How Are Emergencies Different from Other Medical Situations?

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Abstract

Three criteria are necessary for an event to be an emergency: (a) there must be an expectation of serious harm; (b) there must be an expectation that someone can do something to prevent or reduce that harm; and (c) there must be time pressure. Because emergencies are unique in having this set of criteria, standard moral principles, when applied to emergency situations, can require actions that are prohibited in other situations. This can give the impression that there are different moral principles at work in emergencies. This paper argues that this impression is illusory.
Key Words: Moral principles, emergencies, informed consent.

IT IS WIDELY ACCEPTED that there are actions permissible in the emergency department (ED), or in emergency situations, which are not permissible in non-emergency situations. Perhaps most obviously, physicians are more frequently permitted to treat without informed consent in emergency than in non-emergency situations. This sort of observation has tempted some to suppose that standard morality does not apply in emergencies. Normally, physicians are morally required to get informed consent before treating patients; in emergency situations this not always the case. Does this mean that different moral principles are at work?

Part of what I want to show in this article is that, while different moral rules or principles may seem to apply in emergencies, there is an important and fundamental sense in which the applicable rules or principles remain the same. The same basic morality applies in the ED and in all other medical contexts. In fact, the same basic morality applies to any human interactions. But when the same rules are applied in different contexts, different conclusions result. And there are important ways in which emergency contexts are different.

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Here are several cases that illustrate the fact that applying the same principle does not always mean doing the same thing: Virtually everyone will agree that it can be appropriate to provide different information to different patients, even when they have precisely the same illness. This is because one patient might prefer to know only what is absolutely necessary, while the other wishes to know as much as possible about his disease. In each case the physician behaves appropriately if she follows the rule: "Give a patient all of the relevant information he wants." If she follows the same rule in both cases, she has done the same thing both times: She gave the patient all the relevant information he wanted. But in another sense she did something different each time—she gave the first patient less information than she gave the second. Or, to take an example from my own profession: Although I apply the same principles to grading all of the papers in a class, and am in that sense doing the same thing as I grade each paper, there is another sense in which I do something different—when I give one paper an A and another a C. Thus, there is no contradiction in saying that the same moral rules apply whether or not the situation is an emergency, while at the same time holding that different actions are permissible in emergencies than in non-emergencies.

In the previous example, what made withholding certain information from a patient morally permissible (and even morally obligatory) in one situation, while doing so in the other would have been

immoral, was a specific morally neutral fact—the fact that the first patient preferred not to receive certain information. Thus, if we want to know why certain types of actions are permissible in emergencies that are not permissible in non-emergencies, it will be useful to consider the morally neutral ways that emergencies differ from non-emergencies. In other words, what makes a particular situation an emergency?

There are three interrelated criteria that a situation must fit in order to be an emergency:

(a) There must be an expectation of serious harm.
(b) There must be an expectation that someone can do something to prevent or reduce that harm.
(c) There must be time pressure.

If a situation is a medical emergency, the expected harm must be of the sort that medicine treats. For instance, if a child is caught in a burning house, that is certainly an emergency. But if the child is rescued quickly, before sustaining any physician harm, then there is no medical emergency. In what follows I will be discussing only medical emergencies.

It seems pretty clear that all three of the listed conditions are necessary in order for something to be an emergency. If a person is going to get a paper cut unless someone acts quickly, that does not constitute an emergency. But neither does seriousness of harm alone constitute an emergency. The fact that a person is in the end stages of renal failure may not constitute an emergency, even though the person is going to die. That is because there may be nothing to be done to prevent her from dying.

Even though all three of these conditions are necessary in order for a situation to be an emergency, in medicine the third condition stands out as the most salient. In the vast majority of medical situations, someone is attempting to prevent or reduce the harm that a patient might otherwise suffer, and these harms are often serious. Emergencies differ because what is going to be done must be done (relatively) quickly. This does not mean that all decisions in emergency situations must be made in a matter of seconds. But it does mean that there is time pressure. There isn't as much time as one would like—time to order tests, convey information to patients, find surrogates, etc.

One might think that another element is necessary for a situation to be an emergency. Aren't emergencies unexpected? Certainly, most of the people who come into the ED did not expect whatever brought them there. They didn't expect the heart attack or the automobile accident. But what makes the ED appropriate for treating emergencies is precisely the fact that the ED staff are prepared to deal with them; this is a place where emergencies are not unexpected. Of course, no one in the ED expected this particular person to arrive with a gunshot wound, or with her appendix about to burst, but they expect that someone will appear with such problems, and therefore they, unlike most other people, are prepared to deal with these emergencies.

A situation can even be an emergency when it is not a surprise to anyone. So, for instance, someone who does not have medical insurance may have a condition that he knows will become acute. He might even know more or less when it will become acute, and the ED staff may be familiar with him and know this too. Despite all of this, when the man presents at the ED, and his malady is acute, this is a genuine emergency. It is an emergency now, even though everyone involved saw it coming, because right now somebody had better do something quickly, or the man will die.

Nonetheless, it is easy to see why we so often think of emergencies as unexpected. In most cases, if we see that something bad is likely to happen, we can and do take measures to prevent it. But sometimes we can't, and sometimes we merely don't. So, even though an event doesn't need to be unexpected to be an emergency, in fact, most actual emergencies are a surprise to someone, and that's the way we are likely to think of them.

I bring this up because it is important to recognize the difference between expected and unexpected emergencies. The fact that a particular emergency is unexpected can be morally relevant (1). In particular, there are many situations in which an emergency's unexpectedness excuses behavior that would otherwise be condemned. This is not usual in the practice of medicine; however, it does happen sometimes.

For instance, consider the case of a young woman interning in a small town, where gunshot wounds are extremely rare. This woman might sincerely but mistakenly believe she knows how to treat a patient who has entered the ED with a gunshot wound, and that calling someone more experienced would take too much time. Even if the intern is mistaken, and the patient suffers or dies because of her decision, she might still be excused. If it does not seem to you that an intern would be excused for making a bad decision in this situation, substitute a situation in which it does seem to you that an intern would be excused. Some of the mistakes made by those who are new to the profession of medicine are excusable. It takes a certain amount of experience to judge these things. She was unprepared, but in this case perhaps it was not her fault. She needed more experience. Because

the intern had no reason to expect that she would need to be prepared to deal with this kind of emergency, we do not hold her fully accountable for the bad choice she made because she was unprepared. We might even praise her intentions. But we would not praise her decision or her action. We would tell her that her decision was not the right one, and that she should behave differently next time.

So the intern was excused. This means that even though she did not make a good choice, she should not be held fully morally accountable. The claim that an action is excused is sometimes confused with the claim that it is justified. But unlike a decision or action that is excused, a decision or action that is justified is not a bad one. To say that an action is morally justified is to say that although the action belongs to a category of actions that are usually immoral, in this particular case, circumstances make that action morally permissible (and possibly obligatory). For instance, intentionally killing another person is a type of action that is usually considered immoral. But there are circumstances in which it is justified. For instance, one of the few factors that justify killing a person is that the other person is trying to kill you. Notice that someone who kills in self-defense is not merely excused, he's justified. (I have in mind a situation in which lethal force was necessary to stop the assault. Someone who could have simply run away is not justified in killing in self-defense.)

To say that the person was justified means that we don't merely condone his intention, we condone his decision and his action. And it's the fact that he would otherwise have been killed that justifies that action. We don't say that he shouldn't have killed his assailant, although we understand why he did—as we would if he were merely excused. We do not tell him to behave differently if this situation arises again. Rather, we say that he did the right thing, and we encourage anyone else in the same situation to behave in just the same way. That wasn't what we told the excused intern.

It is worth emphasizing that when we talk about justifying actions we are talking about justifying actions of a type that are usually considered immoral. Most actions aren't of this type, so most actions don't need to be justified. You don't need to justify your choice of where to eat lunch, or what birthday card to send, or which shampoo to use. But physicians often do things that do need justification, such as sticking people with needles. In the normal run of things, sticking people with needles is considered immoral. But there are many medical situations in which physicians are justified in—and even praised for—sticking people with needles. The reason for this is that when physicians stick people with needles, they prevent more serious harms from befalling those people, and the physicians normally have their permission.

Notice, however, that neither one of these reasons by itself—having permission or preventing harm—is usually sufficient justification for sticking people with needles. You normally need both. That is, even if getting a flu shot is a good way to avoid more serious harm, it's immoral to go around inoculating people who don't want inoculations. But neither does having people's permission to stick them with a needle make doing so okay, all by itself. We don't think very well of someone who is willing to stick people with needles (or remove bodily organs) for no other reason than that the person gave her permission to do so.

Despite the fact that being unprepared for an emergency can provide people with an excuse for suboptimal behavior, the fact that the situation is an emergency rarely excuses the actions of trained emergency personnel. This is because, as noted earlier, the emergencies that emergency personnel are dealing with are rarely unexpected in the relevant sense. That is, emergency personnel have been trained to deal with such situations. Moreover, they have a moral (as well as professional) obligation to be prepared for any sort of emergency they have reason to believe they will be called upon to deal with. So, unless the emergency is quite uncommon, and quite unlike others with which the experienced physician should be familiar—for instance, a case of Ebola virus in a small town in Wyoming—the mere fact that a senior physician is unprepared would itself be a moral failing. But to say that the behavior of experienced emergency personnel is rarely excused because they are dealing with emergencies is not to say that this fact does not often justify what they do. That is, actions of a type that are usually considered immoral may be justified in emergencies, because in emergencies the circumstances are not usual, and the ways in which they are unusual may be morally relevant.

So, there are many medical situations in which it is acceptable (or even good) to do things that would normally be considered immoral. In these situations, health care workers are not excused from standard morality. Instead, standard morality justifies their actions. And there are facts about emergencies that justify actions that would not be justified in non-emergencies. Nonetheless, this does not mean that different moral principles apply in emergencies.

Let us consider a particular principle. One fundamental moral principle of contemporary health care is: Do not treat a patient without first receiv-

ing fully informed consent either from that patient or from his proxy. That is, full respect for autonomy demands that physicians (and other health care workers) keep their hands off patients unless those patients or their proxies have given the physicians explicit permission to touch or treat them. Obviously, this is not a principle that is uniformly adhered to in the ED. Nor is it one that the general public would want emergency health care workers to follow. Patients needing immediate medical attention too often arrive at the ED unconscious or incoherent, and taking the time to find a legally designated proxy would too often make effective medical treatment impossible. So, this might look like a principle that applies in standard health care settings, but not in health care emergencies.

However, I don't think that this is a principle applied even in standard health care settings. Notice that no one accepts such a principle—keep your hands off people unless they give you explicit permission to touch them—in non-medical settings and emergencies. Keeping your hands off people unless you have their explicit permission would require, for instance, that lifeguards get permission from drowning people before dragging them to safety, or that firemen get permission from unconscious or frantic people before carrying them out of burning buildings. Clearly, if there is a general moral principle that requires us to respect autonomy by keeping our hands off people unless they give us permission to do otherwise, no one believes that it applies in these emergencies. But my main point here is not simply that no one would endorse this as a good moral principle in such situations. My main point is that no one believes that lifeguards and firemen are typically impinging on the autonomy of those they rescue.

This suggests that there might be something mistaken about thinking that treating an unconscious or incoherent person in an emergency situation normally threatens that person's freedom or autonomy. It is true that an emergency physician should not treat a patient unless she has good reason to believe that the patient wants to be treated. When the patient is conscious and coherent, the best way of determining what he wants is to ask him. But it is possible to have good reason to believe that a patient wants (or would want) to be treated even though he is incapable of expressing that preference. When it comes to most emergency health care decisions, there is a great deal of agreement among people that they would want to be treated. In many actual instances, this gives emergency health care workers very good reason to believe that a particular patient wants to be treated. For instance, one good reason for believing that the unconscious victim of an automobile accident would want her broken arm set is that just about anyone would want his or her arm set in similar circumstances. Thus, the ED staff are justified in setting this patient's arm, in testing for internal injuries, etc., not simply because this is the best way to minimize the harm she will suffer, but also because they have excellent reason for believing that they would have her explicit permission, if she were capable of giving it.

I previously discussed a specific way in which emergencies are sometimes said to be different from non-emergencies. And I have written as if very general principles (such as respecting patient freedom) must be applied case by case in emergencies and non-emergencies alike. Even in the case of the unconscious automobile accident victim, I argued that there was good reason to believe that she would give consent to treatment, in this very case, if she could.

But this focus on individual cases is somewhat misleading. When we talk about medical ethics, in large part we are talking about how to design good moral policies for health care. (What measures must be taken to preserve patient confidentiality, and when are violations of confidentiality required? How should physicians deal with situations in which family members insist on continuing futile care? Etc.) For the most part, writings on medical ethics do not evaluate individual actions, but policies. This having been said, it is clearly important to have policies that apply specifically to emergency situations. Nonetheless, I want to stress that what makes these good moral policies is that they accord with the same moral rules that govern good moral policies for medical practice in general. That is, if a policy designed for emergencies is to be justified, it must be justified by reference to the same moral principles as any other hospital policy.

It is because of the moral importance of such policies that it can even be permissible to override a conscious patient's explicit rejection of emergency treatment. For the most part, any competent person wants to be permitted to make his own decisions regarding his own health care. That is, most people do not want to be at the mercy of what someone else thinks is good for them. But competent people also recognize the need to guard against certain sorts of situations in which they might make bad decisions. So, for instance, most people would not want to have the last word about their emergency care while they are in shock, or under the influence of drugs or alcohol. Similarly, they do not want emergency physicians to be required to act on choices that they as patients might make when they don't have time to hear all the rel-

evant information. So most of us, as people who might at some time need emergency care, prefer ED policies that allow physicians to treat us even when we refuse, if the situation is an emergency and the physician has any question about our competency to refuse. But this does not mean that we would advocate policies allowing her to treat us when she knows that we are competently refusing.

Notice how important it is that emergencies involve time pressure. When there is no time pressure, most of us would not want there to be policies that would allow physicians to make decisions for us. That is not to say that patients want a policy forbidding them from deferring to a physician's suggestion. But that is still a policy in which the patient has the final word. That is because when there is no time pressure, the physician can wait for us to make our own decision, or can find appropriate legal proxies. For instance, if a physician has an appointment to discuss concerns about possible prostate problems, and the patient shows up drunk, it is not a good idea to act on that patient's stated choices. But neither should the physician make the choice for him. In this case, however, this is not a problem. The physician can wait for the patient to sober up, or reschedule for another time.

Obviously, there are characteristics of medical emergencies that make them relevantly different from other medical situations. Only in emergencies do health care workers have a severely limited amount of time in which to make decisions that are likely to significantly affect how much harm a patient suffers. This is important, because it means, for instance, that policies regarding emergencies must allow for decisions to be made quickly. Policies that take a lot of time to follow have different consequences in emergencies than they do in other health care settings, and those consequences could be disastrous. So, for instance, in emergencies health care workers must be allowed to act with less information than would be required in non-emergency situations—less information about what a particular patient wants, but also about her medical history, and even about her current ailment. Without such policies, many more people would die or suffer additional physical harm: something both health care workers and patients certainly want to avoid.

I hope I have shown that many principles, including respect for patient freedom, are just as important in emergencies as they are elsewhere. Because of the unique characteristics of emergencies, respecting these principles may take different forms than in non-emergencies, but they are no less important. Nor does the fact that a situation is an emergency provide health care professionals with an excuse for taking the situation less seriously.

Creating policies is really a way of planning. It is a way of thinking ahead of time about what one will do in a variety of different situations. And thinking ahead of time about predictable decisions is what ensures that when the ED staff is confronted with an emergency it is capable of dealing with it as responsibly as possible—both medically and ethically. Even relatively mundane policies, for instance, those that govern admitting patients or storing supplies, contribute to—or should contribute to—providing for the welfare of patients. If there were no policies concerning these things, new decisions would have to be made constantly, and this would certainly waste a great deal of precious time. Similarly, there must be policies regarding who has which responsibilities, and what, precisely, those responsibilities are. Again, making these decisions on an *ad hoc* basis would take time precisely when that time is needed most, and this is why policies designed specifically for the ED are necessary.

Conclusion

It is certainly true that emergencies are different from other medical situations, and this fact morally requires that there be policies designed especially for emergency situations. But the unique nature of emergencies does not mean that those who provide emergency medical care are excused from standard morality, or that a different set of basic moral principles apply. It is also important to recognize that the moral requirement for designing policies for emergencies is broad, and does not apply merely to decisions that obviously fall under the purview of medical ethics, such as those having to do with informed consent or decisions regarding the futility of treatment. It applies to any aspect of what happens in emergency situations that has the potential for affecting the welfare of patients.

References

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