Ethics in Emergency Medicine

Steven K Kulick, MD MBA FACEP

September 11, 2025

United Healthcare | Optum Health Education™

Introduction

- Steven Kulick, MD MBA
- UHC Chief Medical Officer, Medicare & Retirement, WI, IL, AR
- Emergency Physician
  - -ABEM Diplomate
  - -Fellow, American College of Emergency Physician
- Health system leadership experience, including service on Ethics Committees

Disclaimer

- I have no conflicts to disclose.
- All opinions expressed are my own.
- Nothing I say should be construed as medical or legal advice.
- I will approach this topic from the point of view of a physician, acknowledging that medicine, and especially emergency medicine, requires teamwork.

Agenda

- Overview of medical ethics
- Current ethics guidelines from national medical organizations
- Ethical issues and challenges in emergency medicine: Case presentation format

Learning Objectives

- Demonstrate a general understanding of medical ethics
- Apply these concepts to situations that commonly arise in the emergency department
- Identify situations in the emergency department where ethical conflicts may arise

Overview of Medical Ethics

Ethics: “The discipline concerned with what is morally good and bad and morally right and wrong. The term is also applied to any system or theory of moral values or principles.”

Brittanica.com

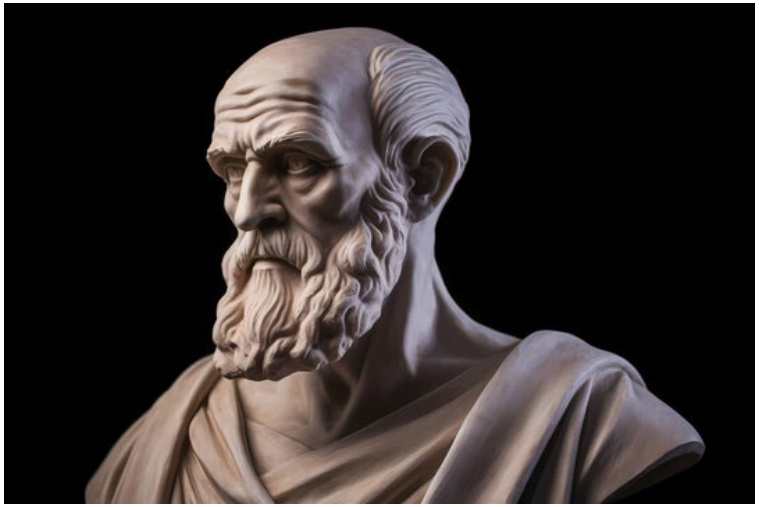
Ethics

- Morality and ethics are closely related but are not exactly the same thing. Morality is what we believe. Ethics provides guidelines for what we do.
- The professions – business, law, medicine, nursing, etc. - have their own ethical standards and guidelines.
- I think it is useful to think of ethics as a system of principles. Medical ethics is the application of these principles to clinical scenarios and medical practice.

A Brief History of Medical Ethics

Hippocrates:

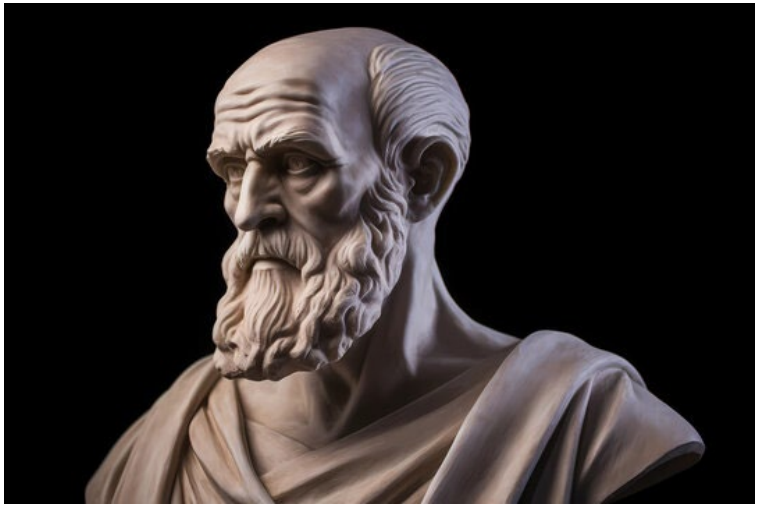
- Greek physician and philosopher of the classical period who is considered one of the most outstanding figures in the history of medicine. He is traditionally referred to as the "Father of Medicine."
- Hippocrates is credited as the first person to believe that diseases had natural causes and were not a result of punishment by the gods, etc.



Hippocrates
c. 460 – c. 370 BC

A Brief History of Medical Ethics

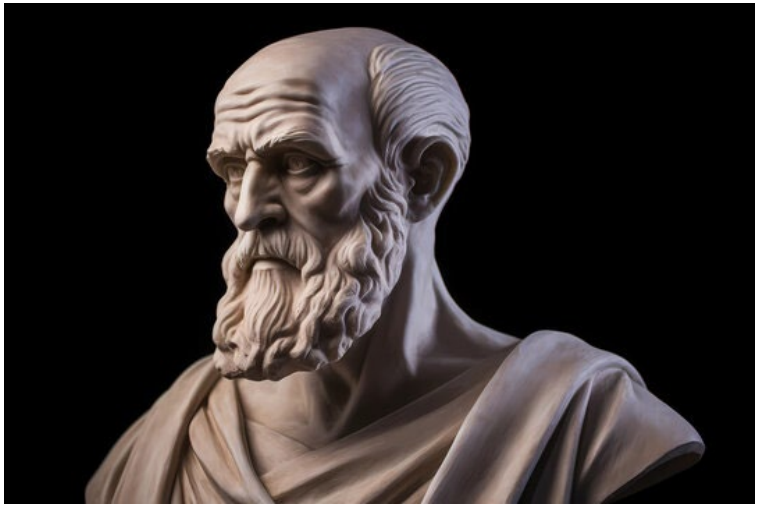
- The **Hippocratic Oath** is an oath of ethics historically taken by physicians. It is one of the most widely known of Greek medical texts. The oath is the earliest expression of medical ethics in the Western world, establishing several principles of medical ethics which remain of paramount importance today. These include the principles of medical confidentiality, beneficence, and non-maleficence.



Hippocrates
c. 460 – c. 370 BC

A Brief History of Medical Ethics

- "And whatsoever I shall see or hear in the course of my profession…..I will never divulge, holding such things to be holy secrets."
- "I will use my powers for the benefit of the sick according to my ability and judgment, and will keep them from harm and injustice."



Hippocrates
c. 460 – c. 370 BC

A Brief History of Medical Ethics

- The term medical ethics first dates back to 1803, when English author and physician **Thomas Percival** published a document describing the requirements and expectations of medical professionals. The Code of Ethics was then adapted by the American Medical Association in 1847, relying heavily on Percival's words.

The Four Pillars of Medical Ethics

1. Autonomy
2. Beneficence
3. Non-Maleficence
4. Justice

Autonomy

- Autonomy is the principle that respects the patient's right to make their own decisions about their healthcare, based on their values and beliefs. Patients have a right to refuse treatment, even if it's medically recommended.
- In order to respect autonomy, informed consent for treatment is required.
- “Nothing about me without me.”
- “You’re not the boss of me.”

Beneficence

- The principle of beneficence requires healthcare professionals to act in the best interests of their patients and to promote their well-being. It means providing care that is beneficial and avoiding unnecessary care and avoidable risks.
- Basically, it's why we do what we do in health care, no matter our role.
- "To help people live healthier lives and help make the health system work better for everyone."

Non-Maleficence

- This principle obligates healthcare providers to avoid causing harm to their patients. This includes minimizing risks and preventing negative outcomes.
- Often summarized as, “First, do no harm.”
- Scope of practice.
  - “I will not use the knife, not even on sufferers from stone, but I will give place to such as are craftsmen therein.”
- Avoid unnecessary care.
- “Don’t just do something, stand there.”

Justice

- This principle calls for fair and equitable distribution of healthcare resources and treatment, without discrimination. It means ensuring that all patients have access to the care they need, regardless of their background or circumstances.
- Resource allocation can be a logistical as well as an ethical challenge in emergency situations.
- Justice in the allocation of healthcare resources is a societal issue; we know that disparities exist.

Current Medical Ethics Guidelines

AMA Code of Ethics

- **Principles**
- I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.
- II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
- III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.
- IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.
- V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

AMA Code of Ethics (cont.)

- **Principles (cont.)**
- VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.
- VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
- VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.
- IX. A physician shall support access to medical care for all people.

- Adopted June 1957; revised June 1980; revised June 2001.

ACEP Code of Medical Ethics

Principles of Ethics For Emergency Physicians

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

1. Emergency physicians shall embrace patient welfare as their primary professional responsibility.

2. Emergency physicians shall respond promptly and expertly, without prejudice or partiality, to the need for emergency medical care.

3. Emergency physicians shall respect the rights and strive to protect the best interests of their patients, particularly the most vulnerable and those with impaired decision making capacity.

ACEP Code of Medical Ethics

American College of Emergency Physicians®

Principles of Ethics For Emergency Physicians

4. Emergency physicians shall communicate truthfully with patients and secure their informed consent for treatment, unless the urgency of the patient's condition demands an immediate response or another established exception to obtaining informed consent applies.

5. Emergency physicians shall 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. Emergency physicians shall deal fairly and honestly with colleagues and take appropriate action to protect patients from health care providers who are impaired or incompetent, or who engage in fraud or deception.

ACEP Code of Medical Ethics

American College of Emergency Physicians®

Principles of Ethics For Emergency Physicians

7. Emergency physicians shall work cooperatively with others who care for, and about, emergency patients.

8. Emergency physicians shall engage in ongoing study to maintain the knowledge and skills necessary to provide high quality care for emergency patients.

9. Emergency physicians shall act as responsible stewards of the health care resources entrusted to them.

10. Emergency physicians shall 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.

Code of Ethics for Emergency Physicians

[Ann Emerg Med. 2017;70:e7-e15.]

The Ethical Pillar of Justice and the Law: EMTALA

- EMTALA, the Emergency Medical Treatment and Labor Act, is a federal law that requires Medicare-participating hospitals with emergency departments to provide a medical screening examination to anyone who comes to the emergency department requesting care, and prohibits hospitals from refusing to treat or transfer patients with an emergency medical condition until they are stabilized. This means that hospitals cannot discriminate based on a patient's ability to pay, insurance status, or other factors when providing emergency care.

- AMA Code of Ethics: “A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.”
- ACEP Code of Ethics: “Emergency physicians shall respond promptly and expertly, without prejudice or partiality, to the need for emergency medical care.”

- **Emergency physicians don’t get to choose their patients, and emergency patients don’t get to choose their physicians.**

Institutional Support

- Ethics committee
- Legal counsel
- Other consultants and colleagues

Ethical Issues in Emergency Medicine

Case 1

- Mr. M is a 58-year-old man from out of town who is visiting his brother. He became pale and sweaty and told his family he was having chest pain. His brother insisted he come to the emergency department. His vital signs are stable, but his EKG shows an acute STEMI (heart attack) and his cardiac enzymes are elevated. After initial treatment his pain resolves and he says he feels fine. You explain to him that he is having a heart attack and the treatment is to have a cardiac catheterization to restore blood flow to his heart and prevent further damage. He calmly states, “I feel better now and I want to go home. I don’t want to stay. I just don’t like hospitals.” He is sober, awake, and alert. You ask him to demonstrate understanding of the situation and he says, “I know this might be serious, but I feel fine now and I just don’t want to stay. I will come back if the pain happens again. Can you please discharge me now?”

Case 1 Discussion

- Would you discharge him?
- Would you refuse to let him leave?
- Would you make him leave against medical advice (AMA)?
- What ethical issues are involved here?

Case 2

- Mrs. S is an elderly woman who comes to the ED from an assisted living facility. She was recently diagnosed with mild dementia. She told the staff where she lives that she was having abdominal pain and had an episode of vomiting. On assessment, her vital signs are stable, but she has a low grade fever. She is a poor historian and has difficulty describing the pain, its duration, etc. On exam she has diffuse lower abdominal tenderness. An IV is started and blood and urine tests are ordered. Urinalysis shows no evidence of infection. White blood cell count is elevated at 12,000. You are concerned that the patient may have a surgical problem. You order a CT scan of the abdomen and pelvis.
- Before the CT scan can be performed and before a nurse can get to the bedside, the patient gets off the bed and pulls out her IV. As you enter the room, you note that the patient is agitated. She is partly dressed but her clothes are in disarray. She states that she has, “been in this office long enough.” She states that the nurses are trying to harm her and she plans to walk home.
- What do you do next? Can Mrs. S refuse care and leave the ED?

Decision Making Capacity

- In this case, your assessment is that the patient lacks capacity for decision making.
- Need for surrogate decision maker involvement, etc.
- Patients who lack capacity for medical decision making are very common in the emergency department.

Decision Making Capacity

- Decision-making capacity refers to a person's ability to understand information relevant to a healthcare decision, appreciate the consequences of that decision, and make a choice based on their values and preferences. Capacity is a clinical determination, distinct from the legal concept of competence, which is determined by the courts.
- It is critical to apply the pillars of medical ethics – autonomy, beneficence, non-maleficence, and justice – to situations where a patient may lack capacity.
- Failure to protect patients who lack capacity can also create legal issues for emergency physicians.

What Happens when Patients Lack Capacity?

- If a patient lacks capacity, a surrogate decision-maker (like a designated healthcare proxy or family member) will be consulted.
- Surrogates make decisions based on the patient's previously expressed wishes or, if those are unknown, what is deemed to be in the patient's best interest.

Importance of capacity assessment

- Ensures patients' autonomy and right to make informed healthcare decisions.
- Protects vulnerable individuals from making choices they don't fully understand or appreciate.
- Helps healthcare professionals provide appropriate care based on the patient's wishes and values.

Factors that may Compromise Decision Making Capacity

1. Cognitive Impairments:

- Dementia and other neurological conditions:
  - Can significantly impact a patient's ability to understand information, weigh options, and make rational choices.
- Intellectual disability:
  - Individuals with intellectual disabilities may require support and guidance in making healthcare decisions.
- Acute mental status changes:
  - Sudden changes in mental state due to illness or injury can temporarily impair decision-making capacity.

Factors that may Compromise Decision Making Capacity

2. Mental Health Conditions:

- Psychiatric disorders:
  - Conditions like severe depression, psychosis, etc., can affect a person's ability to think clearly and make sound judgments.
- Substance use:
  - Intoxication or withdrawal from alcohol or drugs can impair cognitive function and decision-making ability.

Factors that may Compromise Decision Making Capacity

3. Communication Barriers:

- Language barriers:
  - Patients who don't speak the same language as their healthcare providers may not fully understand information or express their preferences.
- Lack of Health Literacy:
  - Patients with limited health literacy may struggle to understand complex medical information, even if they speak the same language.

Assessing Capacity in the Emergency Department

- A full capacity assessment is a complex undertaking, and it can be challenging for emergency physicians to carry this out in a busy ED with a patient who may be uncooperative.
- The following questions are a reasonable screen. A capable patient should be able to answer all of these questions after their situation and options have been explained to them.
  1. What is the nature of your current medical problem? (i.e., What is wrong with you?)
  2. What options are available to you? (i.e., Do you know what your options are?)
  3. What's likely to happen if you accept the offered treatment? If you refuse it?
  4. What is your choice?
  5. Why have you made this choice?

Case 3

- Mr. B is an elderly man with metastatic cancer and pneumonia with sepsis. He is initially alert in the ED. You ask him about his wishes if his condition were to worsen. He clearly affirms to you that he does not wish to be intubated or to receive CPR because he has been fighting cancer for a long time and doesn't want any more care. He states that he is at peace and has lived a good life. He also declines placement of a central line for aggressive care of his sepsis. He begins to grow confused as his blood pressure gradually drops, and you call his family to be at his bedside because you suspect that he is close to death.

Case 3 (cont.)

- His son arrives in the ED and becomes very upset when he sees his father dying. He demands that the patient should have aggressive care, including intubation and a central line. When you explain that his father had expressed that he did not want a central line or intubation, his son argues “My father would never want that. Our beliefs are that we should do everything to stay alive. My father must have been confused because he’s so sick.” Your assessment is that his father was not confused and expressed his wishes knowingly and genuinely. His son is furious and accuses you of trying to kill his father by withholding care and threatens to sue you and the hospital for murder. The patient is now barely conscious and unaware of his surroundings.
- What do you do?

Case 3 Discussion

- End of life issues are common in the emergency department.
- Autonomy is a paramount ethical value.
- Competent people can choose to accept or reject even life sustaining care.
- In this case, compassion, empathy, and good communication skills are essential.
- Other members of team – pastoral care, ethics committee members, senior staff, etc. – may be helpful in diffusing an emotional fraught situation.

Case 4

- Mrs. L brings her 12-month-old son to the emergency department and states that she can’t get him to stop crying. She thinks he might have fallen. The patient is crying and you note that palpation of his right arm causes him to withdraw and cry harder. He has scattered bruises on his extremities and his back. An X-ray shows spiral fractures of the right radius and ulna.
- What do you do next?

Mandatory Reporting

- Physicians and nurses are mandatory reporters of suspected child abuse and neglect, and must also report abuse and neglect of the elderly and other vulnerable populations.

- "The emergency physician and others in the emergency department are uniquely positioned to identify people at risk or who pose a risk, and to report them as required or allowed under the law. In some circumstances, these duties may conflict with ethical duties such as respect for patient autonomy or to protect confidentiality."

Geiderman JM, Marco CA. Mandatory and permissive reporting laws: obligations, challenges, moral dilemmas, and opportunities. J Am Coll Emerg Physicians Open. 2020 Jan 21;1(1):38-45. doi: 10.1002/emp2.12011. PMID: 33000012; PMCID: PMC7493571.

Mandatory Reporting

- Physicians (as well as nurses, teachers, and clergy) are mandated reporters of suspected child abuse and neglect.
- In this case, the injury is suspicious, and the physician is required to report this injury.
- In this case, the physician would immediately notify Child Protective Services.

Mandatory Reporting

- Mandatory reporting laws raise important ethical questions, because they prioritize public and patient welfare and set aside both patient autonomy and the physician's duty to protect confidentiality; that is, to not disclose what a patient reveals during their encounter with their physician.
- Reporting laws seek to prevent harm from coming to the index patient or other patients (non-maleficence) or to directly benefit patients (beneficence) by protecting them from specific harms. Alternatively, reporting that overrides patient autonomy may cause the patient either to distrust the provider or facility or to avoid care altogether.

Geiderman JM, Marco CA. Mandatory and permissive reporting laws: obligations, challenges, moral dilemmas, and opportunities. J Am Coll Emerg Physicians Open. 2020 Jan 21;1(1):38-45. doi: 10.1002/emp2.12011. PMID: 33000012; PMCID: PMC7493571.

Mandatory Reporting

- In many states and counties, reportable conditions include traffic accidents, gunshot wounds and other penetrating trauma, animal bites, falls, residential fires, occupational injuries, poisoning, overdose, sexual assault, suicides, and drowning. Reporting is aimed at either preventing future injuries, enforcing statutes designed to protect the public, or solving crimes.

- Some infectious diseases are also reportable.

Geiderman JM, Marco CA. Mandatory and permissive reporting laws: obligations, challenges, moral dilemmas, and opportunities. J Am Coll Emerg Physicians Open. 2020 Jan 21;1(1):38-45. doi: 10.1002/emp2.12011. PMID: 33000012; PMCID: PMC7493571.

Case 5

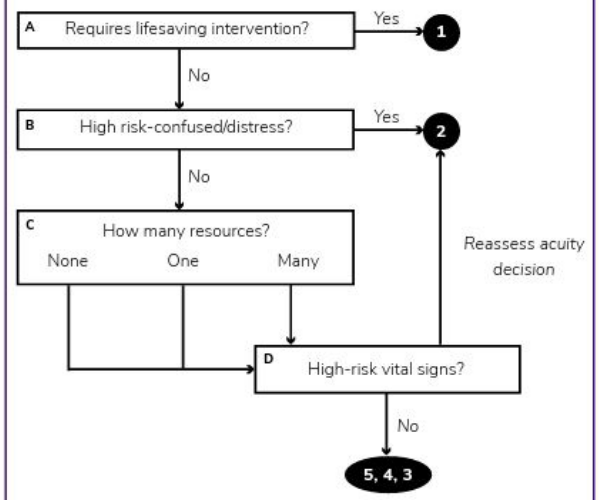
- You are the only physician on duty in a suburban emergency department. There is also a physician assistant on duty, along with an RN and an ED tech. You get an ambulance call stating they have been dispatched to a local manufacturing facility where there has been an explosion and fire. Law enforcement then calls the ED to confirm the developing situation. Although EMS (emergency medical services) has a protocol to distribute patients to local facilities in the event of a mass casualty incident, your hospital is closest to the scene. You activate your hospital's mass casualty incident plan, and help is on the way, but you are made aware that there are 5 ambulances heading in now with critically injured and burned patients.

Triage, mass casualty events, and pandemics

- Triage: The preliminary assessment of patients or casualties in order to determine the urgency of their need for treatment and the nature of treatment required.
- Note that resources and staffing are not infinite. This can lead to conflicts and stress.
- Ethical concepts and protocols provide a framework to address these challenges.
- Justice is a particularly important concept in emergency resource allocation.

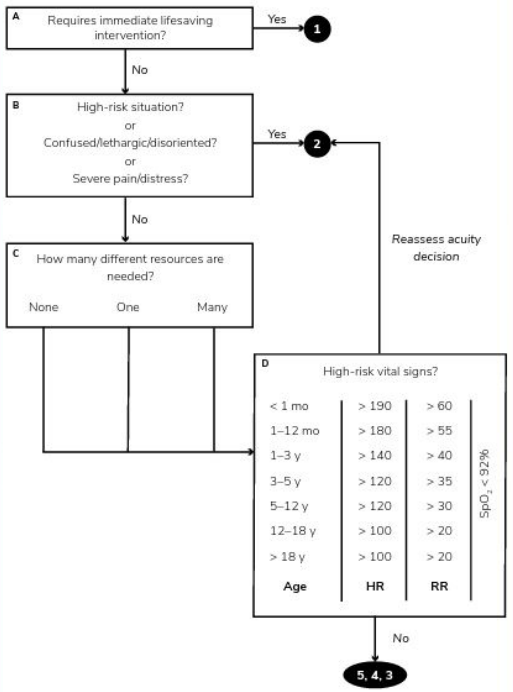
Emergency Severity Index

Figure 2-1. Emergency Severity Index Conceptual Algorithm



Emergency Nurses Association
Emergency Severity Index Handbook
Version 5

Figure 2-2. ESI Triage Algorithm, Version 5



A. Immediate life-saving intervention required: Airway or respiratory support, emergency medications, hemodynamic interventions such as fluid resuscitation or blood products

Clinical presentations requiring lifesaving interventions include the following: intubated, unresponsive, pulselessness, apneic, severe respiratory distress, profound hypotension or hypoglycemia.

Unresponsiveness is defined as a patient who either:

1. Is nonverbal and not following commands (acutely)
OR
2. Requires noxious stimulus (P or U on AVPU scale)

B. High-risk situation: May become unstable, have high risk for deterioration, or exhibit newly altered mental status. Severe pain or distress is determined by patient report, corroborated with clinical observation.

C. Resources: Count the number of different types of resources, not the individual tests or radiographs.
(*For example, complete blood count, electrolytes, and coagulant studies equal one resource because they are all laboratory tests, while complete blood count plus chest radiograph equals two resources because one is a laboratory test and one is imaging*).

ESI Resources	Not ESI Resources
• Labs (blood, urine) • Electrocardiogram, radiographs • Computed tomography, magnetic resonance imaging, ultrasound, angiography • Intravenous fluids (hydration) • Intravenous, intramuscular, or nebulized medications • Specialty consultation • Simple procedure = 1 (laceration repair, urinary catheter) • Complex procedure = 2 (procedural sedation)	• History and physical exam (Including pelvic) • Point-of-care testing • Saline or heparin lock • Oral medications • Tetanus immunization • Prescription refills • Phone call to primary care physician • Simple wound care (dressings, recheck) • Crutches, splints, slings

D. High-risk vital signs: Reassess to determine whether the patient warrants a higher acuity level if a patient has one or more vital signs outside the normal parameters for the patient.

Pediatric Fever Considerations

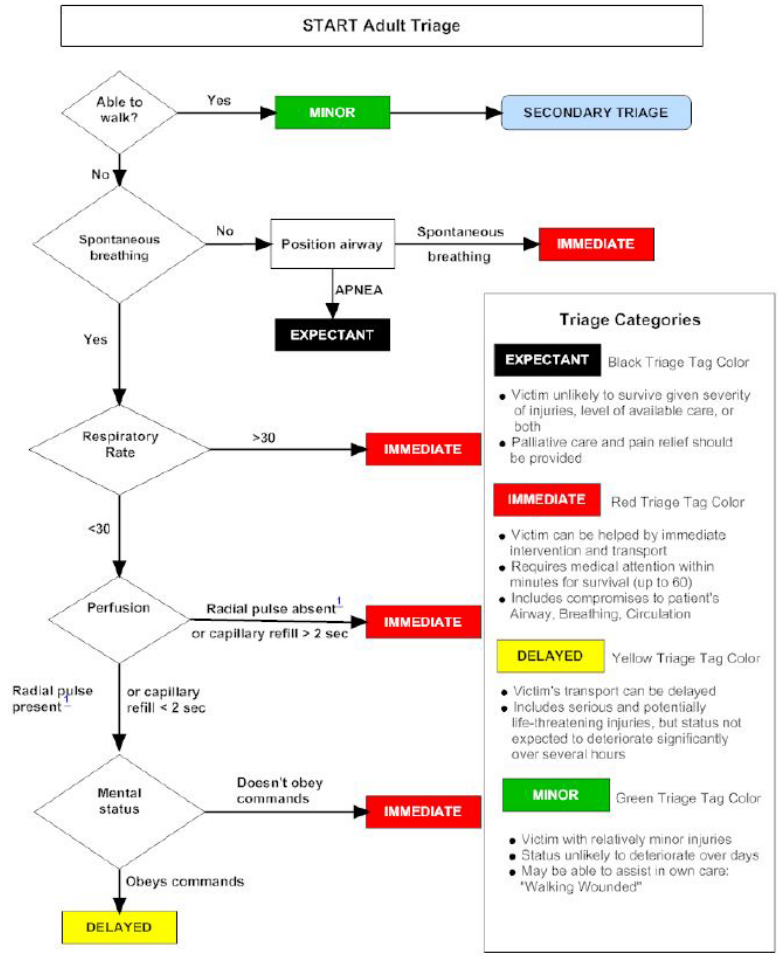
1-28 days of age: Assign at least ESI 2 if T > 38° C (100.4 ° F)

1-3 months: Consider assigning ESI 2 if T > 38 ° C (100.4 ° F)

3 months and older: Consider assigning ESI 2 or 3 if:

1. T > 39°C (102.2°F) or < 36°C (96.8°F), or
2. Incomplete immunizations,
OR
3. No obvious source of fever

Mass Casualty Triage



Adopted from http://www.start-triage.com

REMM RADIATION EMERGENCY MEDICAL MANAGEMENT REMM.hhs.gov

The NEW ENGLAND JOURNAL of MEDICINE

PERSPECTIVE

The Toughest Triage — Allocating Ventilators in a Pandemic

Authors: Robert D. Truog, M.D. , Christine Mitchell, R.N., and George Q. Daley, M.D., Ph.D. Author Info & Affiliations

Published March 23, 2020 | N Engl J Med 2020;382:1973-1975 | DOI: 10.1056/NEJMp2005689 | VOL. 382 NO. 21

Summary

- Ethics is essential to the appropriate delivery of healthcare.
- The four pillars of medical ethics are:

1. Autonomy
2. Beneficence
3. Non-Maleficence
4. Justice

- There are unique ethical challenges in emergency medicine due to time, resource availability, the lack of pre-existing doctor – patient relationships, the frequency of patients who lack capacity for decision making, and situations where disclosure may conflict with confidentiality.

- But that's what makes it interesting and rewarding.

Thank you!