AMA Journal of Ethics®

May 2016, Volume 18, Number 5: 479-484

ETHICS CASE

What is an Emergency Ethics Consultation?

Commentary by Jeremy R. Simon, MD, PhD

Dr. Rodriguez is an emergency medicine physician at a large, urban hospital. It was a Tuesday evening and the day had been relatively calm. At 6:30 p.m. she admitted an unconscious male who had been airlifted by emergency services from his home in a rural region 200 miles from the city.

Upon assessing the man, she noted that he had markedly shallow and infrequent respirations. She was informed that he was found, unconscious, in the bathroom with an empty bottle of barbiturates on the floor. He had been found with a do-not-resuscitate (DNR) form and a hand-written letter stuffed in one of his pockets, in which he detailed his belief in rational suicide. The form and the letter had been discovered en route to the hospital by the paramedics. Of note, the man's daughter—who had found him and called emergency services—had informed them that they should disregard any DNR order he had "on file" because she was under the impression that he had been depressed. Upon hearing this, Dr. Rodriguez quickly read the letter that had been found with the patient. In this letter, the man listed his psychiatrist's phone number, so Dr. Rodriguez decided to call him to try to get more information.

Upon reaching him, she learned that four years ago the patient had come in to see the psychiatrist at the request of his daughter. The patient suffered from a progressive neurodegenerative disease and had a morbid fear of crippling disability and pain; he had informed his daughter that, should his disease progress to a point at which his quality of life became unacceptable to him, he would consider killing himself. His daughter had found this very disconcerting, leading her to request that he see a psychiatrist before deciding about the DNR. At the time the psychiatrist felt that he was not acutely suicidal but was simply expressing his belief in rational suicide. The psychiatrist felt he had capacity and that depression was not playing a role in his decision about his DNR status.

Normally, Dr. Rodriguez would have intubated the patient immediately; however, this discussion and the DNR order and letter made her pause. The daughter, who was the only other source of information on the patient, had not yet arrived at the hospital. The patient, on the other hand, was rapidly progressing towards respiratory failure and death. Dr. Rodriguez decided to call the director of the adult ethics committee at her institution for an emergency ethics consultation. She explained to him what she knew, recounting her conversation with the psychiatrist and confirming that there were no

family members present with whom to discuss the patient's status and care plan. She also explained that she needed to make a decision quickly because of how rapidly the patient was progressing to respiratory failure. After making sure he understood all the details Dr. Rodriguez had communicated to him, the director of the ethics committee reasoned that, because the DNR order had been signed in the setting of a progressively disabling neurodegenerative disease—in addition to the fact that the patient had been screened for depression before and also had a documented belief in rational suicide—Dr. Rodriguez could refrain from beginning invasive resuscitative measures. After deliberating for as long as she thought she could, Dr. Rodriguez decided this course of action was in the patient's best interest and did not intubate him. Half an hour later the patient died.

An hour later the daughter of the deceased patient arrived at the hospital. Upon learning of her father's death, she became extremely upset. She informed Dr. Rodriguez that her father had advanced multiple sclerosis (MS), which had been causing him increasing pain over the years. Four years ago he had inquired about a DNR form, and, after hearing that he believed suicide to be an option if his disease progressed beyond what he wanted to live with, she had wanted him seen by a psychiatrist for possible depression. The psychiatrist felt he was not depressed and that he had capacity to decide about a DNR order. However, she insisted that her father had not been "the same since he last went to the psychiatrist." Her father's younger brother, with whom he had a close relationship, had died suddenly of a heart attack two months ago. Although her father had not sought help with his grief since his brother's death, she reported that he had been "acting depressed" and that this had caused her to be worried for him. She started checking in on him every evening after work, which is how she found him. She argued that his DNR status was no longer valid because the context in which her father had made that decision had changed significantly due to the recent death of his brother—he now wanted to take his life because of his acute depression rather than because of his progressive neurological condition. Furthermore, she was upset that her explicit instructions to attempt resuscitation despite his DNR status had been ignored.

Dr. Rodriguez explained that it had been a difficult decision. She also explained that she had consulted with the chair of her hospital's ethics committee. Upon learning this, the daughter became even more upset, accusing Dr. Rodriguez of justifying her "inaction" on account of a "short conversation with someone who knew nothing" about her father. She was firmly of the opinion that, because of its urgency, the ethics consultation that had taken place was not a valid ethics consultation at all. "What is the value of an ethics consultation if the family and friends aren't even consulted? I have to live with the consequences of this decision and my input wasn't considered ethically relevant?"

Commentary

As is the case in most of medicine, even emergency medicine, few matters are actual emergencies. Nonetheless, all clinicians must be prepared for those emergencies they might encounter, ethics consultants included.

If we are to discuss emergency ethics consultation, it would be useful to begin with a working definition, or at least a general understanding, of what constitutes an emergency in this context. For our purposes, we can characterize an emergency as a case in which one must act promptly and, because of that time constraint, potentially without the information or tools one would use under ordinary circumstances.

There a few things to notice about this definition. First, not all emergencies will necessarily occur, start to finish, within a short time frame. A case can start out ordinary, with seemingly adequate time for deliberation, but, as the initially reasonable deadline for a decision draws near and one still does not have all of the information (or tools) one would like to have, an ordinary case can turn into an emergency. This is not surprising, as all cases have background; most emergencies, whether avoidable or not, often start as something less obviously concerning. It is only as matters reach a crisis that a case becomes an emergency, and ethics consultations are no different. Second, this definition does not necessarily apply to all clinical uses of the word "emergency." Thus, one could plausibly describe emergency surgery as surgery that must occur before there would otherwise be an opening in the operating room schedule, even if one has all the information, tools, and (momentary) patient stability one would ordinarily want for surgery. Nor is it the same as the meaning of the word implicit in the practice of emergency medicine, where an emergency is whatever a patient thinks is an emergency.

As I said at the beginning, one must be prepared for emergencies. The first step in preparation, at least logically, is being able to recognize an emergency. To make the above definition less abstract, we can say that an ethics consultation is an emergency when we do not yet have all the ethically relevant information we would want, the question concerns a medical decision that must be made promptly or the opportunity to choose among courses of action will be closed off, and, whatever course one chooses, the decision is irreversible.

Each of these conditions eliminates some cases that might be perceived to create an ethics emergency. If all of the data and interested parties are present, then, although we might have to act fast, there is no true emergency, at least not in the sense that the case must be handled in a special way. Second, if the urgency is driven not by an impending change in the patient's clinical situation, but rather by the staff's perception that "it's time to make a decision" and waiting for all the ethically relevant pieces to fall into place will "take too long," there likewise is no ethics emergency—at least assuming the pieces would fall into place in a reasonable length of time, even if staff does not want to wait. A

"reasonable length of time" does not have a fixed value but is relative to the situation at hand. In an emergency department, where events occur on the order of minutes to hours, waiting two days to make a decision is not reasonable. Waiting two hours can be. On the other hand, on an inpatient service, waiting two days, or maybe even two weeks, would be reasonable though waiting two months likely is not. Finally, the third condition suggests that if the irreversible decision can be deferred, there is no ethics emergency, even if an apparently important decision must be made. Thus, if there is a question whether to intubate an elderly patient with impending respiratory failure due to pneumonia and the patient's health care proxy is not available, one would probably intubate the patient. If the proxy determines that the patient should not have been intubated, the patient can then be extubated and allowed to die of respiratory failure. Of course, in this latter case, an ethics consultant may need to respond emergently, because the clinical team needs to act and may not know the right thing to do, but there is no true ethics emergency, as the irreversible decision can be effectively deferred.

The case presented would, it seems, be an emergency. Since Dr. Rodriguez knew the daughter objected to honoring the DNR order but initially did not know why, there is certainly missing information here. Second, as subsequent events make clear, there was little time to intubate the patient if Dr. Rodriguez was to save him; she could not necessarily wait for the daughter to arrive. Finally, a decision to intubate may not be reversible. Unlike pneumonia in an elderly person, whose severe respiratory distress will likely last for a while, even after intubation, respiratory failure as a result of overdose may be transient. After a few hours, the patient may regain the ability to breathe on his own, and reversing the intubation will not return us to the point we were at before we intubated. If our goal was to allow the patient to die, we will have lost our opportunity. Therefore, just as a decision not to intubate would be irreversible, leading to the patient's death, a decision *to* intubate might also be irreversible, leading to the patient's living even if the patient is extubated soon thereafter at the request of the surrogate. If the proper decision from an ethical perspective would have been not to intubate the patient and let him die, then, ethically, his living would be the wrong outcome. (We should note here that the question of honoring advance directives, including DNR and do-not-intubate (DNI) orders, is—in cases of attempted suicide—a difficult issue on which there is not clear consensus. I will not engage this question in this discussion, but instead assume that not intubating this patient is at least possibly appropriate.)

Having identified this case as an emergency, the question is how to proceed with an ethics consultation. In some cases, the approach, at least from a technical perspective, is straightforward. If the problem is that the case's urgency means that some information cannot be obtained or some people (in this case, the patient's daughter) not spoken to before a decision must be made, then one must make a decision with the information one has using the usual principles of medical ethics decision making. No decisions, even nonemergent ones, are made with perfect information, and even many medical ethics

cases with no time pressures need to be decided with information missing. In some cases, as, apparently, the one presented here, proceeding with the information available may mean proceeding without talking to some of those who have an interest, if perhaps not a say, in the outcome. When time is short, there may be no other option.

Sometimes, however, the problem will be a relative, not absolute, lack of information. That is, there is no information that is inaccessible, but there is not time to gather all the information one would want. In this case, one must prioritize and decide which questions to ask and whom to speak to. There is, of course, no rule to guide a consultant about where to turn first and which pieces of the story to defer gathering, with the understanding that deferring could turn into ignoring. Each case will be different. A consultant needs to have the ability to quickly assess a case, identify the key ethical and clinical factors, apply the relevant ethical knowledge, and respond quickly and decisively. To a certain extent, these skills are matters of experience and temperament, but they can also be taught. Just as emergency physicians learn how to approach neurological, cardiac, and surgical emergencies, ethics consultants can learn to quickly identify key features of various types of cases. But just as the parts of the physical exam that can be skipped in a neurological emergency differ from those that can be skipped in a patient with an abdominal surgical catastrophe, different ethics questions demand that different key parts of the medical and social history take priority. There is no fixed template.

Regardless of the nature of the missing information, when doing an emergency consultation, one must be prepared for potential further developments. In this case, the ethics consultant should have anticipated the arrival and possible responses of family members and others who were not present to contribute to the discussion when the decision was made. Even when family members do not have decision-making authority for a patient, they have an important role in ethics consultations. First, they may have important information, as did the daughter here regarding her father's possible recent depression. Equally important, decisions made in ethics consultations, especially regarding removal or withholding of life-sustaining treatment, can have a profound impact on the family. Even if the decision made is not the one a family member would have wanted, participation in the process, being present for the appropriate discussions, can be valuable, allowing the family members to feel heard and to understand and come to terms with the decision.

In emergency cases, however, family members might not have the opportunity to participate as they might want to, and this can lead to conflicts, as this case demonstrates. Anticipating this problem will assist an ethics consultant and/or treating clinician in helping the family members understand and accept the outcome, even if the family objected to it. In this case, Dr. Rodriguez knew the patient's daughter wanted him intubated (based on her request to ignore the DNR order). Dr. Rodriguez could have been prepared to make clear that her goal was to act in the patient's best interests, and that a

decision had to be made promptly, with the information at hand. She could also make clear that of course the daughter's input would have been valuable, but that, given the circumstances of the case, it was not possible to wait for her while still acting in what seemed to be the patient's best interests. This is not to say that such approaches will always completely resolve all these conflicts. However, given that the treating physician and consultant may be faced with quick, strong, reactions from the late-arriving family, anticipation will allow them to deal with this in the most constructive and compassionate manner possible.

Another type of further development one should be prepared for is further information that indicates one may have made the "wrong" decision—wrong not in the sense that one should *in fact* have decided otherwise, but in the sense that, had this information been available at the time the decision was made, one would have decided otherwise. In this case, the fact that the patient may have recently been depressed calls into question the determination that this was an act of rational suicide, even though the patient believes in rational suicide in general. Had the clinicians and consultants known of this depression, the consultant might have advised Dr. Rodriguez to intubate the patient. However, decisions can only be made based on the information available at the time of the decision; later revelations do not make an earlier decision wrong, and one should not feel one has made a mistake. Only if the information available at the time was not gathered and acted on appropriately can a decision truly be considered wrong.

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ISSN 2376-6980