
Ethics of Emergency Care

Beverly J. Fauman, M.D.

Ethical conflicts are as likely to arise in the course of assessment and decision making in an emergency situation as in any other psychiatric setting. Careful consideration must be given to these decisions, even though they must often be made quickly and with little information, because of the short-term, long-term, and potentially life-threatening consequences.

The psychiatrist must act ethically with the emergency patient as with all patients. However, the following areas, discussed in several sections of *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry* (American Psychiatric Association 2001), are particularly susceptible to ethical conflict in the emergency situation (Larkin et al. 1994; Mayer and Thibodeau 1997; McCurdy et al. 1996; Montoya 1994; Young et al. 1993).

~

Section 1

*A physician shall be dedicated to providing
competent medical service with compassion and
respect for human dignity.*

Compassion and respect for human dignity are more difficult to sustain in dealing with some chronically mentally ill patients, whose appearance or methods of communication may cause the physician to respond



as though the patient were retarded or immature. This was illustrated by the experience of a patient well known to the community mental health center associated with a major university.

The patient arrived in the waiting room of the community mental health clinic, oozing serosanguinous fluid from between his fingers, which were pressed to his chest. The staff, thinking he had just been assaulted, encouraged the patient to go to an emergency department because the clinic was not equipped to handle the medical problem he appeared to have. He refused to leave, saying he was afraid of the emergency department. Finally, a psychiatrist he knew began to question him as to his obvious physical signs and determined that recent surgery, not an acute injury, was producing the effluence. Arrangements were made to have him seen in the surgery clinic. The patient related that whenever he went to an emergency department, the staff generally did not inquire about physical illness because he was so obviously psychiatrically chronically ill. He observed that only the mental health center staff listened to him.

Psychiatric patients who come to an emergency department even with obvious physical illness often are sent directly to the psychiatrist, frequently without even a determination of vital signs. This is sometimes due to the behavior of the patient, who either does not want to speak to anyone other than a psychiatrist or who acts in a bizarre or psychotic manner. The patient may attribute his or her physical symptoms to delusional causes.

A 78-year-old man was sent to the emergency department from his senior citizens' housing unit because he was being disruptive repeatedly at night. He volunteered that he had to stay up all night to keep the witches from coming into his window; furthermore, he felt that banging on the windows was additional insurance that they would stay away. Careful questioning revealed that he had decided they came in at night whenever he fell asleep, because when he woke up on those mornings, his legs were swollen. Treatment with haloperidol and digitalis enabled him to return to his home.

Psychiatric patients often anticipate being misunderstood or mistreated in general medical settings. Often, the emergency physician may collude with the psychiatric patient in this regard, since such patients can make other physicians anxious and eager to refer the patient to psychiatry. For example, acutely paranoid patients may respond with hostility to a request to remove their clothes or bare their arms so that blood pressure or pulse can be checked.

A woman presented to the emergency department demanding an examination to confirm her belief that she had been raped the night before. As she further described the assault, the emergency physician concluded that the patient was delusional, since she stated that she had been asleep throughout the attack and nothing in her apartment was disturbed. He decided to request a psychiatric consultation immediately, but she refused and demanded to leave the hospital. He barred her way, insisting on the consultation, at which point she began to threaten him. He then felt he had grounds to commit her and became even more forceful in restricting her departure. By the time the psychiatrist arrived, the tension in the examining room was extreme. The psychiatrist resolved the immediate impasse by ascertaining that the patient's threat was only in response to the provocation she felt and that she was not in any immediate danger to herself or anyone else. He allowed her to leave.

Maintaining a sense of respect or human compassion for patients who are psychotic, threatening, or manic may be difficult, but remembering that the patient still has the right to refuse treatment recommendations is essential, until a decision has been made to commit the patient to some sort of confinement. Even when confined, patients have the right to refuse medication unless their lives are at immediate risk or unless they will likely endanger others' lives. Furthermore, patients have the right to refuse medical treatment, such as chemotherapy for a malignancy, even when their reasons for doing so are based on delusional beliefs.

Patients with no underlying psychiatric disorder may present with behavioral symptoms that are caused by a medical illness. Here, also, patients are frequently referred to a psychiatrist before their illnesses have been adequately assessed. Unfortunately, psychiatric diagnoses tend to stay with patients even when the true etiology is later identified. This can affect a patient's ability to obtain insurance, employment, further medical care, or a security clearance. Custody of minor children may be influenced by a diagnosis of a major psychiatric illness. Even though laws now protect the rights of patients with psychiatric illness, these laws are often breached surreptitiously, for example, by employers. Consider carefully any psychiatric diagnosis applied to a patient for the first time. Whenever some uncertainty exists, less stigmatizing options, such as acute stress reaction or adjustment disorder, give patients the benefit of the doubt.

A patient presented to the emergency department with a description of such bizarre symptoms that she was fairly quickly admitted to the psychiatric unit without undergoing much more than a cursory evaluation in the emergency department. On the psychiatric unit, during



the physical examination, the combination of markedly depressed vital signs, “hung-up” reflexes, and a 12-inch well-healed scar at the base of her throat led to the diagnosis of hypothyroid disorder, secondary to the removal of her thyroid gland some 20 years earlier. Laboratory studies and rapid response to thyroid replacement confirmed the diagnosis. The patient did not quite understand the ramifications of her condition and had stopped taking the thyroid medication soon after discharge, because she felt well. When she was brought back to the emergency department approximately 3 months later, treatment of her myxedema coma was delayed because the emergency department staff remembered that she had been admitted to the psychiatric unit on her previous visit and presumed she was now catatonic.

In an emergency, clinicians often do not have all the information needed to make a diagnosis. Psychiatric diagnosis, however, is not the most important task of an emergency assessment. The first obligation is to preserve life, stabilize the patient, assess the circumstances surrounding the situation, and determine the best next step. Diagnoses such as schizophrenia and bipolar disorder cannot be made with certainty with a single episode of illness. Major depressive disorder also implies that the patient’s symptoms have been present for a period of time, and although the patient may give a fairly convincing history to support the diagnosis, often there is insufficient evidence to be certain.

Other issues that relate to Section 1 of *The Principles of Medical Ethics* include certifying a patient for treatment, maintaining confidentiality, and being honest with patients. These issues are discussed in more detail in other chapters of this primer.



Section 2

A physician shall deal honestly with patients and colleagues.

Dealing with a patient honestly in an emergency situation becomes conflictual when a psychiatrist determines the need to hospitalize a patient and the patient refuses to sign in. Common practice in this instance involves marshaling resources, such as security guards, other health care personnel, and transportation—as well as contacting the receiving hospital—before alerting the patient of an intention to certi-

fy him or her; this is done out of concern that the patient would try to leave the emergency department if he or she knew about the hospitalization. Reassuring a patient falsely until one has control of the situation is not unusual.

Certification deprives the patient of significant personal freedoms and may in the future harm him or her if used by another to obtain certain legal advantages against the patient (e.g., custody of minor children, leverage in a divorce action, power of attorney). The patient may be stigmatized by a history of psychiatric hospitalization, when, in fact, the patient's signs and symptoms were caused by an organic illness that was misdiagnosed. Furthermore, certification may not necessarily accomplish the objective of getting treatment for the patient, even when the etiology is psychiatric. History of a psychiatric hospitalization stigmatizes a patient not only by the implied impairment that occasioned the hospitalization, but also by the blow to one's self-esteem from the experience. Even when a patient agrees to sign into a hospital voluntarily, the agreement may be coerced by a threat of commitment. Unlike rules regarding informed consent, it is not only difficult to identify the risks and benefits of psychiatric hospitalization, but it is also uncertain whether the acutely ill psychiatric patient is able to comprehend them.

In situations of domestic violence or child abuse, a clinician may forgo his or her obligation to be honest with the patient. The staff may deceive the parent or spouse to gain time while arranging for a judicial order or transportation to emergency shelter. When a patient is the child or the battered spouse and his or her safety is the primary concern, no conflict exists. When the assailant is the patient, an ethical dilemma arises that may not be resolved in the short term.

~
Section 3

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.

Laws regarding commitment vary from state to state and have undergone significant changes over the last couple of decades. Nonetheless,



psychiatrists often feel bound by the legal constraints of certification petitions. These address the need for society's protection from a patient but may not permit the psychiatrist to treat the patient, only to contain him or her.

Honesty is also one of the guiding ethical principles in this section, and conflicts arise in the discovery of illegal behavior, such as child abuse or abuse of illicit substances; the former mandates a duty to report the patient, which may substantially interfere with the psychiatrist's ability to encourage the patient to get into treatment. The patient must be informed that legal obligations of the psychiatrist necessitate reporting, commitment, and limits to confidentiality. Some states have so-called "Miranda" rules, which declare that the patient must be informed ahead of time that statements he or she may make to the psychiatrist, such as expressed threats of harm to others or of suicidal intent, may be used to justify an involuntary hospitalization. Mandatory reporting of child abuse or elder abuse overrides the promise to a patient, whether explicit or implied, to maintain confidentiality.

At times, a second psychiatrist may be necessary to evaluate the patient and complete the certification paperwork, when the first psychiatrist has begun an assessment before recognizing that the patient may need to be hospitalized. An ethical dilemma may arise under these circumstances if the patient subsequently denies thoughts or acts that were revealed to the first psychiatrist. Alternatively, when the psychiatrist promises confidentiality, he or she could explain that exclusions exist according to the constraints of the law. This unfortunately may cause the patient to be quite guarded in the information he or she supplies.



Section 4

*A physician shall safeguard
patient confidences within the
constraints of the law.*

Some of the problems that present in the emergency situation have been discussed in prior sections of this chapter. Confidentiality may

also be unintentionally violated in the emergency situation. The psychiatrist must consider whether he or she actually has the right to examine the patient. A patient who has come to an emergency department for treatment of a self-inflicted injury, treatment of an unexpected reaction to a drug or medication, or treatment of injuries sustained in domestic violence may not want to talk to a psychiatrist. Yet the patient's disclosures to the initial treating physician may directly result in the physician's request for a psychiatric consultation. Family members who express concern about the patient want reassuring information, which the psychiatrist may not be at liberty to reveal.

A 21-year-old student had a psychotic episode while attending college several hundred miles from his home. Although his parents were aware that his phone calls to them over the previous few weeks had seemed increasingly disjointed and even bizarre, they did not appreciate the degree of looseness of thought and associations that was observed in the emergency department. The patient did not want his parents to be notified, fearing that they would pull him out of school. When the family contacted the treating psychiatrist, she was obliged to explain that no information about the patient could be divulged.

This decision may not appear to be in the patient's best interests. Remember, however, that the family does have other resources, such as the patient himself, the roommate, or possibly the dean of the college. Maintaining confidentiality in such a circumstance is uncomfortable but is an ethical imperative. Permission to speak with family members, to obtain additional information that may help assess and treat the patient, may be denied by that patient. Other facilities that have knowledge about the patient appropriately guard the legal right of the patient not to release any information to family and any other non-medical individuals, even when the information may facilitate the patient's assessment and hasten stabilization. This circumstance is quite similar to the health care provider withholding the patient's history of diabetes or cancer from family and non-medical individuals. Health care providers sometimes disclose this information; however, they should apply the same ethical principle of confidentiality to all medical information.

Confidentiality is difficult to protect when approaching an acutely ill psychiatric patient in the company of other staff, which is often necessary. Security guards, aides, or other staff may need to be present when action is required—for example, with the discovery of behavior that is illegal or dangerous to the patient or others.


Section 6

A physician is free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

The principle of freedom of choice does not extend to the emergency situation. Thus, even when a psychiatrist has not chosen to practice in an emergency setting, emergencies may arise in which the psychiatrist will be obliged to treat patients he or she would ordinarily not wish to treat. Until the care of the patient has been delegated to another, the psychiatrist must continue to treat such a patient until he or she is stabilized and safe to release. The psychiatrist must balance the care of each patient with the care of other patients and must resist the demand to discharge a patient because of pressures exerted by financial concerns, just as assuredly as he or she must attempt to prevent hospitalization through competent crisis management.


References

- American Psychiatric Association: *The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry*. Washington, DC, American Psychiatric Association, 2001
- Larkin GL, Moskop J, Sanders A, Derse A: The emergency physician and patient confidentiality: a review. *Ann Emerg Med* 24:1161–1167, 1994
- Mayer D, Thibodeau L: Ethical issues in alcohol-related emergencies and emergency care of alcoholic and intoxicated patients, in *Advances in Bioethics, Vol 3: Values, Ethics, and Alcoholism*. Edited by Shelton WN, Edwards RB. Greenwich, CT, JAI Press, pp 287–308, 1997
- McCurdy DB, Brown FB, Shackelton RA, et al: Disclosure vs confidentiality when disaster strikes. *Making Rounds in Health, Faith, and Ethics*. 22:1:1, 3–5, 1996
- Montoya MA: If I tell you, will you treat me? *John Marshall Law Review* 27:363–372, 1994
- Young EWD, Corby JC, Johnson R: Does depression invalidate competence? Consultants' ethical, psychiatric, and legal considerations. *Camb Q Healthc Ethics* 2:505–515, 1993