
Introduction

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Issues in Medical Ethics: Special Challenges of Emergency Medicine

“But it’s an emergency!” This is a reason commonly offered—and accepted—as justifying an action that would otherwise be condemned as a violation of the rules of ordinary morality. That the building is on fire warrants breaking doors and windows, even though destruction of another’s property is usually prohibited. That a child is in danger of drowning warrants the unauthorized use of another’s property in a rescue effort, even though doing so is otherwise counted as theft. That someone is in harm’s way can justify pushing the person to the ground to avoid the danger, even though the identical action would be an assault had there been no threat. In sum, whether or not we specifically acknowledge the differences, we generally agree that the rules we live by may and sometimes must be broken when we confront an emergency.

Emergency situations can be important enough to justify departures even from the normal and customary ethical standards of medical practice.

In routine medical practice, physicians are supposed to elicit their patients’ informed consent before performing tests or initiating treatments. And a patient who refuses a test or intervention should not have to undergo it. Yet sometimes, in a medical emergency, physicians cannot stop to provide all of the relevant information required for an informed decision. Sometimes, under emergency circumstances, patients are not even capable of expressing consent or refusal.

Under normal circumstances, when patients lack the capacity to make their own treatment decisions, physicians invest time and effort to identify an appropriate surrogate who will make decisions on behalf of the patient. When no obvious surrogate is available, physicians will even ask the courts to appoint a legal guardian for making medical decisions. Frequently, however, emergency physicians cannot delay treatment in order to identify an appropriate surrogate, and there are even urgent circumstances when physicians cannot wait to elicit informed consent to treatment from a previously identified surrogate decision maker.

Confidentiality is an important and broadly acknowledged principle of medical ethics. Without the assurance that patient information will be closely guarded and not shared with others, patients would normally be reluctant to divulge personal information, particularly information about behavior that might be shameful or illegal. Yet it could be crucial for a physician to have such information, in order to make the correct diagnosis and identify the appropriate course of treatment. So the promise of confidentiality is critically important for the ethical practice of medicine. Nevertheless, when physicians obtain information that signals imminent, significant and avoidable harm to either the patient or another person, they may violate the rule of confidentiality in order to save life.

In the standard practice of medicine, patients are assured that their physicians will act in their interest. Medical students are carefully taught to put their patients’ interests before their own and to care deeply about the well-being of each patient; senior clinicians earn the esteem of their peers because of their selfless devotion to their patients’ needs. However, in emergencies with large numbers of casualties, where the need for treatment greatly exceeds the available resources for rendering care, the best interests of some patients are sacrificed so that the collective outcome can be optimized. Deliberately setting the interests of some patients aside because they are not likely to survive, regardless of the intervention, or because saving them would require a tremendous investment of very scarce resources, is an accepted part of medical triage. Clinicians who prepare for disas-

ters actually develop triage plans to assure that these principles will be followed.

Clinical research is governed by complex rules designed to assure that people are enrolled in studies only after they have provided their informed consent to serve as research subjects. Yet because some of the injuries and illnesses that befall people also leave them unable to provide informed consent or because they arise under conditions of such urgency that there is no time to elicit informed consent, clinical research under these conditions may require compromising this important principle.

The seventeenth New York Regional Conference on Issues in Medical Ethics at Mount Sinai School of Medicine was held to explore these issues. The conference, entitled "Special Challenges of Emergency Medicine," was jointly sponsored by the departments of Medical Education and Emergency Medicine. Philosophers and emergency medicine physicians presented views on these challenging dilemmas and participated in a lively discussion of the issues.

The following articles are based on presentations from that meeting. First, philosopher Heather J. Gert introduces the broad subject with her paper, "How Are Emergencies Different from Other Medical Situations?" She explains the criteria for classifying a situation as an emergency and offers ways to understand the ethical responses to such conditions. Then, the topic of informed consent and patient refusal of treatment is addressed in "What Part of 'No' Don't You Understand? Patient Refusal of Recommended Treatment in the Emergency Department," by Arthur R. Derse, who is both a law professor and an emergency medicine physician. Physicians Laura G. Iavicoli and Reza Keshavarz both address the

kinds of cases that test the limits on confidentiality in the emergency department. Dr. Iavicoli's "Mandatory Reporting of Domestic Violence: The Law, Friend or Foe?" raises questions about the law, the effectiveness of interventions to forestall harm, and the advisability of imposing mandatory-reporting statutes. Dr. Keshavarz's paper, "Adolescents, Informed Consent and Confidentiality: A Case Study," discusses the issues of capacity and trust with regard to adolescent patients.

The two final papers in this issue raise broader policy questions. "Disaster Preparedness and Triage: Justice and the Common Good," by philosopher Robert M. Veatch, explains how funding for disaster preparedness as well as policies for allocating scarce resources during a medical disaster can be regarded as matters of social justice that should be decided according to principles of justice. In her paper, "The Ethics of Research without Consent in Emergency Situations," Lynne D. Richardson, who is both an emergency medicine physician and a health services researcher, explores public policy concerning the ethical conduct of human subject research

Taken together, the papers in this issue provide valuable insight into the ethical problems posed by medical emergencies and their challenge to the ethics of routine medical practice. These papers illustrate how medicine's several important goals can sometimes conflict, and explore how the sacrifice of some may be justified in emergencies. A final point: It is important to recognize and fully value the sacrificed values as well as the values that are honored, in order to be able to justify our decisions and assure that the traditional ethics of medicine have not been set aside.