

Ethical Considerations in Emergency Care

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Physicians worldwide are embracing emergency medicine as a specialty and this awakening interest has brought with it a concomitant flurry of new programs and practitioners. While, as an intensely clinical specialty, emergency physicians must acquire significant medical expertise, the Emergency Department (ED) is also a site at which ethical dilemmas inevitably arise—where life may be so evanescent that it is sometimes difficult to pinpoint when death occurs. Educating ourselves to respond to the many types of ethical challenges is a no less important aspect of emergency medicine.

Emergency physicians, nurses, medics and corpsmen slog together through the emergency department battleground. Their rapid decisions can save lives or not, ease suffering or prolong inevitable deaths, wastefully expend resources on futile efforts or conserve them for those who can benefit and promote respect for patients as persons or yield to the ever-lurking and ego-enhancing desire to exercise power and control over others.

Deep reflection is not typically a part of emergency medicine practice. As one Israeli internist-bioethicist perceptively observed, “Emergency medicine is comprised of disciplined practice of routines and guidelines under conditions of uncertainty, pressure and time limits. More than any other medical area, emergency physicians learn to act ‘automatically’, faster than the speed of philosophical thinking.”⁽¹⁾ Indeed, emergency physicians have a markedly different relationship with patients than do other practitioners, especially others providing primary care (**Table 1**) (2, 3). Emergency physicians often care for patients who are unfamiliar to them and to the institution. Although practitioners, who either know their patients or who care for them in less acute settings, often have other mechanisms for making ethical decisions, emergency

physicians generally have limited options.

Therefore, it should come as no surprise that our specialty’s greatest ethical failing is that we often do not recognize problems that confront us as being in the ethical, rather than in the strictly “medical,” realm. Our second failing is misperceiving ethics either as what secular or religious law commands, or as a discipline that describes irresolvable issues.

The moral precepts that underpin ethical decisions are derived from a wide variety of sources, including individual, cultural and communal value systems. Unlike the law, which is relatively rigid and, particularly in the case of scientific and medical issues, can lag years or even decades

Table 1: Differences between Emergency and Primary Care Practice

Emergency Practice	Primary Care Practice
Patient often brought in by ambulance, police or family.	Patient chooses to enter medical care system.
Patient does not choose physician.	Patient chooses physician.
ED personnel must gain patient trust.	Physician and nurses already enjoy patient’s confidence and trust.
ED personnel do not know patient, family or values.	Physician and nurses often know patient, family and values.
Patient experiences an acute change in health.	Patient has chronic medical problems.
Anxiety, pain, alcohol and altered mental status are frequent.	Anxiety, pain, alcohol and altered mental status are less frequent.
Decisions are made quickly.	There is more time for discussion and deliberation.
Physician makes decisions independently.	Physician has a greater opportunity to consult with patient, family, other physicians, ethics committees, lawyers, courts and ethicists.
Physician represents institution and medical staff.	Physician represents self or medical group.
Work environment is open and less controlled.	Work environment is private and controlled.
ED personnel frequently have a stressful work schedule.	Work schedule often set or canceled by physician.

Adapted from (same information as in Reference 2)

behind modern developments, the bioethical construct allows a greater flexibility in decision making. This is a crucial factor in the crucible of the emergency room, which demands reasonable action. Emergency physicians (EPs) are often called on to integrate a patient's personal, cultural, religious, or community values and to balance them with their own personal and professional ethos. A working knowledge of bioethics greatly enhances the EP's ability to make reasonable, ethical decisions in the limited time frame common to emergency departments.

Discussing medical ethics and its application to Israeli emergency medicine is not premature. However, it is done with the recognition that emergency medicine in Israel has not yet matured to the point of having a unified approach to patient care. Much like most emergency departments in the United States until the mid-1980s, Israeli patients continue to be distributed to various specialty physicians based on their presenting symptoms (1). In itself, this may serve to diminish some patients to the sum of their chief complaint in the eyes of healthcare workers. When better than now to try to reverse this perception?

This paper will address a number of common ethical dilemmas that arise in emergency medicine, especially those relating to the elderly. What follows will be a brief discussion of what constitutes bioethics, the derivation and importance of patient values, the differences between withholding and withdrawing treatment in emergency medicine, futility issues, surrogacy and advance directives. Finally, there is a discussion of how to use this and additional ethical knowledge in emergency medicine

practice to act in the face of relative uncertainty. This includes the description of a rapid ethical decision-making model for emergency medicine and a brief comment on "prospective ethics," that is, changing the law to resolve ethical issues that commonly arise.

What is bioethics?

Ethics is the application of values and moral rules to human activities. Bioethics is a subset of ethics that uses ethical principles and decision making to solve actual or anticipated moral dilemmas facing clinicians in medicine and biology using reasoned and defensible solutions. Unlike professional etiquette, which relates to standards governing the relationships and interactions between practitioners, bioethics deals with relationships between practitioners and patients, practitioners and society and society and patients (4).

Modern bioethics has developed during the last four decades largely because the law has often remained silent, inconsistent, or morally wrong on matters vital to the biomedical community. The rapid increase in biotechnology, the failure of both the legal system and the legislatures to deal with new and pressing issues and, in the United States, the increasing liability crisis has driven the medical community to seek answers to some of the difficult questions practitioners have had to work through on a daily basis (4).

It is said that good ethics makes good law, but that good law does not necessarily make good ethics. How does bioethics differ from law, both of which incorporate societal values? Laws are rules of conduct established by legislatures, administrative agencies, courts or other governing bodies. They often vary from locale to locale and are enforceable in the jurisdiction where they prevail. Ethics incorporates the broad values and beliefs of correct conduct. Although bioethical principles do not change because of geography (at least not within one culture), interpretation of the principles may evolve as societies change. Significant overlap exists between legal and ethical decision making, frequently on basic issues (5), although they also differ significantly (Table 2).

Although bioethics is neither law nor religion, it absorbs and applies elements of both, as well as theories and principles from various philosophical schools. Yet the clinical application relies on case-based (casuistic) reasoning, usually giving most weight to patients' autonomy and values, but also considering other relevant bioethical principles, including those values encompassed in communal ethics and professional oaths and codes (4). A value pertinent to Israeli practice, for example, is the concern Orthodox Judaism has expressed with patient autonomy. Chaim Zwiebel wrote, "The doctrine of unlimited personal autonomy in

Table 2: Relationship between Law and Bioethics

BIOETHICS	FUNCTION	LAW
✓	Case-based (casuistic)	✓
✓	Has existed from ancient times	✓
✓	Changes over time	✓
✓	Strives for consistency	✓
✓	Incorporates societal values	✓
✓	Basis for healthcare policies	✓
	Some unchangeable directives	✓
	Formal rules for process	✓
	Adversarial	✓
✓	Relies heavily on individual values	
✓	Interpretable by medical personnel	
✓	Ability to respond relatively rapidly to changing environment	

From Iserson KV: Principles of biomedical ethics. In: Marco CA, Schears RM (eds.): Ethical issues in emergency medicine. The Emergency Clinics of North America. 1999;17(2):283-306

medical decision making is totally repugnant to the foundations of our faith." Yet, even he admits that it is just such autonomy that allows individuals to make healthcare decisions consistent with their faith (6). It is incumbent upon emergency physicians, whenever possible, to determine not only their patient's individual values, but also whether their patient subscribes to an individualistic or communitarian ethic. That may help decide who the most appropriate decision makers may be if the patient lacks the capacity to make his or her own decisions.

Why are patient values so important?

In homogenous societies, religions have long been the arbiters of ethical norms. Western societies, however, are multicultural, with no single religion holding sway over the entire populace in most countries. Israel also is multicultural, with about 80% of the population being Jewish, albeit with many different affiliations and orientations and the balance composed of Muslims, Christians, Druze and a variety of smaller groups. Therefore, a patient-value-based approach to ethical issues is necessary.

While ethical theories and principles give an overlying structure, values are the standards by which we judge human behavior. They are, in other words, moral rules, promoting those things we think of as good and minimizing or avoiding those things we think of as bad. We learn these values, usually at an early age, from observing behavior and through secular (including professional) and religious education. Many of these learned values overlap, yet each source often claims moral superiority over the others, whether the values are generic and cultural, or stem from legal norms, religious and philosophical traditions, or professional codes (7).

A key to making bedside ethical decisions is to know the patient's values. While many people cannot answer the question, "What are your values?" physicians can get an operational answer by asking what patients see as their goal of medical therapy and why they want specific interventions. These responses represent concrete expressions of patient values. In patients too young or incompetent to express their values, it may be necessary for physicians to make general assumptions about what the normal person would want in a specific situation or to rely on surrogate decision making. But with patients who are able to communicate, care must be taken to discover what they hold as their own, uncoerced values (5).

While various religions may appear dissimilar, most have a form of the Golden Rule, "Do unto others as you would have them do unto you," as a basic tenet. Problems surface when trying to apply religion-based rules to specific bioethical situations. For example, nearly all religions accept the dictum, "Do not kill." However, the interpretation of the activities that constitute killing, active

or passive euthanasia, or merely reasonable medical care vary with the world's religions as they do among various philosophers (5,8). Judaism has given a number of interpretations to when and how interventions for the dying are required, optional or forbidden (9).

As members of a democracy with significant populations practicing a number of religions and subgroups of those religions, Israeli medical practitioners must behave in a manner consistent with each patient's values. The underlying question must be: What is the patient's desired outcome for medical care? Not only religion, but family, cultural and other values contribute to patients' decisions about their medical care. Without asking, there is no way to know what decision they will make. It is important to note that religion influences modern secular bioethics, which uses many religion-originated decision-making methods, arguments and ideals. In addition, clinicians' personal spirituality may allow them to relate better to patients and families in crisis (5).

Clinicians have their own ethical values, as do professional organizations and health care institutions. Conscience clauses permit clinicians to "opt out" when they feel that they have a moral conflict with professionally, institutionally or legally required actions. These conflicts, which may stem from a religious, philosophical, or practical basis, prevent them from following the normal ethical decision-making algorithm. When such conflicts exist, it is morally and legally acceptable, within certain constraints, for the physician to follow a course of action based upon his or her own value system. The constraint generally requires that there be the provision of timely and adequate medical care for the patient - which may be particularly difficult to achieve in emergency medicine. When conflicts over values exist, however, it is essential for the practitioner to recognize the patient's identity, dignity and autonomy, to avoid the error of blindly imposing one's own values on others (5).

What is the difference between withholding versus withdrawing treatment?

As the ambulance screams to a halt and the medics bring in a patient in critical condition, only rarely will the emergency physician have enough information to make a judgment that intervention would be futile (see next section). They usually lack vital information about their patients' identities, medical conditions and wishes. Therefore, they must intervene quickly to try to save a life (2,10). Only later, when relatives arrive or medical records become available, they may discover that the patient has a terminal disease or is imminently dying (goes), did not want resuscitative efforts, or even has excruciating pain and was wishing for death. Yet, due to the limited information they possess when the patient arrives in the ED, the EPs' mandate to attempt resuscitation is morally justifiable.

Many ethicists and rabbis do not distinguish in many cases between withholding treatment and withdrawing treatment (through an act of omission) (9). Yet, in emergency medicine, a significant difference rightfully persists between withholding and withdrawing life-sustaining medical treatment. The justification for this stems, in part, from the nature of emergency medical practice and the unique manner in which clinicians apply many ethical principles. While a clear moral distinction between withholding and withdrawing treatments may be absent from other medical areas, emergency medical care's unique circumstances continue to make this distinction relevant and morally significant.

In the usual medical setting, withholding further medical treatment is done quietly, often without input from the patient or surrogate decision maker, while withdrawing ongoing medical treatment can be more obvious and difficult. This situation is reversed in the emergency medical setting. Withholding emergency medical treatment is much more problematic than later withdrawing unwanted or useless interventions. Society has specific expectations of emergency medical practitioners. Due to the nature of emergency medicine, both in the prehospital and the emergency department settings, the distinction between withdrawing and withholding medical treatment has never disappeared—and is not likely to do so in the future (10).

While lifesaving medical interventions may not be appropriate in all cases, emergency clinicians, whenever possible, should provide patients with palliative care. As the Steinberg Report noted, terminal patients have the right to receive state-of-the-art palliative care (11). Palliation often includes analgesics and may include diuretics, sedation, oxygen, paracentesis or thoracentesis, or other medications or procedures to alleviate suffering. Medical personnel should never withdraw or withhold care - only treatment. While medical practitioners, surrogate decision makers and sometimes patients find it emotionally easier to forego new interventions than to withdraw ongoing treatment, no orders, policies or directives should ever prevent emergency physicians from caring, i.e., alleviating discomfort.

The purpose of palliative interventions is not to prolong the dying process, but rather, when death is inevitable, to make it as comfortable for the patient as possible. As patient advocates, emergency physicians may need to “push” to have the patient admitted to a hospital, hospice or nursing home, or to get ancillary personnel (social workers, home health nurses, etc.) to intervene for the patient.

Is “futility” an issue in emergency care?

Emergency physicians, nurses and emergency medical system (EMS) personnel may, in some circumstances, feel

that further medical interventions are “futile.” Yet only three circumstances meet the most commonly accepted definition (12). The first, which clinicians can only identify in a very limited set of circumstances, is when the intervention is effective in <1% of identical cases - based on the medical literature. ED thoracotomies for blunt trauma are just such a circumstance. However, individual clinician's experiences cannot be relied upon, since they are often skewed due to selective memory, limited numbers of similar cases and other biases. A common scenario with survival rates approaching 0% is the out-of-hospital cardiac arrest that is unwitnessed or arrives from a long-term care facility (13).

The second futile circumstance is “physiological futility,” when known anatomical or biochemical abnormalities will not permit successful medical interventions. Examples generally accepted by EMS systems as reasons not to intervene or provide transport to hospitals include rigor mortis, algor mortis, patients burned beyond recognition, or injuries incompatible with life (e.g., decapitation). These, along with prolonged normothermic resuscitative attempts without success or prolonged “down time” with an isoelectric ECG, or a patient with Pulseless Electrical Activity (PEA) are the criteria often used to help determine whether EMS personnel can pronounce death on the scene. EMS, in these instances, need not expend valuable resources in a futile resuscitative effort.

The third category, based on the patient's values, when known, is that intervention will not achieve the patient's goals for medical therapy. Since this course is based on knowing the patient's values related to medical treatment, it is necessary to have talked with the patient in advance (rare in the ED setting), have received surrogate-supplied information or decisions, or have access to the medical record. The danger is that differences in values between caregivers and patients may lead to over- or under-treatment. Communication, if necessary using a third party, may help resolve these issues.

A fourth futility category has been discussed, but is only applicable when based on the patient's values - that of “qualitative futility,” where medical interventions will not lead to an acceptable quality of life (14). Recognizing that, the American College of Emergency Physicians asserted, “physicians are under no ethical obligation to render treatments that they judge have no realistic likelihood of medical benefit to the patient.”(15)

The futility concept, however, should not be used to deny care to dying patients. Even terminal patients have medical emergencies that require intervention. The goal is to ease pain and suffering. How that is accomplished depends upon the patient, the medical condition causing their discomfort and their value system.

What part does surrogate decision making play in emergency care?

When patients cannot make their own healthcare decisions, others must make such decisions for them. Two questions arise: When do patients lack such capability? Who then makes the decision?

Emergency physicians must often quickly decide whether patients lack “decision-making capacity,” the ability to make their own healthcare decisions. While this is obvious in the unconscious or delirious patient, it is often less so when the patient remains verbal and at least somewhat coherent. Decisions in emergency situations must often be made rapidly and, unlike other medical venues, bioethics consultation may not be readily available.

Emergency physicians, therefore, must be capable of assessing a patient’s decision-making capacity, which differs from a simple mental status examination. To have adequate decision-making capacity in any one circumstance, individuals must understand the options, the consequences of acting on the various options and the costs and benefits to them of these consequences in terms of their own personal values and priorities (Table 3) (16,17). Disagreement with the physician’s recommendation is not by itself grounds for determining that the patient is incapable of making a decision. In fact, even refusing lifesaving medical care may not prove the person incapable of making valid decisions if the decision is based on firmly held religious beliefs (5).

If patients lack capacity to participate in some decisions about their care, surrogate decision makers must become involved. Although the 1996 Patient’s Rights Act prohibits Israeli physicians from discussing patients’ conditions with their families without prior consent, in practice, physicians have these discussions (18). The more recent Steinberg Report, which suggests changes to laws surrounding death and dying, recognizes the surrogate standing of both “close friend and kin” and the special role of the “caring physician,” usually the patient’s primary care doctor (9).

In most locales, the patient’s advance directive may designate surrogates, or they may be detailed in institutional policy or law. Surrogates often include spouses, adult children, parents (of adults) and others, including the attending physician. On occasion, bioethics committees or the courts will need to intervene to help determine the decision maker. On occasion in Israel, rabbinic, medical or other quasi-judicial panels may act as surrogates, although these normally are mobilized far too slowly to be effective in emergency department cases.

Children represent a special situation. Individuals less than the age of majority (or unemancipated) are usually deemed incapable of making independent medical

decisions, although they are often asked to give their assent to the decision, allowing them to “buy-in” to their medical treatment plan. In many cases, when deciding which children have decision-making capacity, the same rules that apply to adult capacity apply to children. The more serious the consequences, the more the capacity to understand the options, consequences and values involved is required of children to make a decision (5).

What are advance directives and how can they help in emergency medicine?

The term *advance directives* describes several types of legal and quasilegal documents. These documents indicate what is to be done for a patient *in extremis* who is no longer able to give or withhold permission for medical treatment. Advance directives are usually written to avoid prolonging an inevitable, often painful or non-sentient dying process. However, they can also be used to instruct surrogates and the patient’s medical team to “do everything,” whenever possible. Physicians are most familiar with the do-not-resuscitate (DNR) order, normally initiated in hospitals, nursing homes and hospices (The DNR order is not strictly an advance directive, but does serve to transmit a conditional order to other healthcare personnel and is operative only if the patient’s condition follows a certain pattern.).

Until 1996, a panel of three senior Israeli physicians could enforce treatment or withhold it. That year, the Patient Rights Act gave that power to institutional ethical-judicial committees. Since that law is deliberately silent on end-of-life issues, the Steinberg Committee (with its subsequent report) was formed to address them. Its findings are still being deliberated.

As 2004 dawns, no advance directive has legal status in Israel and only the current spouse and court-appointed guardians have legal status as surrogate decision makers. These surrogates, though, do not have the legal right to reject medical treatment that doctors believe is in the patient’s best interest (1). Although controversy exists among Orthodox Jews concerning the use of advance directives, especially those that limit resuscitation, a form consistent with some interpretations of *Halacha* exist,

Table 3: Components of Decision-Making Capacity

1. Knowledge of the options.
2. Awareness of consequences of each option.
3. Appreciation of personal costs and benefits of these consequences in relation to relatively stable values and preferences (When ascertaining this, ask the patient why they made a specific choice.).

Adapted from Iserson KV, et al.: Ethics in Emergency Medicine, 2nd ed., Tucson, AZ: Galen Press, Ltd., 1995, p. 52.

especially those that name surrogate decision makers (e.g., www.jlaw.com/Forms/) (19).

The following discussion of advance directives describes the situation in the United States, Canada and a number of other countries. It may be an area in which Israeli emergency physicians want to promote legislation as "proactive ethics."

Do- Not- Resuscitate Orders. A DNR order is a physician order in the hospital chart informing other medical personnel that they should not institute CPR in the event of cardiopulmonary arrest. Ideally, this order is put on charts only after consultation with the patient (possessing decisional capacity) and family and usually involves chronically ill patients with a poor prognosis for long-term survival. The newer acronyms, DNIR (do not *initiate* resuscitation) or DNAR (do not *attempt* resuscitation), more honestly suggest that physicians are not always successful in resuscitation attempts. These orders usually work well within a specific institution, but if patients are transferred, often from a nursing facility or home to the ED, the act of transfer or activation of the EMS system negates the order. This can be directly contrary to a patient's wishes for terminal care. However, if a patient arriving in the ED still has the capacity to make a decision concerning resuscitation, part of an EP's duty is to document such a decision in the patient's chart, including the specific actions to be limited, the circumstances of the discussion and the individuals present during the discussion (20,21). Many institutions have now recognized that simple DNAR forms are inadequate descriptions for other healthcare personnel to interpret and have changed to limitation-of-treatment forms specifying exactly what is not to be done for a patient (e.g., antibiotics, blood products, mechanical ventilation, surgery, etc.).

Prehospital Directives. During the past several years, 43 states in the United States have enacted methods whereby patients outside of healthcare facilities can avoid unwanted resuscitation attempts (22). These usually take the form either of a prehospital DNAR order or, in a few cases, a prehospital advance directive. Often confused, the two forms differ greatly in their philosophy. The prehospital DNAR order is a physician-originated and approved document. The prehospital advanced directive is generated by a patient or legal surrogate with little or no involvement from healthcare personnel. Both instruct EMS personnel who have been erroneously called at the time of death to not attempt to resuscitate the patient (or to stop resuscitation efforts if they have already begun when such a form is found). Both types of form have proved effective (23-26). The most common reason for creating physician-initiated forms is the specter of murders and suicides being aided by patient-initiated documents. In practice, this has not occurred (27).

Israeli emergency medicine is ripe for the introduction of these types of advance directives. As one Israeli academic

observed, "The daily reality is that Israeli emergency services are maximalist. Paramedics must intubate every patient who is gasping or comatose."(1) This was the same situation when the American public, in a state-by-state effort, demanded and received legislation authorizing these directives.

Living Wills. The living will is a relatively standardized form adopted in nearly all of the United States (22). This document usually requests healthcare workers to not perform future resuscitative measures, although they can also be used to request that "everything possible be done." It goes into effect only if the individual lacks decision-making capacity; until that point, the patient continues to determine the medical course, despite anything said in a living will. Living wills normally require both that a physician certifies an individual as terminally ill and that the designee has the mental capacity to understand its provisions [Arizona, in a break with tradition, does not use "terminally ill," since all extant definitions are unclear. No ill effects have resulted (25)]. States allow varying levels of specificity in the document, including, in some cases, the refusal of artificial nutrition and hydration.

Although most EPs have encountered relatives waving living wills at them during a resuscitation, U.S. living wills specify that the patient's physician must have seen and accepted the document's provisions in advance. For patients, this requirement establishes a physician contact who the patients know will act on their behalf. For physicians, this protects those whose value system will not allow them to abide by the document's provisions. It also encourages families and physicians to discuss the circumstances surrounding the time of death and the actions they can take.

With its standard format, the EP will rarely, if ever, be in the position of having accepted a living will's provisions. In the setting of an ED resuscitation, the best that a living will can do, assuming that the patient is correctly identified, is to suggest what the patient's wishes were. However, the document does not in any way restrict the EP's actions (27).

Durable Power of Attorney. A more commonly employed advance directive is the durable power of attorney with medical provisions. Such directives are the norm throughout the United States (22). The durable power of attorney has existed for centuries and was initially designed to allow business affairs to be continued when individuals were out of contact with civilization for long periods. The document in its usual form takes effect immediately. However, when it is used as a medical advanced directive, specific provisions take effect when the individual no longer has the capacity to make medical decisions, such as specifying a surrogate decision maker. This document allows more flexibility than living wills, because the surrogate can make any healthcare decisions that the patient would ordinarily make.

In Israel, the 1996 Patient's Rights Act permits naming a surrogate, but that individual can only consent to, not refuse, medical treatment (18). The law proposed in the 2002 Steinberg Report would expand the role of surrogates (9).

Non-Standard Advance Directives. EPs occasionally encounter medallions, tattoos, or other indications that seem to be advance directives (28,29). These may cause consternation, since they fall outside society's bounds for indicating life-determining decisions. What should clinicians do if these indicators come to light during resuscitations? To be useful, advance directives must be available to the treating clinicians when they are needed, be a product of the patient's (or sometimes the surrogate's) deliberations, be understandable and must cover the patient's current medical situation. Non-standard directives, usually abbreviated or abstract (such as a tattooed symbol for "do-not-defibrillate"), fail to meet these requirements. Of special concern is that such indicators may make it unclear whether the patient or surrogate either understood how their "directive" might be interpreted or whether it still reflects their desires. In general, EPs should not rely on these indicators to make critical patient decisions.

What are do-not-hospitalize orders (for hospice and nursing home patients) and what are their limitations?

One type of advance directive or physician order that has been used successfully in many locales is the "do-not-hospitalize" order. Normally used for hospice and nursing home patients, it prevents many unwanted ED resuscitation attempts and procedure-laden hospitalizations.

Do-not-hospitalize (physician) orders instruct nurses not to send patients to the hospital if further medical interventions are not desired, either by the patient or their surrogate decision maker. This allows people to die peacefully, rather than having the "last rights of CPR" performed, either when it is futile or unwanted.

While do-not-hospitalize orders appear to be very common in Israel, they have not been formalized. Based on oral agreements between the family, patient and the nursing home, this casual arrangement seems to be relatively effective (1).

The only caveat to applying do-not-hospitalize orders is that staff must know that patients should still be sent to hospitals if they need palliative care not available in the nursing facility.

How to make ethical decisions at the bedside in the emergency department: The "Rapid Ethical Decision-Making Model."

The method of ethical case analysis described in **Figure 1** is designed to provide the EP in need of a fast answer to an ethical dilemma a method of avoiding an ethically incorrect course of action.

Stopping at the first step-using a known precedent-is the most productive way to use this method. However, this takes planning, reading and thinking about ethical problems. Many physicians are unprepared to do this. Just as with the indications for any emergency procedure, EPs should be prepared with a course of action for at least the most common ethical dilemmas they may face in the ED. But even the prepared clinician can encounter cases without relevant known precedents.

With no precedent to rely on and no way to "buy time," the practitioner must select a possible course of action and test it for ethical validity. The three tests involved in the method are the Impartiality Test, the Universalizability Test and the Interpersonal Justifiability Test. The Impartiality Test is whether the practitioner would accept this action if he or she were in the patient's place. In essence this is a form of the Golden Rule. The Universalizability Test asks whether the practitioner would feel comfortable having all practitioners perform this action in all relevantly similar circumstances. This generalizes the action to all colleagues, asking whether a rule for the contemplated behavior is reasonable. The Interpersonal Justifiability Test asks whether the practitioner can supply good reasons to others for the action. Will peers, superiors, or the public be satisfied with the answers? If all three tests can be answered in the affirmative, then the practitioner has a reasonable probability that the proposed action falls within the scope of ethically acceptable actions (4,27).

What are "proactive ethics"? How can emergency physicians change the rules?

In every medical system, practitioners find that they repeatedly face identical ethical dilemmas. The normal reaction is to gripe about it and often to get an incomplete and often unsatisfactory solution from administrators, lawyers, bioethics committees, or others.

There is a better solution. "Proactive ethics" involves changing the rules under which we operate. Easier done in some settings than in others, the process requires that all "stake holders," those with a vested interest in an equitable solution, first come to the table and reach a compromise. Such groups will often include physicians, nurses, EMS personnel, lawyers, religious authorities and representatives of affected groups (e.g., an organization of elder individuals in the case of issues about the aged). Although under government sponsorship, which may have limited their ability to compromise, Israel's Steinberg Report emanated from just such a group (9,11). Armed with this agreement or even sample legislation that they can present to politicians, it becomes relatively easy to change laws or administrative rules to address recurrent ethical dilemmas.

Rapid Approach to Emergency Ethical Problems

Is this a type of ethical problem for which you have already worked out a rule or is it at least similar enough so that the rule could reasonably be extended to cover it?

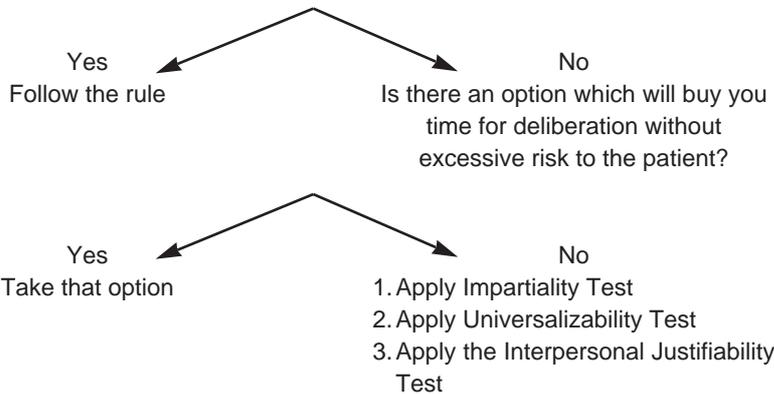


Figure 1: Adapted from: Iserson KV, et al.: *Ethics in Emergency Medicine*, 2nd ed., Tucson, AZ: Galen Press, Ltd., 1995, p. 45

One example of such a process led to a landmark pre-hospital advance directive law, which markedly lessened unwanted resuscitation attempts in the EMS (25). It also led to an extensive statutory surrogate list and a simplified set of advance directives. Proactive ethics lies in the role of public policy - an area in which emergency

physicians are particularly suited to play a large role.

Conclusion

As the emergency medicine system matures in Israel under the stewardship of practitioners uniquely skilled in the necessary myriad of techniques and possessing the required wealth of knowledge, we must remember to incorporate an awareness of the commonly encountered ethical issues and to teach methods with which clinicians can quickly and appropriately address them. Imparting ethical problem-solving knowledge and strategies leads to more elegant, confident and appropriate emergency medical practice.

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