

Code of Ethics for Emergency Physicians

Approved by the ACEP Board of Directors June 1997

Reaffirmed October 2001 by ACEP Board of Directors

This statement replaces Ethics Manual approved January 1991

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I. PRINCIPLES OF ETHICS FOR EMERGENCY PHYSICIANS

The basic professional obligation of beneficent service to humanity is expressed in various physicians' oaths. In addition to this general obligation, emergency physicians assume more specific ethical obligations that arise out of the special features of emergency medical practice. The principles listed below express fundamental moral responsibilities of emergency physicians.

Emergency Physicians Shall:

1. Embrace patient welfare as their primary professional responsibility.
2. Respond promptly and expertly, without prejudice or partiality, to the need for emergency medical care.
3. Respect the rights and strive to protect the best interests of their patients, particularly the most vulnerable and those unable to make treatment choices due to diminished decision-making capacity.
4. Communicate truthfully with patients and secure their informed consent for treatment, unless the urgency of the patient's condition demands an immediate response.
5. Respect patient privacy and disclose confidential information only with consent of the patient or when required by an overriding duty such as the duty to protect others or to obey the law.
6. Deal fairly and honestly with colleagues and take appropriate action to protect patients from health care providers who are impaired, incompetent, or who engage in fraud or deception.
7. Work cooperatively with others who care for, and about, emergency patients.
8. Engage in continuing study to maintain the knowledge and skills necessary to provide high quality care for emergency patients.
9. Act as responsible stewards of the health care resources entrusted to them.
10. Support societal efforts to improve public health and safety, reduce the effects of injury and illness, and secure access to emergency and other basic health care for all.

II. ETHICS IN EMERGENCY MEDICINE: AN OVERVIEW

A. Ethical Foundations of Emergency Medicine

Although professional responsibilities have been a concern of physicians since antiquity, the last twenty-five years have seen dramatic growth of both professional and societal attention to moral issues in health care. This increased interest in medical ethics is because of such factors as the greater technologic power of contemporary medicine, the medicalization of societal ills, the growing

sophistication of patients, efforts to protect the civil rights of disadvantaged groups in our society, and most recently, the rapidly escalating cost of health care. All of these factors contribute to the centrality, the complexity, and the urgency of moral questions in contemporary emergency medicine.

1. Moral pluralism

In addressing these questions, emergency physicians can consult a variety of sources for moral guidance. Professional oaths and codes of ethics are an important source of guidance, as are general cultural values, social norms as embodied in the law, religious and philosophical moral traditions, and professional role models. All of these sources claim moral authority and together they can inspire physicians to lead rich and committed moral lives. Problems arise, however, with the realization that different sources of moral guidance can, and often do, come into conflict in our pluralistic society. Numerous attempts have been made to find an overarching moral theory able to assess and prioritize moral claims from all of their various sources. Lacking a conclusive argument for the primacy of any one of these theories, we are left with a pluralism of different sources of moral guidance. The goal of bioethics, then, is to help us understand, interpret, and weigh our competing moral values as we seek reasoned and defensible solutions to the moral problems.

2. Unique duties of emergency physicians

The special setting and goals of emergency medicine give rise to a number of distinctive ethical concerns. First, patients often arrive at the emergency department with acute illnesses or injuries that require immediate care. Thus, emergency physicians have little time to gather additional data, consult with others, or deliberate about alternative treatments. Instead, in emergent situations, there is a presumption for quick action guided by predetermined treatment protocols. Second, patients in the ED often are unable to participate in decisions regarding their health care because of acute changes in their mental state. Thus, emergency physicians often are unable to consult with patients about their treatment preferences. Third, emergency physicians typically have had no prior relationship with their patients in the ED. Patients often arrive in the ED unscheduled, in crisis, and sometimes against their own free will. Thus, emergency physicians cannot rely on earned trust or on any prior knowledge of the patient's condition, values, or wishes regarding medical treatment. Fourth, emergency physicians typically practice in an institutional setting, the hospital ED, and in close working relationships with other physicians, nurses, emergency medical technicians, and other health care professionals. Thus, emergency physicians, to function appropriately, need to understand and respect institutional regulations and inter-professional norms of conduct. Fifth, emergency physicians have, in the United States, been given the social role and responsibility to act as health care providers of last resort for patients who have no other ready access to health care. Sixth, emergency physicians have a societal duty to render

emergency aid outside their normal health care setting when such intervention may save life or limb. Finally, by virtue of their broad expertise and training, emergency physicians are expected to be a resource for the community in prehospital care, disaster management, toxicology, cardiopulmonary resuscitation, public health, injury control, and related areas. All of these special circumstances shape the moral dimensions of emergency medical practice in important ways.

B. The Emergency Physician-Patient Relationship

The physician-patient relationship has been and remains the moral center of medicine and the major defining element in biomedical ethics. Broad principles can help to categorize the emergency physician's (and the patient's) ethical duties, but the unique nature of emergency medical practice, and the diversity of emergency patients, pose special moral challenges for the emergency physician. For example, the emergency physician-patient relationship is usually episodic, dictated by the patient's urgent need for care. Thus, the patient's willingness to seek emergency care and to trust the physician is based on institutional and professional assurances rather than on a personal acquaintanceship. The emergency physician's ethical duties in these relationships may be categorized into those dealing with beneficence, autonomy, fairness and nonmaleficence. Patients have ethical responsibilities in these relationships as well.

1. Beneficence

Physicians serve the best interest of their patients by treating or preventing disease or injury and by informing patients about their conditions. Emergency physicians respond quickly to acute illnesses and injuries to prevent or minimize pain and suffering, loss of function, and loss of life. In achieving these goals, emergency physicians serve the principle of beneficence, that is, they are acting in the best interests of their patients.

2. Respect for patient autonomy

Adult patients with decision-making capacity have a right to, and physicians the concomitant duty to respect, their preferences regarding their own health care. This right is grounded in the legal doctrine of informed consent. According to this doctrine, patients with decision-making capacity must give their voluntary consent to treatment after receiving appropriate and relevant information about the nature of the affliction and expected consequences of recommended treatment and treatment alternatives. Emergency physicians also should respect decisions about a patient's treatment made by surrogate decision makers or agents named in a health care durable power of attorney, if the patient lacks decision-making capacity. Emergency physicians should be able to determine whether a patient has decision-making capacity and who can act as a decision maker if the patient is unable to do so.

Emergency physicians may treat without securing informed consent when immediate intervention is necessary to prevent death or serious harm to the patient. This is, however, a limited exception. When the initiation of treatment can be delayed without serious harm, informed consent should be obtained. Even if all the information needed for an informed consent cannot be provided, the emergency physician should, to whatever extent time allows, inform the patient (or, if the patient is incompetent, a surrogate) about the treatment he or she is providing, and should not violate the competent patient's explicit refusal of treatment. Federal regulations also permit the waiver of consent for a limited number of emergency research protocols, provided they are ethical, approved by the appropriate governing bodies, and obtaining consent is not otherwise feasible.

To act autonomously, patients must receive accurate information on which to base their decisions. Emergency physicians should relay sufficient information to patients for them to make an informed choice among various diagnostic and treatment options. Emergency physicians, when speaking to patients and families, must not overstate their experience or abilities, or those of their colleagues or institution. Neither should they overstate the potential benefits or success rates of the treatment, procedures, or the research they propose. In some cases, for personal and cultural reasons, patients will ask that information be given to family or friends and that these third parties be allowed to make treatment choices for the patient. Patients may, if they wish, transfer decision-making authority over their care to others. Emergency physicians should rarely be the persons assuming this role.

Special moral issues may arise in the care of terminally ill patients. Emergency physicians should, for example, be willing to respect a terminally ill patient's wish to forgo life-prolonging treatment, as expressed in a living will or through a health care agent appointed under a durable power of attorney for health care. Emergency physicians should also be willing to honor "Do Not Attempt Resuscitation (DNAR)" orders appropriately executed on behalf of terminally ill patients. Emergency physicians should understand established criteria for the determination of death and should be prepared to assist families in decisions regarding the donation of a patient's organs for transplantation.

3. Fairness

Emergency physicians should act fairly toward all persons who rely on the ED for unscheduled episodic care. They should respect and seek to understand people from many cultures and from diverse socioeconomic groups. In the United States emergency physicians provide necessary emergency care to all patients, regardless of ability to pay. Emergency physicians also should strive to avoid having patient finances govern access to appropriate inpatient or follow-up medical care. Provision of emergency medical treatment should not be based on

gender, age, race, socioeconomic status, or cultural background. No patient should ever be abused, demeaned, or given substandard care.

4. Respect for privacy

Emergency physicians should be compassionate and truthful in all of their communications with patients. Emergency physicians also have a responsibility to protect the confidentiality of patient information. Sensitive information may only be disclosed when such disclosure is necessary to carry out a stronger conflicting duty, such as a duty to protect an identifiable third party from serious harm or to comply with a just law.

5. Nonmaleficence

Nonmaleficence, or not harming patients, is a key to maintaining the emergency physician's integrity and the patient's trust. Emergency physicians must never endanger patient safety or subject their patients to excessive harms or risks. Acting on the principle of nonmaleficence, emergency physicians also should do what is necessary to physically protect themselves, their coworkers, and their patients from violent acts by known perpetrators, other patients, or by visitors to the ED. Emergency physicians should also strive to protect patients from impaired health care providers or other third parties that place the health of patients at risk. Physicians who lack appropriate training, experience, and knowledge of emergency medicine should not misrepresent themselves as emergency physicians. Physicians without adequate training and knowledge should not practice unsupervised in the ED or prehospital setting.

6. Patient responsibilities

Any relationship has two sides. Patients also have ethical responsibilities in the emergency physician-patient relationship. Patients should use emergency services only when they either have what they believe to be an emergency or when they have no access to health care elsewhere. Patients also should deal openly and honestly with their emergency physicians to foster understanding, trust, and therapeutic success. Patients must also strive to respect triage decisions and seek to understand the need to prioritize emergency patients.

C. Emergency Physicians Relationships with other Professionals

The practice of emergency medicine requires multidisciplinary cooperation and teamwork. Emergency physicians interact with other participants in the health care system, usually more directly than physicians from other specialties. General ethical rules governing these interactions include honesty, respect, appreciation of other perspectives and needs, and an overriding concern for patient benefit.

1. Relationships with other physicians

Emergency physicians, keeping patient benefit as a primary goal, must participate with other physicians in the provision of health care. Channels of communication between health care providers must remain open to optimize patient outcomes. However, communication may be interrupted when a sick patient requires immediate and definitive intervention before discussion with other physicians can take place. When possible, emergency physicians should cooperate with the primary physician to provide continuity of care that satisfies the needs of the patient, and minimizes burdens to other providers. Although the patient's primary physician has a moral, legal, and often financial interest in coordination of care, patient benefit must remain paramount. Concerns regarding the extent of primary care rendered and referral required should be discussed with the primary physician whenever possible.

Physicians who provide on-call services to ED patients usually are fulfilling an obligation of medical staff membership; they may also be financially supported for these services. On-call physicians, like the emergency physicians, are morally obligated to provide appropriate medical care. In turn, the emergency physician should strive to treat consultants fairly, and to make efficient care possible. Consultant choice may be guided by the preferences of both the primary care physician and the patient or by a rotation system of some sort. The hospital and its medical staff are obligated morally and legally to provide appropriate and timely "back-up" care for patients who present to the ED requiring such care. If a designated consultant refuses to evaluate a patient in the ED, the emergency physician may have to call another consultant, discuss the situation with the hospital administrator, or transfer the patient to another facility that has the resources available to care for the patient.

If multiple physicians work in the ED, each patient should have a clearly identified physician who is responsible for his or her care. Transfer of this responsibility should be clear to the patient, families, and staff involved, and should be clearly documented on the patient's medical record. When a patient is discharged from the ED, there must be a clear transfer of responsibility to the admitting or follow-up physician. This transfer must be clearly communicated to the patient when possible.

Contractual relationships between an emergency physician and an emergency physician group should be fair to all parties involved. Compensation should take into account both clinical and administrative services rendered by the physician. Disagreements arising from contractual arrangements should be arbitrated appropriately using a due process approach, whenever possible. Physicians with disabilities, injuries, or infections such as HIV may practice emergency medicine if their duties do not constitute a threat of harm to patients or others.

2. Relationships with nurses and paramedical personnel

Although the emergency physician assumes primary responsibility for patient welfare, emergency medicine is almost always a team effort. For any specific patient, the physician must coordinate the efforts of nurses and support staff. For patient care in general, physicians must work with others to develop systems and protocols that provide effective care for patients who present to the ED. The specific skills and expertise of nurses and other support staff are most effectively utilized if there is input from all involved in the design and execution of these systems and protocols.

In the prehospital setting, emergency medical technicians of all levels rely on, and rightfully expect the cooperation of emergency physicians with whom they work. Base station command physicians and other emergency providers should strive to work harmoniously with prehospital personnel to optimize care for the patient. Patient-centered, nonjudgmental, and open communication is an important part of ethical medical command. Hospital and prehospital providers must respect patient confidentiality and the dignity of all personnel involved.

While the emergency physicians may have greater expertise in scientific and technical matters, the physician shares equal expertise with other health care workers with regard to moral judgment. Physicians should encourage involvement of other providers and staff when ethically problematic cases arise.

3. Impaired or incompetent physicians

The principle of nonmaleficence dictates that patients be protected from physicians who are incompetent or impaired. While no physician is perfect, emergency physicians should strive for technical and moral excellence. They should perform in a manner that exemplifies high levels of skill and character, avoiding fraud or deception. When any physician is found deficient through peer review or other means, it is morally imperative to protect patients and to assist that physician in addressing and possibly overcoming such deficiencies. Corrective action may include internal discipline and/or remedial training. Appropriate remediation will ensure that only physicians with appropriate training and skill will practice as attending emergency physicians.

Whenever a colleague or consulting physician is believed to be incompetent or impaired by drugs, alcohol, or psychiatric or medical conditions, there is a duty to report the impaired physician to the chief of service, the chief of medical staff, and appropriate committees or regulatory agencies. This should be done with great discretion and sensitivity, with a clear intention toward helping the impaired physician embark on the road toward treatment and recovery. Physicians who conscientiously fulfill this responsibility should be protected from adverse political, legal, or financial consequences.

4. Relationships with business and administration

Emergency physicians should be advocates for emergency medical care as a fundamental right. Cost effective and efficient care is important so that resources can be available to provide care when needed. Cooperation with persons whose expertise is in the management and administration of health care systems is essential for provision of efficient care. The physician's role is to keep patients' interests paramount in administrative decisions.

Incentives from businesses, including managed care organizations and biomedical companies, should not unduly influence patient-centered clinical judgment. Gatekeeping activities that threaten patient safety are unethical as are clauses that prevent physicians from informing patients about reasonable treatment alternatives. Physicians should not accept expensive gifts, trips, or items from pharmaceutical or medical equipment companies or their representatives, except when the item is specifically and solely for patient use or educational purposes.

5. Relationships with trainees

Emergency physicians must take seriously their responsibilities to medical students, residents, prehospital care personnel, and trainees of all types to teach them both the moral and technical aspects of emergency medical practice. The fundamentals of honest doctor-patient communication and the ethical aspects of academic emergency medicine, teaching, and research should also be taught and modeled for students by emergency physicians in practice.

Trainees, like patients, are a vulnerable population, and they must not be mistreated, abused, or coerced for faculty self-interest. Teaching physicians must fulfill their obligation to teach and provide appropriate levels of supervision for students under their tutelage. Written appraisals of performance and letters of recommendation require a careful assessment of the trainees' strengths and weaknesses. Such evaluations must be accurate and clearly identify those individuals who may jeopardize patient care. Patient interests should not be compromised in the education process, and patients should never be required to participate in teaching activities or research without their consent. Trainees, in return, must strive to master the discipline of emergency medicine, emphasizing their moral duties to patients, profession, and society.

6. Relationships with the legal system as an expert witness

To protect patients and to uphold the standards of high quality emergency care, it is morally and legally appropriate for emergency physicians with sufficient expertise to testify in a court of law. The American College of Emergency Physicians has suggested that to act as an expert witness, at a minimum, a physician should be board certified or board prepared in emergency medicine and be in the active practice of emergency medicine for three years prior to the date of the incident.

As an expert witness, the physician has a clear ethical responsibility to be objective, truthful, and impartial when evaluating a case on the basis of generally accepted standards of practice. It is unethical to overstate one's opinions or credentials, to misrepresent maloccurrence as malpractice, to bear false testimony, or to use the name of the College as prima facie evidence of expertise.

Expert legal testimony should not be provided solely for financial gain lest the access to payment unduly influence the testimony one may provide. Reasonable compensation for a physician's time is ethically acceptable, but financial remuneration must remain secondary. Expert testimony by emergency physicians can be useful to patients, the profession, and society, but professional peer review of an expert's testimony is encouraged.

7. Relationships with the research community

The emergency physician researcher should abide by the basic principles as outlined by the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and the Declaration of Helsinki. Emergency physician researchers must abide by federal, institutional, and professional guidelines that govern human and animal research. To be ethical, studies must be well designed and be worth the risks to patients and society. Approval from the appropriate institutional review boards is required, but it is the responsibility of the investigator to ascertain that informed consent, confidentiality, and patient well-being are adequately protected. New federal regulations allow a limited waiver of informed consent for some critically ill patients in FDA-approved protocols. It is imperative that data be collected carefully, interpreted correctly, and reported accurately. Research misconduct and fraud are grounds for disciplinary action and loss of funding. Responsible authorship also is important; co-authors are required to actively participate in all parts of the study including literature review, study design, data collection, data analysis, and manuscript preparation.

D. The Emergency Physician's Relationship with Society

1. The emergency physician and society

The emergency physician owes a duty not only to his or her patient, but also to the society in which the physician and patient dwell. Though the emergency physician's duty to the patient is primary, it is not absolute. The emergency physician must balance the patient's interest against the interests of society, which enables the doctor-patient relationship to prosper. Emergency physicians duties to the general public inform decision-making on a daily basis; for example, the emergency physician has duties to steward resources, oppose violence, and promote public health that sometimes transcend duties to patients. The larger

community places limits on the ability of the physician to act in the patient's interest on the basis of concerns for equity and justice.

2. Resource allocation and health care access: problems of justice

In its broadest sense, justice means giving each person his or her right or due-- what he or she is owed. Applying this formal notion of justice impartially to the issue of allocating resources, the community must consider how benefits and burdens should be distributed among the various members of a given population. The actual distribution of these benefits and burdens is known as allocation. Society, as a matter of distributive justice, seeks the best way to distribute scarce resources among those who have some claim to them. Emergency medical practice impacts the use of expensive technology and the distribution of health care resources; therefore, emergency physicians must attempt to reconcile the goals of equitable access to health care and just allocation of health care with the increasing scarcity of resources and the need for cost containment.

3. Central tenets of the emergency physician's relationship with society

a. Access to emergency medical care is a fundamental right

Because it is an essential part of health care, access to quality emergency care is a fundamental individual right and should be available to all who seek it. All impediments to access to emergency care should be removed. Denial of emergency care or delay in providing emergency services on the basis of race, religion, gender, ethnic background, social status, type of illness or injury, or ability to pay is unethical. Emergency physicians have an ethical duty to act as advocates for the health needs of indigent patients and to assist them in finding appropriate care. Insurers, including managed care organizations, must support insured patients' access to emergency medical care for what a prudent layperson would reasonably perceive as an emergency medical condition. Society, through its political process, must adequately fund emergency care, both for the underinsured and the indigent.

Decisions to limit access to care may be made only when the resources of the ED are depleted or when emergency care is available elsewhere in the community. If overcrowding limits access to care, that limit must be applied equitably, unless the hospital has a unique community resource such as a trauma center, in which case the selection of a special category of patient may be acceptable.

Prehospital care is an essential societal good that emergency physicians, in conjunction with government, industry, and insurers must continue to make available to all members of society. All patients seeking assistance of prehospital care providers should undergo assessment by emergency medical technicians or paramedics in a timely fashion. Decisions concerning transport to a medical

facility should be made on the basis of medical necessity, patient preference, and the capacity of the facility to deal with the medical problem.

b. Adequate inpatient and outpatient resources must be available to guard emergency patient interests

Patients requiring hospitalization for further care should not be denied access to an appropriate medical facility on the basis of financial considerations. Transfer to another appropriate accepting medical facility for financial reasons may be effected if a.) the patient provides consent and b.) there is no undue risk to the patient. Admission or transfer decisions should be made on the basis of a patient's best interest.

It is unethical for an emergency physician to participate in the transfer of an emergency patient to another medical facility unless the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the risks of the transfer or unless a competent patient, or a legally responsible person acting on the patient's behalf, gives informed consent for the transfer. Emergency physicians should be knowledgeable about applicable federal and state laws regarding the transfer of patients between health care facilities.

Although the care and disposition of the patient are primarily the responsibility of the emergency physician, it is critical for on-call consultants to share equitably in the care of indigent patients. This may include an on-site evaluation by the consultant if requested by the emergency physician.

For patients who do not require immediate hospitalization but need medical follow-up, adequate outpatient medical resources should be available both to properly continue treatment of the patient's medical condition and also to prevent the development of subsequent foreseeable emergencies resulting from the original medical problem.

c. Emergency physicians should promote prudent resource stewardship without compromising quality

Emergency physicians have the obligation to ensure that quality care is provided to all patients presenting to the ED for treatment. Participation in quality assurance activities and peer review are important for assuring that patterns of inadequate care are detected. Participation in continuing education activities, including the development of scientifically-based practice guidelines, assists the emergency physician in providing quality care.

Health care resources, including new technologies, should be used on the basis of individual patient needs and the appropriateness of the therapy as documented by medical literature. Diagnostic and therapeutic decisions should

be made on the basis of potential risks and benefits of alternative treatments versus no treatment. The emergency physician has the obligation to diagnose and treat patients in a cost-effective manner and must be knowledgeable about cost-effective strategies; but, under the principle of nonmaleficence, the physician should not allow cost containment to impede proper medical treatment of the patient.

The limitation of health care expenditures is a societal decision that should ideally be made in the political arena and not at the bedside. Lacking a societal consensus, however, emergency physicians must keep the patient's interest as a primary concern while recognizing that inappropriate, marginally beneficial and futile care is not morally required. Thus, the emergency physician has dual obligations to steward resources prudently while honoring the primacy of patient's best medical interests.

d. The duty to respond to out-of-hospital emergencies and disasters

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. This responsibility is buttressed by local Good Samaritan statutes that protect health care professionals from legal liability for good-faith efforts to render first aid. Physicians should not disrupt paramedical personnel who are under base station medical control and direction.

In a situation where the resources of a health care facility are overwhelmed by epidemic illness, mass casualties, or the victims of a natural or manmade disaster, the prudent emergency physician must make important triage decisions to benefit the greatest number of potential survivors. When the numbers of patients and severity of their injuries overpower existing resources, triage decisions must classify patients according to both their need and their likelihood of survival. The overriding principle should be to focus health care resources on those patients most likely to benefit who have a reasonable probability of survival. Those patients with fatal injuries and those with minor injuries should be made as comfortable as possible while they await further medical assistance and treatment.

e. The duty to oppose violence

Serving as a societal resource, emergency physicians have the dual obligation to protect themselves, staff, and patients from violence and to teach EMS personnel under their supervision to do likewise. Hospitals have a duty to provide adequate numbers of trained personnel to assure a safe environment. Ensuring safety may mean that patients who appear to present a high risk of violence will lose some autonomy as they are restrained physically or chemically. Emergency physicians never should resort to restraints or medication for punitive or vindictive reasons. Restraints are indicated only when there is a reasonable possibility that patients

will harm themselves or others. The need for restraint of ED patients should constantly be reevaluated.

The emergency physician has an ethical duty to prevent, diagnose, treat, and properly refer victims of domestic violence, including abused children and the elderly, and to report the violence to the appropriate governmental authorities where mandated.

f. The duty to promote the public health

Emergency physicians advocate for the public health in many ways, including the provision of basic health care for the many uninsured. As the safety net for victims of economic, physical, and emotional disaster, EDs are a vanguard against a constellation of medical and social ills.

Emergency physicians have first-hand knowledge of the grave harms caused by firearms, motor vehicles, alcohol, and other vectors of preventable illness and injury. Inspired by this knowledge, emergency physicians should participate in efforts to educate others about the potential benefits of well-designed laws, programs, and policies that advance the overall health and safety of the public.

CONCLUSION

Serving patients effectively requires both scientific and technical competence, knowledge of what can be done, and moral competence, knowledge of what should be done. The technical emphasis of emergency medicine is slowly being eclipsed by the ethical. Increasingly, the profession is being asked to help patients die comfortably rather than secure life at all costs. In the next millennium, the difficult questions of the specialty may not be scientific so much as moral.

In spite of future uncertainties and challenges, ethics will remain central to the clinical practice of emergency medicine. Both technical and moral competence can and should be nurtured through advanced preparation and training. The time and information constraints inherent in emergency practice have made reflection on important ethical principles and values difficult at the bedside. This Code is offered both for thoughtful consideration away from the bedside and as a resource when issues arise in clinical practice. The principles of emergency medical ethics identified herein may serve as a guide for the masters and students of this developing art. Through the process of moral reflection and deliberation, emergency physicians may be empowered to base future time-sensitive decisions on a sound moral framework.

III. A COMPENDIUM OF ACEP POLICY STATEMENTS ON ETHICAL ISSUES

The policy statements listed in the Compendium section of the Table of Contents of this policy are available from ACEP's Customer Service office (800-798-1822, touch 6) or on ACEP's Web site (<http://www.acep.org>).

<http://www.acep.org/3,1118,0.html>

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This page last updated on August 11, 2002 at 5:34:55 pm.