

# Chapter 8

## Cancer Care Ethics in the Emergency Center

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### Chapter Overview

The emergency center (EC) is a technical, specialized, fast-paced environment where time is of the essence. Falling into a process by which the need for immediate response overshadows the need for ethical examination of important aspects of

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patient care is easy. Our purpose is to provide clinicians with some ethical considerations that can be made and reduce challenges to caring for the cancer patient in the EC. Cancer patients are often seen in ECs because of issues at the end of life, uncontrolled physical pain, and psychosocial or coping issues. This chapter deals with some of these and other common issues, including delirium, quickly changing conditions, and possible drug-seeking behaviors for coping. Also considered are clinician responses to these as well as issues to recognize when assisting patients and their surrogates with decision-making during these difficult times. Case examples, discussion of the ethical challenges, and suggestions for the clinician and health care team are used to highlight and examine some of the ethical dilemmas faced in the EC.

## Introduction

Cancer patients in ECs may pose special challenges because of the nature of their disease processes, pain control, and their increased incidence of end-of-life issues. Emergency physicians practice in an institutional setting, usually the EC of a hospital, and must work closely with prehospital providers, hospital consultants, and outside physicians. Decisions regarding treatment and disposition are often influenced by institutional policies and practices. The ethical values steeped in clinical decision-making represent an inescapable element of patient care in the emergency center. These values include autonomy, informed consent, and decision-making capacity, which are concepts that are foundational to Western bioethics.

Respect for an individual's political and legal right to self-governance (autonomy) is dependent on the individual's ability to make decisions based on the information disclosed and weighed against his or her values and preferences (decision-making capacity) and, thus, ability to give permission for the proposed action (informed consent). Patient autonomy refers to the right of the patient to participate in the decision-making process and direct the course of his or her medical treatment within the bounds of medically and ethically appropriate options. If a patient does not have decision-making capacity, the physician should seek the permission of the appropriate surrogate decision-maker for treatment and inform him or her before treatment in the same manner that would be used with the patient if the situation allowed it.

We present below several case examples to illustrate common ethical challenges with cancer patients in ECs and the ethical principles used to deal with them. Highlighted at the conclusion of this chapter are practice points to assist clinicians when faced with cases involving questions of autonomy (patient and provider), informed consent for medical treatment, decision-making capacity, surrogate decision-making, advanced care planning and advance directive documents, personal and professional culture and values, withholding and withdrawing treatment (including life-sustaining measures), beneficence and nonmaleficence, justice, and professional integrity.

## **Informed Consent and Treatment Refusal**

### ***Case***

A 62-year-old woman with breast cancer who has been receiving adjuvant chemotherapy and has resultant myelosuppression presents to the EC after an episode of melena. She feels weak and dizzy, but she is hemodynamically stable. She is thrombocytopenic, with a platelet count of 12,000/ $\mu\text{L}$ , and anemic, with a hemoglobin level of 6.1 gm/dL. The patient appears to be confused when giving information about her chemotherapy, specifically, the dates and number of cycles she has received. The emergency physician advises her that she may need transfusion support, but she declines, stating that her personal beliefs do not allow her to accept blood products.

### ***Ethical Challenges and Principals***

As a clinician, you are faced with the choice of whether to accept the patient's refusal. An important point to keep in mind is that informed consent is a process. Consent must be given or refused with full knowledge of the benefits, risks, and burdens of what is being offered and the alternatives to the proposed therapy. Sufficient information must be provided to the patient or his or her legal representative, usually a medical power of attorney or guardian.

Ethicists would likely ask you several questions. Have you presented the patient with enough information? Have you presented any treatment alternatives, if any exist? Have you determined whether her confusion is sufficient to warrant an assessment of her decision-making capacity? Have her beliefs been verified, such as with a previous statement or declaration of faith tradition known for that belief? All of these factors are related to the patient's ability to make autonomous decisions.

In a situation like this, the patient does not accept an aspect of the practice of medicine. This may be in direct opposition to what is available and the standard of care in the medical community.

Culture can play a large role in how patients make medical decisions. Because culture is a combination of attitude, behavior, words, beliefs, perceptions, and values, we must take the time to understand them for our patients when dealing with their decision-making. Thinking that all people who state a belief about transfusion of blood or blood products believe the same thing or are in the same faith community can be dangerous. Obtaining information from this patient about her belief is important. She may be a Jehovah's Witness, or her belief may be based on familial experience in which someone received blood and his or her situation did not turn out well.

To understand a patient's values in making a decision, the clinician must be culturally competent, have the desire to inquire and learn, and adapt his or her presentation. This will provide the necessary information about the patient based on the new knowledge that is acquired.

Patients can refuse offered treatments and interventions even in emergencies. Often, the challenge for the emergency physician is knowing how to deal with a refusal. This is especially true when a patient expresses a cultural or faith system that diverges from the clinician's. When the clinician attempts to give information to a patient with some understanding of his or her values, accepting the patient's refusal and remaining compassionate while addressing any symptoms that can be managed under the limitations placed by the patient may be necessary.

## **Cancer Patient with Acute Pain**

### *Case*

A 34-year-old patient presents to the emergency room complaining of severe hip pain. A review of her history indicates she was diagnosed with a femoral neck chondrosarcoma 2 years ago. At that time, she underwent a resection of the femoral head and neck and had a left hip hemiarthroplasty followed by conversion to a total hip arthroplasty. She has been experiencing chronic pain since her diagnosis. She rates her current pain as a 9 on a verbal pain scale (0–10).

The patient's hip pain has been assessed by her primary physician, and she has been taking a regimen of transdermal fentanyl (25 µg) supplemented with morphine (immediate release; 15 mg 3 times a day) to attain a satisfactory level of pain control. During her last visit 2 weeks ago, the patient's drug screen was positive for opiates and cocaine. She was informed that her prescriptions would not be renewed owing to the presence of oxycodone in her screen. The staff informed her that providing scheduled analgesics for any patient who tested positive for a suspected drug of abuse was against their local policy. She was instructed to return in a week and that she could be given pain medication if she demonstrated discontinued use of cocaine.

The patient states that earlier in the day, she went to see her pain management team and was informed they would not dispense pain medication because she had another positive urinary drug screen, this time for amphetamines. According to the nurse practitioner present at the visit, the patient became extremely upset and agitated and verbalized having thoughts about shooting herself. The patient left the office and went to the EC several hours later. The patient claims that she currently does not have any suicidal thoughts and has no intent to harm herself. She also denies ever having tried to harm herself. She does admit to having difficulty controlling her mood and having "racing" thoughts that make sleep difficult. Moreover, the patient has been hospitalized for insomnia. She admitted that she occasionally uses marijuana to ease both her pain and her insomnia. She has a psychiatric diagnosis of bipolar disorder, ongoing medical management of which includes quetiapine hemifumarate (Seroquel), paroxetine hydrochloride hemihydrate (Paxil), valproic acid sodium salt (Depakote), clonazepam (Klonopin), and hydroxyzine dihydrochloride (Atarax). The patient denies abusing any other drugs or alcohol.

## ***Ethical Challenges and Principles***

Pain is a common reason for seeking medical attention at an EC. Emergency providers have an ethical duty to alleviate pain, particularly because they “have been given a unique social role and responsibility to act as health care providers of last resort for many patients who have no other feasible access to care.” Despite the pressures of working in a stressful environment, emergency physicians must “prevent or minimize pain and suffering, loss of function, and loss of life.” In general, pain management is well known to often be inadequate. Cancer pain in particular is highly prevalent and a great source of suffering and despair. Patients with cancer may present to the EC looking for relief from acute pain. Complicated medical histories are not uncommon among cancer patients, and understanding their pain sequelae in the context of their disease is particularly important.

Health care providers often express concern regarding the chronic use and potential for abuse of opioid analgesics. Their concerns are exacerbated with evidence of forum shopping by a patient for pain medications, a history of drug abuse, and positive screens for controlled substances used for self-medication. An ethical approach in caring for a cancer patient includes the imperative to address pain. Treating pain in this context includes understanding both the physiologic causes and its psychosocial and contextual features.

This patient’s history makes evident that she has been diagnosed with and given treatment of chondrosarcoma. The primary question is how should the attending physician treat this patient’s pain, particularly if he or she is concerned about psychiatric issues and the potential for analgesic abuse? A conflict arises between the duty of care to decrease the patient’s pain and the obligation not to be an instrument of addictive and destructive behaviors. Beyond being complicit in such behaviors, a physician may worry about squandering precious resources on nonadhering patients and the larger societal costs attributed to drug addiction. This case presents several ethical dilemmas, including determination of when the risk of drug abuse outweighs the benefit of pain relief and whether this risk ever outweighs the benefit when pain is cancer-related. The ethical principles to be considered in such cases are beneficence, nonmaleficence, risks versus benefits, resource allocation and justice, and professional integrity.

The primary concern should be the patient’s complaint of pain. Discerning the etiology of the pain is important, particularly if it is related to cancer progression, treatment, and/or symptom burden. The mere suspicion of opioid misuse should not serve as a justification for discrediting or marginalizing the patient’s experience of pain. In the present case, the patient had a positive screen for a pain medication that was not prescribed for her. The strict adherence of the clinical team to its hospital’s policy regarding prescription of analgesics to patients with positive drug screens immediately frustrated the patient. The policy is sound in that it attempts to mitigate the acquisition of drugs by individuals who may abuse them. However, the clinical team’s “take it or leave it” approach apparently did not serve the patient’s best interests. Deeper questions must be asked to better understand the apparently dire need

**Table 8.1** Selected core principles of safe, effective pain management

1. The patient's <i>self-report of pain</i> is a <i>critical</i> component of a comprehensive pain assessment.
2. Optimal pain treatment may be enhanced by <i>acknowledging cultural differences</i> in the expression of pain.
3. A <i>comprehensive assessment</i> , including the patient's self-report of pain, will enable the clinician to better evaluate the patient's experience.
4. Analgesic-based management of pain should <i>begin as soon as possible</i> when indicated. Diagnosis of the pain etiology should not delay administration of analgesics.
5. Providers must <i>consider the special needs of patients with addictive disease</i> to ensure adequate, safe delivery of analgesia.
6. Individuals who appear to present with behaviors suggestive of addictive disease should be given brief interventions and referrals for substance abuse treatment. Chronic repeat visits to non-continuity-of-care providers can be addressed via social service interventions, care plans in conjunction with primary care physicians, and <i>analgesic contracts for emergency pain relief</i> .
7. At the end of a health care visit, the patient should receive instructions with an <i>individualized pain treatment plan</i> , including important medication-specific safety considerations.

of the patient for pain medication. Is this really drug-seeking behavior? Does the patient have an underlying psychological issue at the root of her behavior? Is the patient's cancer-related pain not being managed well? A claim that her pain is not being managed would not be audacious, as a substantial body of literature has documented inadequate pain control, even in emergency settings.

The physician should also look for other information in understanding the patient's life, such as the home living environment, support system, and life concerns other than cancer. This will inform other needs that may be addressed by the interdisciplinary team in hopes of positively impacting the patient's care. The physician should assess the patient's perspective on his or her quality of life and therapeutic expectations and gauge how well those expectations are realistically grounded. Discerning what the patient really wants is important. Is it solely pain management, or is it the underlying concerns related to the cancer, medical issues, or other personal matters in developing a comprehensive approach to the patient's care? Table 8.1 lists a selection of principles that may be used to guide pain management.

Although this patient denied having suicidal ideation, the report of the nurse practitioner should be taken seriously. An entirely reasonable possibility is that the patient was merely venting frustration about the hospital's policy and her desire for relief. On the other hand, her comments should not be overlooked, as a psychiatric consult or follow-up visit to the patient's mental health provider may be necessary. The patient's history also may provide insight into treatment adherence. What are the patient's obligations? Patients and caregivers obviously have important roles to play in adhering to treatment plans. Patients also have ethical obligations during the course of their treatment, including consideration of the medical team's advice, compliance, and adherence to a medical contract, if necessary. This contract is commonly employed in situations with concerns about opioid-based therapy and used to formalize an agreement between the physician and the patient. In the present case, should the physician have a concern that the patient may abuse an appropriately prescribed analgesic, an agreement may be used to dispense just enough medication

**Table 8.2** Pain management in cancer patients suspected of substance abuse

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|--|
| 1. Define the mechanism of the pain and treat the primary problem (i.e., infection, tissue ischemia). <sup>a</sup> |
| 2. Distinguish the temporal characteristics of the abuse behavior. <sup>b</sup>                                    |
| 3. Follow relevant pharmacologic principles of opioid use. <sup>c</sup>  |
| 4. Nonopioid therapies should be given concomitantly with or even in place of opioids.                             |
| 5. Specific drug abuse behaviors should be recognized and dealt with firmly.                                       |
| 6. Caregivers should set limits to avoid excessive negotiation about drug selections or choices.                   |

<sup>a</sup>Attention to the primary causes of pain symptoms may greatly reduce the requirement for and negotiations about opioid analgesics

<sup>b</sup>The implications are different for a patient with a recent history of active drug abuse who may need higher than usual starting doses of opioids and one who may not be able to set limits on drug use

<sup>c</sup>Treatment with an opioid agonist-antagonist should not be started for a patient who is tolerant to opioid agonists such as methadone. Mixed agonist-antagonists may precipitate withdrawal if given in this setting

to treat the patient's immediate needs until she can follow up with her regular provider. Table 8.2 provides an approach to managing pain in cancer patients for whom substance abuse is suspected.

## Case Continued: The Patient Returns

### Case

Assume the 34-year-old cancer patient described above is prescribed fentanyl and morphine for 2 weeks with instructions to follow up with her primary physician. The patient presents to the EC again 4 days later having used the entire 2-week supply of her pain medications and requesting a refill. What should the emergency physician do? Also, what should be done if imaging of the patient reveals a suspicious lesion, and she is to undergo biopsy in 3 days followed by either surgical replacement of the femur or revision arthroplasty? Would this finding alter the course of action?

### *Ethical Challenges and Principles*

When the patient returns to the EC, physicians find evidence that she has used her medication much more quickly than indicated. Furthermore, she now has even more evidence of substance abuse. Patients may engage in this revolving door of emergency care needs and drug-seeking behavior, which poses challenges to the medical team described above. A common issue is whether the patient can be discharged from care owing to noncompliance. A physician has a professional, not to mention legal, duty to

keep from being complicit in illegal activities. At the same time, the patient may be in legitimate distress, pain, and suffering. Because emergency physicians want to engage in informed decision-making, they must consider the importance of the patient's ability to understand his or her treatment options. This requires the physician to carefully explain not only the decisions being made but also the rationale for those decisions. For example, if a physician decides not to prescribe opioids, providing a sound rationale for not doing so as well as alternatives to treatment of pain will make that decision appear to be beneficial rather than punitive to the patient.

Does the approach change with the added information that the patient has a new lesion? This may make the physician sympathetic to the possibility that the return of her cancer is a legitimate cause of pain. Thus, the physician may be inclined to work with the patient. At the heart of the matter, a physician should take a compassionate approach to pain management that includes strategies for providing the best method of alleviating a patient's cancer pain.

## **Pain, Delirium, and Surrogate Decision-Making**

### ***Case***

A 51-year-old man has been brought to the EC by paramedics. They were called by his 25-year-old daughter, who was visiting from out of town. The patient previously left the hospital after several months of treatment of pancreatic cancer failed to stop or even slow the progression of the disease. When he was told that his disease had metastasized to the liver and doctors gave him no further aggressive treatment options, the patient chose to enter the care of a home hospice service. That was 27 days ago.

The paramedics were called because the patient was waving his hands and speaking of seeing angels and people from his past who had died. He seemed confused about night and day. He also could not remember his children, confusing them with his own brother and sister. He said he had no pain, but he moaned often.

The patient's wife and 19-year-old son are his primary caregivers, but they were away for the afternoon. His daughter and her husband and child, who live about 200 miles away, were caring for him at the time. The patient's mother also came to the EC. It was she who called the paramedics and was telling the staff, "My son will not die today and will not die in pain!"

### ***Ethical Challenges and Principles***

Delirium is the most common neuropsychiatric syndrome in patients with advanced cancer, particularly elderly patients. It is associated with a high degree of distress in patients, families, and nurses. Delirium is reported at rates ranging from 8 % to 17 % in elderly patients seen in general ECs. Missing a diagnosis of delirium may

cause treatment errors, as delirious patients are often given medications to control pain that is not actually present.

The ethical concerns in this case may center on following the patient's autonomous decisions or accepting a demand to override them by following the wishes of a surrogate decision-maker. The patient's decision was to recognize and accept that his life is nearing the end and undergo hospice care. He is now presenting with possible pain or delirium, which hospice clinicians have the ability to treat.

The primary concern is treatment of the patient's symptoms. This means assessment of him for pain and delirium and then treating what is found. This is based on "doing good" and "avoiding harm" for the patient. Some of his family members have a different opinion. In this situation, documentation from an advance directive by the patient as to whom he would like to make decisions for him when he is unable to do so is missing. He has a wife who is not available in person or by telephone at this time. He also has a daughter who is present and a mother who is both present and demanding treatment of his pain and admission of him to the hospital. The physician must determine whether to follow the decisions of the available surrogate decision-makers, wait for his wife to be available, or adhere to the patient's previous decision to use hospice services.

A surrogate decision-maker can be the best option when a patient cannot directly give his or her decision about emergency care. The hope is that the surrogate will know the patient and which decision the patient would make. An advance directive, in which the patient assigns an individual as a surrogate and gives guidance regarding such decisions, is usually very welcome in such circumstances. Written advance directives are not always available, however. When in doubt about the identity of the appropriate surrogate, check with the hospital's risk manager.

In the present case, the patient made one choice, and at least one of his possible surrogate decision-makers is demanding something different. Thus, the ethical dilemma is related to autonomy and surrogate decision-making. The demand by the patient's mother for pain medication and inpatient admission is a barrier to, or at least a distraction in, the patient's treatment. Individuals may make any such demands or requests based on a lack of information or on personal fear. This case demonstrates that informed consent is essential for appropriate treatment under such scenarios. This can only happen with proper assessment of symptoms and the disease process so that the important information shared is accurate and timely. No matter who the surrogate decision-maker may be in a given situation, following a good informed consent process is essential.

## **Resuscitation**

### *Case*

A 25-year-old Jewish woman who is married and the mother of a 2-year-old has a history of depression that is being treated but is otherwise healthy. In December, she began experiencing left knee pain. In February, she had an open biopsy of a mass on

the knee that had developed since December. She was diagnosed with a high-grade osteosarcoma of the proximal left tibia at an outside hospital. She presented to the cancer center the following month and was evaluated by orthopedic and sarcoma medical oncology specialists. With knowledge of an expected cure rate of 70 %, she began undergoing chemotherapy soon after. After several rounds, her therapy was adjusted owing to neutropenia, thrombocytopenia, and severe mucositis. Two months into treatment, she was evaluated using computed tomography angiography, which yielded a small right common ileac vessel aneurysm versus thrombosis. She began receiving anticoagulation therapy with enoxaparin sodium (Lovenox). One week later, the patient was transported to the EC on active cardiopulmonary resuscitation (CPR), which was started 1 h before arrival at the EC. The patient arrived intubated and had received atropine, epinephrine, and several shocks.

Information about the patient was obtained from a friend who witnessed her collapsing after flushing her central venous catheter line with heparin. Her friend did not notice any concerning symptoms like fever, vomiting, diarrhea, shortness of breath, or bleeding before the collapse. Initially, CPR yielded no palpable pulse or blood pressure, unresponsive dilated pupils, ventilation of both lung fields, and no heart rate. Cardiac monitoring revealed electrical activity alternating with asystole, resulting in pulseless electrical activity. CPR was continued in the EC for 1 h and 40 min. The primary team was informed about the patient's condition. Colleagues in the intensive care unit and the chair of the CPR committee were consulted. Also, the cardiology service was consulted to evaluate the patient for cardiac tamponade. After a total of 2 h and 40 min, the patient had spontaneous agonal breathing, monitoring demonstrated a sinus rhythm of 98 beats per minute, her pulse was palpable, and her blood pressure was not obtainable. The code team was present and transported the patient to the intensive care unit.

The patient's husband was at their home in another state and kept informed of her condition via telephone. His constant request was to evaluate his wife's brain activity and remove life support if she was brain-dead. The EC physician contacted the neurology service to evaluate the patient for brain activity or death. In addition, the patient's father contacted the EC by telephone. However, the physician could not communicate with him, as the patient's father was not willing to listen while making his demands. His constant request was to continue all life-saving measures or he would sue the hospital.

### ***Ethical Challenges and Principles***

We will use this case to summarize many of the important aspects of ethical decision-making in the EC described earlier in this chapter. According to the doctrine of informed consent, physicians must first inform the patient with decision-making capacity about the nature of his or her medical condition and treatment alternatives and their expected consequences and then obtain the patient's voluntary consent to the treatment. As in many cases in the EC, the present patient was not in

a position to exercise autonomy and provide informed consent or refusal for the emergency treatment necessary to save her life. The goal of emergency medicine is to act quickly when caring for individuals with acute illnesses or injuries to prevent or minimize pain and suffering, loss of function, and loss of life. Often, initiation of treatment cannot be delayed to obtain informed consent from the patient or even the surrogate decision-maker. For patients with questionable or no decision-making capacity, and in the setting of immediate need for treatment, emergency physicians intervene to prevent death using the emergency exception rule, also referred to as presumed consent. This is invoked when clear instructions from surrogates, personal physicians, or written directives are not available. According to the principle of presumed consent, physicians act in life-threatening situations under the assumption that life should be preserved in the absence of clear wishes to the contrary by patients or proxies. Treatment that is provided based on presumed consent is founded on the principle of beneficence.

Most states provide instruction on who has the authority to make medical decisions in an incapacitated patient's stead. This dictated hierarchy of decision-makers usually starts with court-appointed guardians and individuals named as powers of attorney for making health care decisions then proceeds to various categories of adult next of kin. In the present case, the state of Texas dictates, as do most other jurisdictions, that if this patient has not named another individual in an advance directive document, her husband is the legally authorized decision-maker. Next would be any grown children followed by the patient's parents. In the case of a minor patient who is not married and therefore emancipated, the primary individuals with decision-making authority on behalf of the patient would be his or her parents or guardians. In the case presented herein, both the patient's husband and father were providing instructions regarding her treatment. We can assume that both were instructing the health care team to act in a manner that would benefit the patient and be consistent with her wishes based on her values, in other words, follow the principle of beneficence—to do good for or act for the benefit of another—a principle inherent in the medical profession and at the core of emergency medicine. The medical team was probably feeling unnecessary pressure to act in a manner that could cause harm, however. Even if the husband and father believed they were acting in the patient's best interests, their instructions may have been perceived as conflicting. When more than one interested party is involved in surrogate decision-making, consensus is ideal but may not be possible. In the present situation, the treating physician may not have been able to lead toward a consensus, especially over the telephone, but other members of the health care team may have been able to assist in discussions that would clarify the patient's current condition, elucidate the husband's and father's understanding of the situation and reasons for their instructions, and clarify misunderstandings. Good communication under such a scenario is always important, even when time is short.

Life-threatening situations afford little to no time for consultation with other physicians or surrogate decision-makers or seeking advance directives for health care that may provide more information regarding this patient's underlying condition and prognosis or her values and wishes regarding medical treatment. This scenario does

not tell us whether the patient completed and provided to the hospital advance directive documents that may have given guidance to the emergency care providers. The conversations with the patient's husband and father may have indicated her values and, more clearly, their own values. Furthermore, ascertaining how the patient's faith might have affected her wishes or the instructions from her family members may have been difficult because of the need for immediate action. As time passed or after she was transferred to the intensive care unit, the emergency team or intensive care team may have had an opportunity to explore this issue. Similar to the first case described in this chapter, a patient's faith and/or cultural tradition may have a significant effect on medical decisions. Medical ethics is built upon the intersection of historical understanding and practices of philosophy, theology, and science. Teachings based on evolving interpretations and advancing knowledge and technologies in these disciplines can lead to a spectrum of practice. When time allows, exploration of these factors may aid shared decision-making or elucidate the reasons behind peculiar or conflicting decisions. Culture and faith likewise can shape the values of emergency care providers, thereby affecting health care providers' decision-making processes and actions.

Faith and cultural traditions can influence specific medical interventions, such as initiating, withholding, or withdrawing life-sustaining measures. Decisions to withhold or withdraw life-sustaining treatments are often difficult to make in an emergency setting. This results from a lack of an ongoing long-term relationship with the patient and his or her family and of time to weigh the decision to limit life support based on medical circumstances. However, these decisions undeniably are an integrated part of medical activity. Physicians, including emergency physicians, are under no ethical obligation to provide or maintain treatments they judge to be of no benefit to patients, but making that judgment can be difficult in the first few moments of a life-threatening emergency. Once the patient has been stabilized, assessment of his or her medical condition, underlying disease, and cause of acute deterioration may lead to the determination that withdrawal of treatment is an appropriate option. In Western bioethics, withholding and withdrawing nonbeneficial treatments hold equal weight in the abstract because either of them, when appropriately applied, allows death to occur naturally owing to the underlying condition. In practice, however, they can feel very different. Some physicians may feel that withholding an intervention is more appropriate than withdrawing one in progress because withdrawal could be interpreted as participating in or hastening the patient's death. Others believe that a stronger argument exists for initiating treatment in an emergency situation and withdrawing it if appropriate when more information is available and can be weighed carefully.

Ethical dilemmas are borne out of conflicts of values and principles, the resolution of which reasonable people may disagree about. This may manifest in competing patient and physician autonomy; competing principles of autonomy versus beneficence, which ideally must be balanced; differing goals of care; or conflicting definitions of beneficence. Often, assessment of beneficial treatment yields different outcomes according to the medical team and patient or surrogate. This may result from different estimations of acceptable quality of life or definitions of benefit and

burden or harm. Quality of life and burden of treatment are socially defined concepts that are determined by the patient. The patient's preferences for or against treatment based on these indicators should be respected within the bounds of medically and ethically appropriate options. The emergency physician respects the principle of nonmaleficence by always seeking to maximize the benefits of treatment and minimize the risk of harm.

## Key Practice Points

- Informed consent is a process.
- Treatment decisions can be effected by both the patient's and physician's culture, faith, and values.
- Pain is to be understood in the context of the patient's disease.
- Suspicion of opioid misuse by itself does not serve as a justification for not treating pain.
- Probe for information to help understand the patient's life.
- Agreements may be used to dispense just enough medication to treat the immediate needs of patients until they can follow up with their regular providers.
- Carefully explain the decisions being made as well as the rationale behind them.
- Be willing to change the approach if information changes.
- When giving treatment to patients at the end of their lives, always assess them for pain and delirium, as they are often confused.
- Determine the appropriate decision-maker at the beginning of the patient encounter.

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## Suggested Readings

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