

Ethics in the trenches: Part 2. Case studies of ethical challenges in emergency medicine

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ABSTRACT

Unique ethical issues arise in the practice of emergency medicine, and common ethical problems are often more difficult to address in the emergency department than in other medical settings. This article is Part 2 of the Series "Ethics in the Trenches" and it presents and analyses 2 cases — each dealing with an ethical challenge that emergency physicians are likely to encounter. The first case deals with patient refusal of care. When a patient refuses recommended care, the emergency physician must ensure the patient's decision is informed and that the patient comprehends the implications of his or her choice. The second case deals with patient involvement in criminal activities. Emergency physicians often encounter patients who have engaged in illegal activities. Although certain activities must be reported, physicians should be mindful of their responsibility to protect patient privacy and confidentiality.

Key words: bioethics; emergency medicine; refusal of care; confidentiality

RÉSUMÉ

Des questions éthiques particulières sont soulevées en médecine d'urgence et les problèmes d'éthique courants sont souvent plus difficiles à aborder au département d'urgence que dans d'autres contextes médicaux. Il s'agit ici de la deuxième partie d'un article intitulé «L'éthique dans les tranchées» et deux cas sont analysés — chacun présentant un défi éthique que les médecins d'urgence sont susceptibles de rencontrer. Le premier cas aborde la question du refus de traitement de la part d'un patient. Quand un patient refuse les soins recommandés, le médecin d'urgence doit s'assurer qu'il s'agit d'une décision éclairée et que le patient comprend les implications de son choix. Le deuxième cas traite de l'implication d'un patient dans des activités criminelles. Les médecins d'urgence rencontrent souvent ce genre d'individu. Bien que certaines activités doivent être signalées, les médecins ne doivent pas oublier leur responsabilité de protéger la vie privée du patient et la confidentialité de ses rapports avec celui-ci.

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Introduction

Ethics in the Trenches is a series of case reports designed to help emergency physicians gain a better understanding of common and challenging ethical problems they will face in clinical practice. The first article in this Series dealt with the interpretation of advance directives and the fair allocation of scarce resources.¹ This article analyses 2 cases, the first dealing with patient refusal of care and the second dealing with patient involvement in criminal activities.

Case 1: “He doesn’t know what he’s saying”

A 27-year-old man is brought to the emergency department (ED) by friends, after consuming an unspecified amount of cocaine intra-nasally. He is unkempt, shivering uncontrollably, and extremely diaphoretic. His vital signs are: pulse 172 beats/min; blood pressure (BP) 196/130 mm Hg; respiratory rate (RR) 36 breaths/min; temperature 37.8°C; oxygen saturation (SpO_2) 100% on room air.

He is connected to a cardiac monitor, given supplemental oxygen, and an intravenous (IV) catheter is inserted. The physician asks the nurse to draw up 10 mg of diazepam. Upon hearing this, the patient says that he wishes to exercise his right to refuse medical treatment. He says he has been through this before and has recovered uneventfully. He feels that he is being judged by the medical staff for his lifestyle choices. He has several friends with him. They say that he “doesn’t know what he’s saying” and are adamant that he should be treated in spite of his stated wishes. When the physician returns to the bedside the patient lists the adverse outcomes that may result if he is not treated, concluding with “and even sudden cardiac arrest.”

How would you proceed?

Ethical considerations

Patients who refuse recommended care pose a significant challenge in the ED. Such patients can be uncooperative, and their ability to understand information may be impaired by medical pathology or intoxicants. The consequences of a decision to refuse emergency care may be serious and permanent. The many competing demands of a busy ED sometimes make it difficult for physicians to properly assess such patients before they are allowed to leave.

A patient with sufficient decision-making capacity has the ethical and legal right to refuse medical care. This refusal can be expressed by the patient, the substitute decision-maker, or through an advance directive.² Respect for patient autonomy requires that physicians provide patients

with accurate and complete information and respect the choices patients make, even if they disagree with those choices.³ However, when care is refused the physician must ensure the patient has the capacity to understand his or her choice, and that the risks, benefits and alternatives have been appropriately explained to the patient. In addition, the decision to refuse care must not be the result of inappropriate pressure or coercion.^{4,5}

When faced with a patient who refuses care, the physician must assess and document the patient’s decision-making capacity. It is not sufficient to simply explain the risks of refusing care and ask the patient to repeat these risks or to sign a form.^{4,6-8} A full capacity assessment is a complex undertaking, and it is impractical for emergency physicians to carry this out in a busy ED with a patient who may be uncooperative. The following questions are a reasonable screen. A capable patient should be able to answer all of these questions after their situation and options have been explained to them:^{6,7,9}

1. What is the nature of your current medical problem? (i.e., What is wrong with you?)
2. What options are available to you? (i.e., Do you know what your options are?)
3. What’s likely to happen if you accept the offered treatment? If you refuse it?
4. What is your choice?
5. Why have you made this choice?

The goal of this capacity assessment is to ensure that patients understand the implications of their choice, and that their decision-making process isn’t impaired. It can be carried out in a brief period of time, and should be done and documented by the treating physician.

Capacity is not an “all-or-nothing” phenomenon. Patients’ decision-making capacities are directly related to their ability to understand their options, appreciate the consequences of their choice, and express a choice that is consistent with their values. The more complex the decision, and the greater the risk a patient is assuming, the higher the degree of capacity that patient must demonstrate.^{6,7} For example, an intoxicated patient who has trouble appreciating some of the consequences of her or his decision may have sufficient capacity to refuse sutures for a small laceration, but not the capacity to refuse a CT scan after a serious head injury.

Intoxicants, hypoxia, brain injury, mental illness and dementia are common problems that can impair a patient’s decision-making capacity.⁶ The mere presence of these does not mean a patient lacks capacity. It does mean the

physician has to be particularly careful that the patient understands the consequences of the decision, and be satisfied the patient would have made the same decision in the absence of the underlying problem.^{4,6}

When a patient lacks decision-making capacity, the physician should institute emergency care, try to enhance the patient's capacity, and look for the substitute decision-maker.^{4,6,7,10} Capacity may be enhanced by administering treatments (e.g., oxygen for a hypoxic patient) or by waiting for intoxicants to wear off.

Outcome

In this case the physician carried out a brief capacity assessment and was satisfied that the patient did indeed understand the implications of refusing care. The IV was removed, and he was allowed to leave, despite his friends' protests.

Case 2: The body packer

A 41-year-old woman presents to the ED reporting that a condom containing "speed," which she had placed in her vagina 1 hour earlier, could not be retrieved. She is requesting examination, removal and return of the condom. Past medical history is significant for IV drug use, seizure disorder and an anxiety disorder.

On examination, she has slurred speech consistent with moderate intoxication, but is ambulating independently. Her vital signs are: pulse 89 beats/min; BP 109/81 mm Hg; RR 18 breaths/min; SpO₂ 97% on room air. She is afebrile. Pupils are mid-sized and reactive. Skin exam shows old and fresh IV access marks. The remainder of the examination is unremarkable.

How would you proceed?

Ethical considerations

This case raises important questions regarding the physician's ethical duty to safeguard patient privacy, and the physician's legal responsibilities in the face of a patient's criminal behaviour.

It is inadvisable to return the drugs to the patient. The patient is committing the crime of trafficking by transporting an illicit substance.¹¹ Returning the drugs might be considered to be abetting the patient in committing this crime.¹² Disposing of the drugs in the ED (e.g., in a toilet or biohazard waste container) is not recommended. Police departments have the means to dispose of illicit substances in accordance with federal regulations,¹³ but hospitals may not. A reasonable option might be to turn the drugs over to

the police after the patient has left the ED. This approach utilizes the proper legal channels to dispose of the drugs (thereby protecting the public), while also safeguarding the patient's privacy.

A physician's ethical duty to keep medical knowledge in confidence enables patients to protect their privacy.¹⁴⁻¹⁷ The confidentiality of a physician-patient relationship allows a patient to comfortably discuss personal information that is pertinent to his or her health. The patient's trust in the physician's discretion is essential to the therapeutic relationship.¹⁵⁻¹⁸

There are situations in which a physician is legally obligated to violate a patient's confidence. Child protection, motor vehicle, and public health statutes require the reporting of certain kinds of confidential information.¹⁵ This raises the question of whether physicians should set aside the duty to keep confidence, and report criminal activities as a matter of good conscience. The Criminal Code of Canada does not oblige a physician to report a patient's criminal activities to authorities (the sole exception being the crime of high treason).¹⁶ Reporting of a patient's criminal activities is supported in case law only when there is clear, immediate risk of harm to an identifiable party.^{16,18} Although it is unlikely a physician would be successfully sued for reporting a patient's criminal activities, any such breach of confidentiality might be cause for sanction from a provincial regulatory college.¹⁶

Because there is no obligation to report criminal behaviour, the individual physician must weigh the likelihood and magnitude of harm to the community against the patient's right to protect her or his privacy.¹⁷ Any decision to violate a patient's confidence must include a frank discussion of the situation with the patient.¹⁷ In this case, the likelihood of significant harm to the community by discharging the patient is small, and probably does not outweigh the physician's duty to keep patient confidence. There are other situations (e.g., patient encounters associated with violent crime) in which the risk posed to the community by the patient is significant, and police involvement may be appropriate.

Outcome

Pelvic examination revealed an empty vaginal vault, and the patient was discharged. ED colleagues, hospital risk management, and staff from other EDs generally agreed that there was no obligation to report the patient. Some physicians stated that they would have reported the patient, citing a feeling of responsibility to protect the community. In this case, the patient's criminal activities were not reported to authorities.

Conclusions

To meet legal and professional obligations and provide the highest quality of care, it is important that emergency physicians understand how to deal with patients who refuse recommended care or who are involved in criminal activities. The purpose of presenting the cases above is to ensure that physicians understand the ethical issues involved, have a sound decision-making process they can utilize if they encounter a similar case in their own practice, and feel comfortable making a rapid decision when necessary.

There are situations when physicians' personal feelings may be at odds with their professional responsibilities. When a belligerent intoxicated patient wants to leave against medical advice it is tempting to let them do so without an appropriate assessment. Many physicians will have a natural inclination to report criminals and criminal behaviours to the police. Although these responses are understandable, physicians must combine their "gut feelings" with a sound knowledge of ethical and legal responsibilities, to ensure they do the right thing in the right way.

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