
- *PROF2: (Accountability)*
- *SBP2: (Systems-based management)*
- *PC8: (Multi-tasking; managing surge)*

Review date: 4/2012

- 10.1 Stewardship of Health Care Resources
- 10.2 Duties and Responsibilities
- 10.3 Moral Issues in Disaster Medicine

10.1 Stewardship of Health Care Resources

Objectives:

1. Explain the meaning of distributive justice
2. Evaluate the importance of resource stewardship for physicians
3. Describe the emergency physician's relationship to societal needs

Case 10.1.1: Patient requesting a non-urgent test.

It is a Sunday afternoon. A 45-year-old woman comes in to the ED complaining of back pain. She has had it for the last two weeks and it radiates down her right leg. She denies any bowel or bladder incontinence or history of fevers or IV drug use. She has been taking Vicodin with minimal relief. On exam she has normal sensation and strength in her lower extremities. She states that she is scheduled for an MRI in two weeks but "just can't wait that long," and requests an MRI today. Performing an MRI would involve calling in a tech from home to perform it as an emergent study.

Case 10.1.1 Questions:

1. What 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?
 3. Would your response be influenced if she had private insurance? Or Medicaid?
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Case 10.1.2: Patient without insurance who will have poor follow-up access.

An uninsured 40-year-old construction worker slipped off open steps while carrying a load into the basement of a house he is framing. He landed on his left leg, and presents with swollen, tenting lateral skin on his ankle. You rapidly reduce the ankle to relatively normal alignment, and X-rays indicate a trimalleolar fracture. You splint the leg temporarily, then call the Orthopedics resident. She asks you to put him in a 3-way splint and call the clinic for follow-up. This has occurred before and you know that the patient will not be seen if he does not have insurance or cash to pay for surgery.

Case 10.1.2 Questions:

1. Is this just?
 2. What has EMTALA done to either help the ED or cause further problems?
 3. What causes “moral distress” in instances like this?
 4. What choices do you have in giving instructions and care to this patient?
 5. How should you respond to the orthopedics resident?
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Case 10.1.3: “Frequent Flyer” in the ED:

A 35 year old woman has sickle cell disease, on MS Contin with hydrocodone for breakthrough pain. She has a specialist following her, but presents for the 4th time this month complaining of nausea, vomiting and severe abdominal pain and leg pain, similar to prior pain crises. When you review her records, she usually requires admission for rehydration overnight, and is constantly requesting pain meds.

Case 10.1.3 Questions:

1. What causes “moral distress” in instances like this?
2. What should you do with this patient? Some options include:
 - a. Admit her directly, assuming you won’t be able to get her pain under control in the ED
 - b. Discharge her without treatment and tell her to go to her regular clinic
 - c. Withhold pain medication until you see the results of her labs, then only give her narcotics if her hemoglobin is low
 - d. Give her the Dilaudid, Benadryl, and Phenergan that she is requesting
3. Should this patient be coming to the ED?
4. If so, how do you alleviate the frustration of the staff?

Background Information

Since health care resources are not unlimited, emergency physicians have an obligation to use those resources wisely. Distributive justice is the principle of fairness in regard to others and to scarce resources. An ethical dilemma is triggered when the interests of individuals or groups compete. When we must make a decision that involves competing interests of individuals or groups, then justice should 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 strongly tied to the idea of human equality. The concept that all humans are equal has been found in many traditions through the ages, including American democratic principles (although this equality was originally limited only to white males).

Different moral theories apply this principle of justice differently, but all agree that equals should be treated equally. This idea, though, does not specify how to determine the equality of two individuals. For example, if a group of workers at a factory brought in a certain amount of profit to the company, what is the just way to divide those profits?

- To each person an equal share. This would mean that every worker, from the machine operator up to the managers and CEO, would receive an equal amount.
- To each person according to need. This would mean that the worker with the most number of mouths to feed at home, or the worker who has huge medical bills, would get a larger share.
- To each person according to effort. This would mean that the workers who worked the hardest were paid the most. But if hard working is defined as physical labor, then the machine operators would make more than the managers. How would you define effort?

These are just a few of the potential ways to determine equality among a group. A theory of justice can accept any, all, or other of these principles.

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—although not necessarily equally—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.

10.2 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 pre-hospital setting and in the Emergency Department.
 3. Define your ethical and legal duty to patients who present to the ED.
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Case 10.2.1: Interactions with insurers and patients.

A patient presents to the emergency department with nausea, vomiting, and mild diarrhea. The patient called her HMO for pre-approval but was denied because she had no fever, significant tenderness, and or dehydration. She feels as though she needs IV fluids and pain medicine, though.

Case 10.2.1: Questions

1. What is the duty of the emergency physician to this patient?
 2. Should you discuss with the patient the possible denial of payment for this problem? What would you say?
 3. Are there circumstances in which you could or should refuse treatment to this patient?
 4. 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?
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Case 10.2.2: Physician obligations in public.

An emergency physician is walking down the street when she witnesses a man with a gun leave a bank with a satchel full of money. The bank robber dashes into the street and is struck by an oncoming car and appears to be lying unconscious on the pavement.

Case 10.2.2: Questions

1. What is the duty of the emergency physician to the patient in this situation?
 2. Under what circumstances might you refuse treatment to a patient?
 3. Does the EM physician have any special duty above and beyond another physician (for example, a psychiatrist or dermatologist) or a lay person when in public?
 4. Is the EM physician liable for complications in such circumstances?
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Background Information:

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

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 the 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 an out-of-hospital 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.

10.3 Moral Issues in Disaster Medicine

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.
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Case 10.3.1: Physician response to a disaster

Police receive a call that a chemical agent has just been released at a crowded sporting 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 received and multiple ambulances arrive with patients complaining 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.

Case 10.3.1: Questions:

1. How should you proceed to care for patients in this case?
 2. Would you give priority attention to the governor?
 3. Could any patient distract you and cause you to pay extra attention or provide longer, more attentive care?
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Case 10.3.2: Triage during an ED disaster

It is February, the height of flu season, and this year your department is getting hit hard. There are few inpatient beds and patients have been boarding in the ED for days. Your waiting room hasn't been empty in about a week. You are seeing patients in the hallway, in triage, and in wheelchairs. The CDC is saying that it will likely get worse before it gets better. Your ED director calls a meeting to discuss what can be done.

Case 10.3.2: Questions

1. Can you change the way your department sees patients to better deal with this crisis?
 2. The first case is an acute disaster; the second is slower in developing. Does this affect your disaster response?
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Background Information

Disasters, by their nature, overwhelm an emergency department's normal operating parameters. These 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 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 rest in 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. Assessment of status by the triage physician dictates further care. Ultimately, the maximum benefit for the maximum number of patients must be given; this requires that non-threatening problems be transferred or postponed, and non-survivable patients be given palliative care.

Patients whose injuries or 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, police officers, firefighters, and medical personnel, should all 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. Futile efforts, such as the attempted resuscitation of a patient with head injury with brain matter visible, are not warranted. 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.

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