Ethics of Emergency Department Cancer Care

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Introduction

Bioethical issues often arise when treating emergency department (ED) and prehospital care patients. Actual or anticipated bioethical dilemmas commonly occur among patients with hematological and oncologic diseases, and these dilemmas may require slightly different approaches than in other ED patients due to people's attitudes toward and the nature of the disease processes. Bioethical dilemmas raised by emergency hematological-oncologic patients fall into four categories (Table 1): decision-making, treatment demands and refusals, system problems, and notifications.

Bioethics can be a nebulous concept, so the first order of business will be to lay the groundwork by describing bioethics and discussing how it fits into our societal and professional value systems. Then, I will briefly review basic ethical (foundational) theories and the methods used to think through ethical dilemmas, followed by a discussion of the mid-level ethical principles with which clinicians may be more familiar. While they may appear superficial or oversimplified, these mid-level principles provide an easy way to think about the issues posed in bioethical dilemmas and policy development. Therefore, when treating emergency patients with hematological and oncologic illnesses, we use them to convey common moral themes, such as decision-making, demands for and refusals of treatment, and system constraints. Finally, I will move into the area of virtues to discuss notifications to patients and survivors.

Table 1 Categories of bioethical issues encountered when working with patients with hematological-oncologic diseases and their families

Decision-making (*autonomy*)
1. Dying. Surrogates and advance directives (PHAD, also)
2. Decision-making capacity
Treatment demands/refusals (Beneficence; Nonmaleficence)
1. Demands to "do everything"
2. Palliative care decisions (demand to do "nothing"—care only)
3. Refusal of analgesia
4. Refusal of possibly beneficial treatment (including decisions based on religious beliefs)
System dilemmas (*distributive justice, confidentiality*)
1. System problems (inability to pay, intentional/unintentional release of patient information, undocumented alien, "wrong" insurance or medical system/group)
2. Collegial problems (refusal to see patient, abandonment, etc.)
3. Research protocols
Notification (*honesty with sensitivity*)
1. Notifying patient/family of diagnosis
2. Died. Notifying survivors

How Bioethics Fits into Our Societal and Professional Value Systems

Bioethics, or clinical ethics, describes how we apply professional and societal values in an organized way to find reasoned and defensible solutions for moral dilemmas. Moral dilemmas are those situations in which an individual must make a decision between conflicting or competing values. The resolutions to such dilemmas, however, do not always hinge on determining right versus wrong or good versus evil. Rather, moral dilemmas more often deal with "gray areas," where the situations or resolutions initially seem to be equivalent, i.e., situations with seemingly equal merit or apparently equal injury. In these more ambiguous situations, we use ethical values to help determine a morally acceptable course of action.

In a pluralistic society, we derive these values from a variety of sources, including the general cultural, philosophical, and religious moral traditions, the social norms embodied in law, and our professional oaths and ethical codes. Each of these sources claims moral superiority. The goal of bioethics is to help us understand, interpret, and weigh these competing moral values [1].

Values in Emergency Medicine

Values describe the standards that individuals, institutions, professions, and societies use to judge human behavior. We learn values, usually at an early age, through indoctrination into the birth culture, from observing behavior and through secular (including professional) and religious education. They are moral rules derived from ethical principles that promote those things we think of as good and minimize or avoid those things we think of as bad. Societal institutions incorporate and promulgate values, often attempting to retain old values even in a changing society.

In pluralistic societies, clinicians must be sensitive to alternative beliefs and traditions, since they treat people with multiple and differing value systems. Not only religious but also family, cultural, and other values contribute to patients' decisions about their medical care; without asking the patient, there is no way to know what decision they will make [2].

Although many people cannot answer the question "What are your values?", physicians can get concrete expressions of patients' uncoerced values by asking what they see as their goal of medical therapy and why they want specific interventions. In patients who are too young or who are deemed incompetent to express their values, physicians may need either to make general assumptions about what a normal person would want done or to rely on surrogate decision-makers [2].

Institutions, including healthcare facilities and professional organizations, have their own value systems. Healthcare facilities often have specific value-related missions. Religiously oriented or affiliated institutions may be the most obvious of these, but charitable, for-profit, and academic institutions also have specific role-related values. Professional organizations' values often appear in their ethical codes [3].

Clinicians also have their own ethical values, based on religious, philosophical, or professional convictions. While conscience clauses permit clinicians to "opt out" when they feel that they have a moral conflict with professionally, institutionally, or legally required actions, they are generally required to provide timely and adequate medical care for the patient—which may be particularly difficult to achieve in emergency medicine [3].

Virtues in Emergency Medicine

Virtues describe admirable personal behavior that Aristotle and other philosophers claim is derived from natural internal tendencies [4]. The virtuous person concept can be summed up with the ancient saying: "In a place where there are no men, strive to be a man" [5]. Virtuous behavior stems from a sense of duty and the perception that it is the right thing to do, rather than from a desire to garner personal benefits. These ideal, morally praiseworthy character traits (e.g., showing kindness) are evident across many situations throughout the person's lifetime. Virtues that may be inherent in emergency medicine clinicians include courage, safety, impartiality, personal integrity, trustworthiness, and fidelity [1].

Courage allows one to fulfill an obligation despite reasonable personal risk. The courageous clinician also advocates for patients against incompetent practitioners and those who attempt to deny them care, autonomy, or confidentiality. *Safety* balances unreasoned courage. *Impartiality* prompts the emergency physician to provide unbiased, unprejudiced, and equitable treatment to all patients, without regard to their race, creeds, customs, habits, or lifestyle preferences. *Personal integrity* incorporates *trustworthiness*, which prompts clinicians to protect their sick and, often, vulnerable emergency patients' interests by exercising ethical principles. *Truth telling* (fidelity, honesty) prompts clinicians to provide patients with the known facts, but tempered with humility and sensitivity.

Bioethics, Religion, and Law

Religion. Organized religions have long been recognized as the guardians of a society's values. Religious values have therefore been an important component of ethical deliberations in medicine, as elsewhere in society. Modern secular bioethics incorporates many religion-originated decision-making methods, arguments, and ideals [6]. Although various religions may appear to be dissimilar, most have as a basic tenet (no matter how it is stated) the Golden Rule: "Do unto others as you would have them do unto you." Religious values are important from two perspectives: the patient's in the exercise of autonomy and the practitioner's in placing limitations on what he or she can morally do. Given the overwhelming importance of patient autonomy in modern Western bioethics and law, however, a practitioner's religious convictions can only guide his or her actions. If their values differ, clinicians must follow the patient's wishes, as long as they are legal and practicable, and they do not violate medicine's basic ethical precepts.

Law. Laws are rules of conduct established by legislatures, administrative agencies, courts, or other governing bodies. They often vary from locale to locale and are enforceable only in the jurisdiction where they prevail. Law and bioethics both provide rules of conduct to follow based on societal values. But, while good ethics often makes good law, good law does not necessarily make good ethics [6].

So, how does bioethics differ from law? The law, unlike bioethics, is relatively rigid and, particularly in the case of scientific and medical issues, can lag years or even decades behind modern developments. Societal values are incorporated both within the law and within ethical principles and decisions. By contrast, ethics is more inclusive within a culture, incorporating the broad values and beliefs of correct conduct. The primary differences between law and bioethics are shown in Table 2 [3].

Emergency physicians often look to the law for answers to thorny dilemmas. Yet, except for the rare cases of

Table 2 Relationship between the law and bioethics

Bioethics	Function	Law
✓	Case based (casuistic)	✓
✓	Has existed since ancient times	✓
✓	Mutates over time	✓
✓	Strives for internal consistency	✓
✓	Incorporates societal values	✓
✓	Healthcare policy source	✓
–	Some unchangeable directives	✓
–	Formal process rules	✓
–	Adversarial	✓
✓	Relies heavily on individual values	✓
✓	Interpretable by medical personnel	–
✓	Ability to respond relatively rapidly to changing environment	–

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Table 3 Comparing ethics codes of EM organizations

	AAEM/AMA	SAEM	AOA/AOCEP	ACEP
Protect patient confidentiality	×	–	×	×
Professional excellence through CME	×	×	×	×
Be a good citizen	×	×	–	–
Change laws to be in patients' best interests	×	–	×	×
Obtain consultation when necessary	×	–	×	–
Choose whom to serve except in emergencies	×	–	×	–
Avoid discriminatory practices	×	×	×	×
Promote highest quality of healthcare	×	×	–	×
Protect patient welfare	×	×	–	×
Honesty	×	×	–	×
Respect the law	×	–	×	×
Respect patient autonomy	×	–	×	×
Report clinical research honestly	×	×	×	–
Prevent patient exploitation	–	×	–	×
Encourage public health thru education	×	×	–	–
Protect patient dignity	×	×	–	–
Full disclosure to patients	×	–	×	×
Expose incompetent/dishonest physician	×	–	–	×
Patient free choice of physician	×	–	×	–
Do not abandon patients	×	–	×	–
Perform duties objectively/accurately	×	–	–	–
Promote harmony with other health professionals	×	–	–	×
Assure death with dignity	×	–	–	–
Transplant/donation conduct	×	–	–	–
No participation in torture/inhumane practices	×	–	–	–

The following is a comparison of five ethical codes used by emergency medicine professional organizations: the American Medical Association (AMA) used by the American Academy of Emergency Medicine, the Society for Academic Emergency Medicine (SAEM), the American Osteopathic Association (AOA) used by the American Osteopathic College of Emergency Physicians, and the American College of Emergency Physicians (ACEP)

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"black-letter law" wherein very specific actions are mandated, clinicians can best resolve these issues by turning to bioethical reasoning, using bioethics consultations, or applying previously developed institutional bioethics policies.

Modern bioethics developed because the law often has remained silent or inconsistent on matters vital to the biomedical community. The rapid increase in biotechnology, the failure of both the legal system and legislatures to deal with new and pressing issues, and the increasing liability crisis drove the medical community to seek answers to the difficult questions that practitioners have to work through on a daily basis [3].

Oaths/Codes

Medical ethics, or bioethics, differs from ethics in other fields just as medicine differs from other professions. This is because physicians treat ill people who are dependent on them and vulnerable to exploitation. For this reason, physicians have used ethical codes since ancient times to guide their behavior. Modern physicians who deliver critical hematologic and oncologic emergency medical services still rely on this guidance to help resolve dilemmas.

Many healthcare professional organizations, including most involved with emergency care, have developed their own values statements, which they often incorporate into their ethical codes. These codes (and the associated oaths) promote moral standards that their members presumably agree with and are expected to follow. The interpretation of those principles often evolves, albeit sometimes slowly, as the larger society changes. For example, although the American Medical Association's Code of Ethics was first published in 1847, it was not until 2001 that it stated that the physician's primary responsibility should be to their patient. While existing medical professional codes differ markedly (Table 3), all try to provide a "bottom line"—that is, a minimally acceptable course of action [2].

Some professional oaths and codes conflate bioethics and professional etiquette. However, these two areas differ markedly: professional etiquette deals with standards governing the relationships and interactions between practitioners, while bioethics is concerned with basic moral values and patient-centered issues [7]. Specifically, bioethics deals with relationships between providers and their patients, providers and society, and society and patients.

Review of Basic Ethical (Foundational) Theories

Foundational ethical theories embody grand philosophical ideas that attempt to coherently and systematically answer two fundamental questions: What ought I do? How ought I live? Philosophers continue to elaborate or reconstruct fundamental ethical theories based on ancient ethical systems. Many were developed in India and China or within the Jewish, Christian, Islamic, and Buddhist religions. Clinicians generally have difficulty directly applying these theories to individual situations. Rather, they rely on "casuistry," a case-based application of bioethical values (described later in this chapter).

There are two main "foundational" theories of ethics: utilitarianism and deontology.

Utilitarianism, sometimes called consequentialism or teleology, is one of the more functional and commonly used ethical theories. Based on writings by John Stuart Mill and Jeremy Bentham, it focuses on getting good or valued results rather than using the right means to achieve those results. This theory promotes achieving outcomes that benefit the majority in the most impartial way possible. In its simplest form, this theory proposes achieving the greatest good (or the greatest sum of pleasure or the least amount of pain) for the greatest number of people. It is often advocated as the basis for broad social policies. Health planners often employ concepts of utility to develop more equitable health delivery systems. Such systems attempt to encourage and maximize the use of treatment that results in the most beneficial outcome for the least resource expenditure. Nevertheless, trying to define what is "good" or who comprises the affected community exposes the major problems with this theory [8].

Utilitarian principles apply to ED triage systems that regulate the resources given to each patient to maximize overall benefit. However, physicians should not use the utility concept as an excuse to deny an individual patient needed and available resources merely to add to society's greater good. In doing this, the physician would be abandoning the traditional healer's role and violating the bioethical principle of beneficence.

Deontology (*rule-based ethics*) is based on moral absolutes—something is either right or wrong. Adherents hold that certain unbreakable moral rules govern the most important aspects of our lives, even if following the rule leads to results that may not be "good." One example of a list of "unbreakable" rules is the Ten Commandments. The philosopher Immanuel Kant is often identified with this theory.

However, major problems can arise in applying rule-based ethics. The first is that moral rules may vary depending on one's culture or subculture. This can lead to great divisiveness over the interpretation of what might seem, at first glance, to be an obvious and straightforward rule. For example, does the common stricture "Do not kill" prohibit passive euthanasia (allowing death without intervening) or physician-assisted suicide (providing a patient with a lethal medication prescription)? The rigidity inherent in rule-based ethics causes difficulties when confronted with real-life situations. For some individuals, however, such a system provides necessary guidelines on how to conduct oneself in life.

Other commonly cited ethical theories include:

Natural Law. This system, often attributed to Aristotle, suggests that man should live life according to his inherent human nature, in contrast to man-made or judicial law. Natural law is often associated with particular religious beliefs, especially Catholicism. The claim that the medical profession has an inherent morality mirrors natural law.

Virtue Theory. This theory asks what a "good person" would do in specific real-life situations. It stems from the writings of Aristotle, Plato, and Thomas Aquinas in which they discuss such timeless and cross-cultural character traits as courage, temperance, wisdom, justice, faith, and charity. The Society for Academic Emergency Medicine adopted a virtue-based Code of Conduct.

Mid-level Ethical Principles

"Mid-level principles" that guide clinical practice and bioethical thought are derived from ethical theories, but are more specific and less abstract. Instead, these ethical principles are "action-guides," basically role-specific duties that physicians owe to patients, consisting of various "moral rules" that comprise a society's values [9].

By melding medicine's goals with societal morality, law, religious values, and societal expectations for the profession, Beauchamp and Childress popularized the most commonly cited mid-level principles: autonomy, beneficence, nonmaleficence, and distributive justice. These four principles provide a handy medical ethics template and a practical, although often difficult to apply, checklist to use when considering the moral implications of specific cases [8, 9].

A question that naturally arises is whether ethical principles are universal. For individual clinicians, the bioethical principles they follow, and the values that stem from them, do not change because of geography. Clinicians practicing or teaching within cultures other than their own have a responsibility to continue applying their core ethical principles while being sensitive to the local population's values [10].

I will discuss autonomy in more depth (below), since it directly affects many decisions and ethical dilemmas that emergency clinicians face when caring for patients with hematological-oncologic problems. These include whether a patient has the capacity to make his or her own decisions, who can act as surrogate decision-makers, and what is the role of advance directives. The other principles—and virtues—will be discussed in relationship to specific ethical dilemmas, such as demanding and refusing treatment, constraints imposed by healthcare systems, and patient/survivor notifications.

Decision-Making Capacity

Autonomy means, as Justice Cardozo said, "Every human being of adult years and sound mind has a right to determine what shall be done with his own body" [11]. Physician adoption of patient autonomy has been a major change from the millennia-old tradition of medical paternalism (or parentalism), that is, doing what the physician thinks is good for the patient regardless of what the patient desires. Grounded in the moral principle of respect for persons, autonomy recognizes the right of adults with decision-making capacity to accept or reject recommended healthcare interventions, even to the extent of refusing potentially lifesaving care. Physicians have a concomitant duty to respect their choices. Over the past several decades, autonomy has become the predominant value in US medicine and society, although paternalism is still the prevailing attitude in most of the world.

One important, and often misunderstood, aspect of autonomy is that individuals who retain decision-making capacity can voluntarily and verbally assign decision-making authority to other people (e.g., family) for a specific decision or time period, such as when they are in the emergency department. Since patients may exercise their autonomy only if they have decision-making capacity, emergency clinicians must be able to determine this at the bedside so that if necessary, surrogate decision-makers may become involved.

While autonomy has become ingrained in US medical professionals, clinicians need to be sensitive to *communitarianism*, which is a counterbalance to autonomy. Communitarianism considers the larger picture of the patient's life, including his or her family and community, when puzzling through a bioethics case or developing public policy. This principle generally holds that the community's welfare outweighs an individual's rights or good and thus requires that deliberations involve communal (e.g., family, elders) discussions [8]. Many cultures rely on communitarian deliberations when making medical choices and use this pattern for public policy decisions. When making bedside ethical decisions, physicians should determine, whenever possible, not only their patient's individual values but also whether the patient subscribes to an individualistic or communitarian ethic [6].

Evaluating Decision-Making Capacity

Many ethical dilemmas in emergency medical care revolve around ascertaining a patient's decision-making capacity. In clinical settings, the question of decisional capacity is most often linked with consent to (or, more often, refusal of) a medical procedure.

Capacity refers to a patient's decision-making ability that, in the ED, emergency physicians determine at the bedside rather than by the courts, a psychiatrist or a lawyer. ("Competence" is a legal term and can only be determined by the court.) Decisional capacity is always related to the type of decision involved, although it is unclear whether it should be based on the potential seriousness or irreversibility of the outcome of a patient's decision (e.g., refusing lifesaving intubation) or on the complexity of the information needed to make the decision (e.g., whether to enter an experimental cancer treatment protocol). In current practice, most clinicians and ethicists use the seriousness or irreversibility of the outcome as the key to determining decisional capacity.

To have adequate decision-making capacity in any circumstance, an individual must understand (a) the options, (b) the consequences of acting on the various options, and (c) the personal costs and benefits of these consequences related to a relatively stable framework of personal values and priorities (Table 4) [12]. Assessing this last criterion can be especially difficult when clinicians have poor verbal skills in the patient's language. An easier, albeit incomplete, method of assessing this criterion is to ask the patient "why" a particular decision was made. This often provides an approximation of the last (and most important) criterion for assessing decisional capacity.

Table 4 Components of decision-making capacity

1.	Knowledge of the options
2.	Awareness of consequences of each option
3.	Appreciation of personal costs and benefits of options in relation to relatively stable values and preferences

From Buchanan AE. The question of competence. In Iserson KV, Sanders AB, Mathieu DR (eds). *Ethics in Emergency Medicine*, 2 ed., Tucson, AZ: Galen Press, Ltd,. 1995, pp 51–56. © 1995 by Galen Press, Ltd., Tucson, AZ. Used with permission

Disagreement with the physician's recommendation is not in itself grounds for determining that the patient is incapable of making his own decisions. In fact, even refusal of lifesaving medical care may not prove that the person is incapable of making valid decisions if he or she makes it on the basis of firmly held religious beliefs, as when a Jehovah's Witness patient refuses a blood transfusion.

Patient Consent

If a patient has decision-making capacity, a clinician who respects a patient's autonomy must get the patient's consent for any intervention. The consent need not be associated with a formal document, although an appropriate level of explanation is always required.

There are three general types of consent: presumed, implied, and informed. Presumed consent, sometimes called emergency consent, covers the necessary lifesaving procedures that reasonable people would usually wish to have performed on them. *Presumed* consent conjoins a patient's "best interest" with physician beneficence. Stopping hemorrhage and securing an airway in an unconscious, unknown patient are common examples of procedures performed under this type of consent. *Implied* consent occurs when a patient with decision-making capacity simply cooperates with a procedure, such as holding out their arm to give blood or to allow placement of an intravenous line. Indeed, this is the most common type of consent in medical practice [13].

Informed consent occurs when a patient who retains decision-making capacity is given all the pertinent facts regarding a particular procedure's risks and benefits, understands them, and voluntarily agrees to undergo the procedure. The requirement for informed consent varies in practice and law from area to area and even among practitioners and institutions in the same area. If a patient lacks decision-making capacity, get a surrogate decision-maker involved.

Advance Directives and Surrogate Decision-Makers

Advance directives loosely include durable powers of attorney for healthcare, living wills, prehospital advance directives [14], and similar documents initiated or approved by physicians, such as prehospital DNAR, inpatient DNAR forms, and Physician Orders for Life-Sustaining Treatment (POLST). They do not, however, include nonstandard and indecipherable directives [15]. The standard and generally recognized documents often express the patient's autonomous wishes about the treatment he or she will receive. However, they only go into effect if the patient lacks decision-making capacity. Otherwise, ask the patient what he or she wants done.

When patients do not have the capacity to make medical decisions for themselves, someone must make the decision for them. Four major classes of decision-makers have been proposed, and actually used, in these situations: family, bioethics committees, physicians, and courts.

Traditionally, and usually in practice, the family, especially the spouse, makes medical decisions when a patient does not have decision-making capacity. A typical prioritization list of those empowered to act as surrogate decision-makers is often stipulated in state statutes, similar to Arizona's landmark law (Table 5) or in a hospital's policy. When no surrogates exist, all potential surrogates refuse to act in that capacity, or an irresolvable conflict exists between surrogates at the same level (such as siblings), the court will intervene.

Table 5 Statutory surrogate decision-maker list: an example

Arizona Revised Statute: Living Wills and Health Care Directives Act, Title 36, Chap 32. 1992. Revised 2005
1. The patient's *spouse*, unless the patient and spouse are legally separated
2. An *adult child* of the patient. If the patient has more than one adult child, the healthcare provider shall seek the consent of a majority of the adult children who are reasonably available for consultation
3. A *parent* of the patient
4. If the patient is unmarried, the patient's *domestic partner* if no other person has assumed any financial responsibility for the patient
5. A *brother or sister* of the patient
6. A *close friend* of the patient. For the purposes of this paragraph, "close friend" means an adult who has exhibited special care and concern for the patient, who is familiar with the patient's healthcare views and desires and who is willing and able to become involved in the patient's healthcare and to act in the patient's best interest
7. If the healthcare provider cannot locate any of the people listed [above], the patient's *attending physician* may make healthcare treatment decisions for the patient after the physician consults with and obtains the recommendations of an *institutional ethics committee*. If this is not possible, the physician may make these decisions after consulting with a second physician who concurs with the physician's decision. For the purposes of this subsection, "institutional ethics committee" means a standing committee of a licensed healthcare institution appointed or elected to render advice concerning ethical issues involving medical treatment

Surrogates make decisions in one of two ways. The first is *substituted judgment*, which is used when the surrogate is not certain what the patient would want done in a particular situation. The second is absent advance directives or other explicit direction, which attempts to determine and act in accordance with the patient's values based on the patient's prior statements and behavior. This is the most worrisome type of surrogate decision-making, because it is based on the most ambiguous grounds. The second way is used when the patient has never had adequate decision-making capacity, and the surrogate must simply act in the patient's best interest. Unless there is already a court-appointed guardian, these cases often end up being resolved in a courtroom.

Children pose a special situation. Individuals less than the age of majority (and unemancipated) are usually deemed incapable of making medical decisions for themselves, although clinicians normally explain the situation to the child and ask for his or her assent. In most cases, the same rules for decision-making capacity that apply to adults also apply to children. The more serious the consequences, the more important it is that the child understands the options and consequences and can articulate the values involved in making their decision. Especially in cases involving religiously or culturally based refusal of potentially lifesaving treatment or when the parents disagree, the court or child protective services may intervene on the child's behalf.

Methods of Applying Bioethics Principals

To apply bioethical principles to a clinical situation, one first must recognize that a bioethical dilemma exists, which is not always an easy task. Once identified, addressing the problem brings its own challenges. Clinicians adhere not only to basic bioethical principles but also, at least tacitly, to a number of professional, religious, and social organizations' ethical oaths, codes, and statements. This complexity can produce a confusing array of potentially conflicting bioethical imperatives.

When dealing with bioethics cases, clinicians need to use ethical reasoning, which includes the application of foundational theories, mid-level principles, and case-based reasoning. This helps us systematically identify elements within moral problems that we otherwise might overlook.

Casuistry, or case-based ethics, attempts to define problems and correct courses of action based on the intricacies of a particular case. It puts an emphasis on what Aristotle called *phronesis*, or "practical wisdom," and is the basis for the emergency rapid decision-making model, described below. To use this method, examine each case for its similarities and differences with select previous cases paradigms, for which you have determined a suitable course of action. Where the present case is similar enough to the paradigm, use the same course of action. When significant differences exist, clinicians must apply the broader mid-level principles derived from rulebased, utilitarian, and other ethical systems, usually giving the most weight to patients' autonomy and values.

In practice it can be difficult to identify and extract the most appropriate and useful principles to apply to a particular case. Some principles may appear too vague, or perhaps several conflicting principles appear to apply to a given case. The key is to prepare for bioethical problems as one would for critical medical events, by reading about, reflecting on, and discussing how to approach these issues. This leads not only to increased personal preparation but also to more general policies that provide guidance for dealing with difficult bioethical issues [2].

Prioritizing Conflicting Principles: The Bioethical Dilemma

Applying bioethical principles can be confusing. When two or more seemingly equivalent principles or values appear to compel the clinician to act in different ways, a bioethical dilemma exists. This situation is often described as being "damned if you do and damned if you don't," where any potential action appears, on first reflection, to be an option between two seemingly equivalent "goods" or "evils." In bioethics, although there may be disagreements regarding the optimal course of action using a specific set of values, there is often general agreement as to what constitutes ethically wrong actions. While we theoretically have a duty to uphold each bioethical principle, none routinely "trumps" another.

Working through bioethical dilemmas generally requires a case-based approach. The key is to use paradigm and analogy (the first step in the rapid decision-making model, described below). Thus, when faced with a troubling case, first identify relevant mid-level principles and alternative courses of action. Then, compare it to similar but much clearer paradigms, that is, cases having resolutions with which virtually any "reasonable person" will agree. Identifying such cases may be difficult; it takes experience and a significant knowledge base. Using bioethics committees and bioethical or legal case databases may help.

Application to Emergency Medicine: The Rapid Decision-Making Model [16, 17]

When faced with bioethical dilemmas, emergency clinicians often must make ethical decisions with little time for reflection or consultation. Ethical problems, like clinical prob-

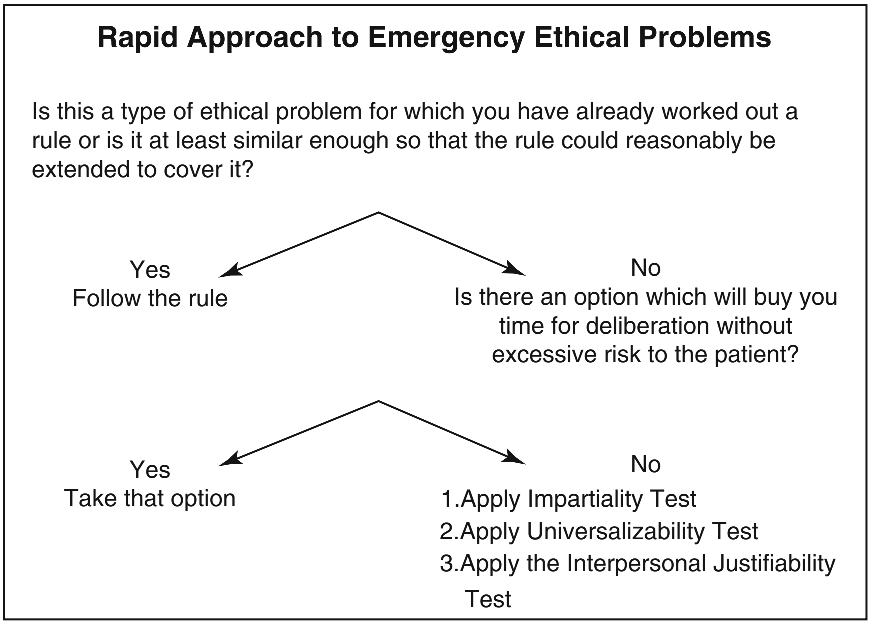

Fig. 1 Rapid decision-making model. From Iserson KV. An approach to ethical problems in emergency medicine. In: Iserson KV, Sanders AB, Mathieu D (eds.). *Ethics in Emergency Medicine, 2nd ed.*, Figure 2, pg 45. © 1995 by Galen Press, Ltd. All rights reserved. Used with permission of Galen Press, Ltd., Tucson, AZ

lems, require action for resolution. For that reason, a rapid decision-making model was developed, based on accepted bioethical theories and techniques (Fig. 1). It provides guidance for emergency medicine practitioners who are under severe time pressures and wish to make ethically appropriate decisions [16, 17].

When using this approach, the clinician must first ask: “Is this an instance of a type of ethical problem for which I have already worked out a rule?” Or, at least, is it similar enough to such cases that the rule could be reasonably extended to cover it? In other words, if there had been time in the past to think coolly about the issues, read about them, discuss them with colleagues, and develop some rough guidelines, could they be used in this case? Just as with the indications for any clinical emergency procedure, emergency physicians should be prepared with a course of action for at least the most common ethical dilemmas likely to occur in the ED. If the case in question does fit under one of those guidelines arrived at through critical reflection, and there is not time to further analyze the situation, then the most reasonable step would be to follow that rule—if it is still appropriate. In ethics, this step follows from casuistry or case-based reasoning.

If the case does not fit under any previously generated ethical rule, the practitioner should consider if there is an option that will buy time for deliberation. If there is such an option, and it does not involve unacceptable patient risks, then it would be the reasonable course to take. Using a delaying tactic may afford time to consult with other professionals, the bioethics committee, and the family.

If there is no acceptable delaying tactic, the clinician should weigh what she considers the best option using a set of three tests, drawn from three different philosophical theories, to help make a decision:

Impartiality Test. “Would you be willing to have this action performed if you were in the other person’s (the patient’s) place?” A version of the Golden Rule, it helps correct one obvious source of moral error—partiality or self-interested bias.

Universalizability Test. “Would you be comfortable if all clinicians with your background and in the same circumstances act as you are proposing to do?” This generalizes the action and asks whether developing a universal rule for the contemplated behavior is reasonable—an application of Kant’s categorical imperative. This helps eliminate not only bias and partiality but also short-sightedness.

Interpersonal Justifiability Test. “Can you give reasons that you would be willing to state publicly? Will peers, superiors, or the public be satisfied with the answers?” This uses a theory of consensus values as a final screen.

When ethical situations arise in cases for which no time exists for further deliberation, it is probably best to go ahead and act on the previously determined ethical rule or take the course of action for which the clinician was able to answer all three tests in the affirmative with some degree of confidence. Once the crisis has subsided, clinicians can hone their ethical decision-making abilities by reviewing the decision with colleagues and bioethicists.

Bioethics Committees and Consultants

Another resource for complicated ethical dilemmas is to use your institution's bioethics committee. Most US hospitals now have multidisciplinary committees or bioethics consultants to help resolve bioethical dilemmas. Bioethics committees and consultants have four roles: (a) education, (b) policy development (proactive ethics), (c) retrospective case review, and (d) concurrent case review (ongoing clinical cases in which they often mediate between dissenting parties) [18]. Some experienced committees and consultants also perform "stat" consultations that can assist in emergency department cases.

Other Principles and Virtues

Other mid-level bioethics principles and virtues often guide clinician behavior. They also may conflict with the principle of autonomy or with each other, posing a bioethical dilemma. In their practice, emergency clinicians commonly use the principles of beneficence and nonmaleficence, as well as the virtue of truth telling. When developing policy, they often use the principle of distributive justice. Therefore, it is instructive to examine how these principles relate to specific clinical scenarios with ED patients, including those with hematological or oncologic illnesses.

Beneficence is the principle of doing good or producing benefits. This principle is one of the medical profession's universal tenets. Society's view of physicians as altruistic reflects the profession's long history of beneficence. In addition, all medical students are taught the basic tenet of nonmaleficence: *primum non nocere* (first, do no harm). This stems from recognizing that physicians can harm, as well as help, their patients.

Clinicians use the principle of distributive justice to develop policies, including triage protocols, affecting patient groups and healthcare systems. Truth telling is the virtue that guides clinicians in what and how they communicate with patients and families, rather than the decisions they must make.

Beneficence

Clinicians enter the healthcare field to help others—to be beneficent or to do good. While ED interventions for hematology-oncology patients will not provide a long-term solution, they often relieve symptoms or provide time to begin more definitive treatments. However, when opportunities to clearly benefit a patient present themselves, clinicians feel intense anguish when a patient or surrogate decision-maker refuses the interventions. This sets up a struggle between patient autonomy and physician beneficence. Probably the most common ethical dilemma in modern US medical practice, it exemplifies physician paternalism, that is, the desire to do what he or she thinks is best for the patient no matter what the patient (or surrogate decision-maker) wants.

Yet, when made by patients with decision-making capacity, clinicians should respect these refusals. That does not mean that the clinician should not clearly explain the options, potential outcomes, and costs involved. If the patient holds firm to the decision, the clinician must follow the patient's wishes, even if they conflict with his or her own values. This is the most difficult part of adhering to patient autonomy.

The only exceptions to this are when a surrogate makes a decision that the clinician believes is contrary to the patient's expressed wishes or is masking (possibly illegal) ulterior motives, or when a child is involved. In any of these situations, obtain legal assistance immediately. In the case of a child, including religion-based refusals of treatment, most courts will order clinicians to institute therapy if any reasonable chance of benefit exists.

Beneficence: Withholding and Withdrawing Treatment

As noted above, resuscitating patients who present to the ED with unknown illnesses and injuries is both ethically appropriate and virtuous behavior. A common fear, and unfortunate misunderstanding, is that once treatment is initiated, it cannot be withdrawn. Actually, there is a much higher ethical and legal bar to withholding treatment in uncertain cases than there is to withdrawing treatment once complete information is known [19].

Withholding treatment. Not infrequently, a patient is brought into the ED in extremis, unable to interact with clinicians, and without any history or direction about care. For example, the patient may be in cardiorespiratory failure or the patient may have metastatic cancer and now be suffering from hypercalcemia, a frequent terminal event. While some have advocated that allowing the patient with hypercalcemia to have a "good death" may be humane and medically appropriate [20], emergency physicians do not have this option. Without knowing the patient, the disease prognosis, or any prior wishes, they are obligated to intervene to preserve life. This obligation is based on the principles of beneficence and nonmaleficence, which are societal values placed on emergency physicians. Our society sees the entire emergency medical care system as being the caregivers of last resort. Arbitrary decisions to do less than everything reasonable to preserve a life signal a lapse in this entrusted function. Unknown and unknowing patients deserve the presumption of life.

Withdrawing treatment. Contrary to popular myth, if the emergency physician (or inpatient physician) later learns that, given the patient's condition or wishes, lifesaving interventions such as ventilation and vasopressors are not appropriate, it is both ethical and legal to withdraw them. This follows the dicta to use only beneficial interventions and to preserve a patient's autonomous wishes. Morally, withdrawing treatment is identical to initially withholding it. That is, withdrawing an IV drip or stopping a ventilator is equivalent to withholding the next drop of medication or the next ventilation. The problems that generally arise with withdrawal under these circumstances are emotional, not ethical [19].

Even though treatment has been withdrawn, clinicians must continue to provide analgesia and any other appropriate care. Healthcare professionals never cease providing care.

Beneficence vs. Patient Autonomy: Refusing Lifesaving Treatment

The following common case demonstrates the ethical dilemma produced by the tension between the physician's motivation of beneficence and the patient's (or surrogate's) desire to determine which treatments to authorize based on his or her values. In the case, the decision is religiously based.

An exsanguinating adult leukemic patient, awake and still with medical decision-making capacity, arrived in the ED and explicitly stated that, owing to long-standing religious beliefs, she wanted no blood or blood products. The physician, with a professional duty and moral commitment to preserve life, did not personally agree with the patient's decision. Yet, society (through the benchmark of court decisions) has repeatedly sided with the patient's right to refuse such treatment.

In this case, the patient's autonomy and right to practice her religion are recognized as the overriding values. The case becomes somewhat less clear when the patient lacks decision-making capacity, is a minor, or appears to be under external pressures (such as from relatives) to make what is a life-threatening decision. In my experience, however, when clinicians truthfully tell patients that they will die quickly without the transfusion, most consent. Some clinicians, steeped in the idea of patient autonomy, forget that informed consent includes informing the patient of all the relevant benefits and risks—including death.

Beneficence vs. Patient Autonomy: Refusing Analgesia

Physicians are expected to follow the medical maxim "cure sometimes, relieve often, comfort always" [21]. In some cases, patients or their surrogates may refuse analgesics to relieve acute pain. This may be due to misguided concepts of drug abuse and addiction or to a fear that taking analgesics will hasten death. Rarely, refusal may stem from religious or cultural values.

The final decision may come down to a balance between autonomy and beneficence. While there may be unique instances when analgesics should be withheld, at least in the short term (e.g., so that the patient can be awake when relatives arrive), beneficence generally outweighs any countervailing argument and the patient should receive analgesia.

Nonmaleficence

The principle of nonmaleficence includes not doing intentional harm to patients, preventing harm, and removing harmful conditions. Nonmaleficence is the profession's protective shield for patients. The following two situations demonstrate how this may not only conflict with other principles, such as autonomy, but also how it forms the basis for the rules regarding clinical research.

Nonmaleficence: Demands to "Do Everything"

No one gets every possible medical intervention. Yet, ED clinicians commonly hear surrogates demand that they "do everything," even for terminally ill hematology-oncology patients for whom further intervention will not change the disease course and may prolong an unpleasant dying process. This request, often coming from distraught and guilt-stricken relatives, poses difficult ethical dilemmas for clinicians. While patient autonomy plays a key role in any decision, surrogates may be unaware that clinicians' interventions must not harm the patient without providing them with a countervailing benefit (nonmaleficence).

The "do everything" request usually presents as one of three scenarios: where a patient knowingly requests intervention, where a patient asked for intervention via an advance directive, or where surrogates ask for the intervention.

The first situation occurs when a patient with decisional capacity who is informed of the options selects a probably non-beneficial and definitely painful course of therapy. In the ED, that may mean intubating and ventilating a terminal cancer patient in severe pain. These decisions fall under the question of patient autonomy, and even if the physician thinks she would not make the same decision herself, she should help the patient implement this choice.

The second scenario occurs when a patient has left instructions via an advance directive to "do everything." This directive carries much less weight than the patient's actual informed decision, described above, because the exact situation with which the medical team is presented could not have been anticipated. Nevertheless, clinicians should make all reasonable efforts to comply with the patient's wishes.

The third situation occurs when families of a terminally ill patient demand non-beneficial care for their relative. Emergency physicians are usually reluctant to provide this, since it only prolongs the predictable dying process. On the other hand, to be beneficent, clinicians frequently admit end-stage cancer patients if they come for pain relief that cannot be provided at home, to temporarily relieve a family of the stress of caring for the patient (respite care), as an interlude to get a patient into a hospice or nursing facility, or who are in the terminal stage of the disease presaging death. However, interventions which simply prolong dying usually violate the ethical principle of nonmaleficence.

Legally, the representative for a patient lacking decisional capacity can make any informed decision that the patient could make about healthcare. After explaining the options and that the interventions will not be beneficial, physicians should abide by these surrogates' requests, even if they seem unreasonable. Note, however, that a physician is never required to offer any treatment through a surrogate that they would not offer directly to a patient, such as cardiopulmonary resuscitation in an imminently dying metastatic cancer patient. This is a struggle between autonomy and nonmaleficence, and the medical team's responsibility is to follow the legal surrogate's instructions to the extent that they would follow a patient's instructions. The assumption is that in most cases, the patient believed that this individual would best represent his or her wishes. When clinicians question whether the agent is acting in the patient's best interest, they can ask a court intervene.

Nonmaleficence and Autonomy: Research Protocols

The horrors inflicted under the guise of scientific research during World War II led to the Nuremburg Code and subsequently the Helsinki Declaration, enumerating basic ethical principles for research studies [22]. With a basis in autonomy, the respect for persons as individuals, these research principles arose from the desire to no longer harm research subjects, as had been done both during WWII and subsequently in the civilian sector.

Research is vital to medicine. In the past, most medical care, including that in emergency medicine, has relied on experience that was unsupported by investigation, so-called nonvalidated practice. Recently, however, clinicians have begun to use evidence-based medicine, which requires research. Over the past three decades, research done within emergency medicine and that done elsewhere but applied to emergency medical practice has improved the elegance of patient encounters, significantly benefiting ED patients. In hematology-oncology, research has driven diagnostic and treatment breakthroughs, and emergency physicians can often assist in these projects.

Yet some aspects of clinical research and research oversight fall short of meeting the ethical standards of safety and patient benefit. Overall, emergency medicine research has been and continues to be a moral endeavor. Even more important than the institutional safeguards, such as the institutional review boards (IRBs), is the individual researcher's moral compass, which must serve to protect the subject-patients of clinical research. Perhaps the greatest moral lapse has been the lack of attention to key populations, such as women and children, within emergency medicine research, with the result that patients most needing acute intervention are the ones who suffer [23].

Funding availability, both from private industry and from government agencies, still drives research agendas. This raises questions about clinical researchers' fiduciary responsibility to their subject-patients.

Finally, the moral responsibility to ensure that any research protocol and its execution are ethical extends to the journals in which the research is published [24]. While emergency medicine has an excellent record of ethical research, a large percentage of human research studies published in the major EM journals fail to mention either IRB review or informed consent [23, 25].

System Constraints: Distributive Justice and Confidentiality

Distributive or comparative justice suggests that comparable individuals and groups should share similarly in the society's benefits and burdens. In contrast to the judicial system's retributive and compensatory justice, this basic bioethical principle does not apply to individual practitioners for ad hoc use in limiting healthcare resources for individual patients [26]. Rather, it is meant to be used at the policy-making level to allocate limited healthcare resources.

For example, triage decisions conform to this principle when they are applied uniformly and impartially to all patients [27]. Other typical issues in emergency medicine for which distributive justice plays a part in designing policies and protocols include admission prioritization; how to work with patients who cannot pay for treatment; patients who have the "wrong" insurance, or belong to the "wrong" medical system or group for the particular hospital or clinic; intentional or unintentional release of patient information; and how to work with patients who are undocumented aliens.

Other principles have also had long-standing importance to medical practice, one of the most important being confidentiality, that is, the nondisclosure of patient information.

Based on a respect for persons (as is autonomy), patient confidentiality has been a cornerstone principle of the medical profession since antiquity. The *Hippocratic Oath*, for example, states, “Whatever, in the course of my practice, I may see or hear (even when not invited), whatever I may happen to obtain knowledge of, if it be not proper to repeat it, I will keep sacred and secret within my own breast.” Confidentiality presumes that, unless they first obtain the patient’s permission, physicians will not reveal to any other person or institution what patients tell them during the medical encounter. Various US federal and state laws have both emphasized (e.g., HIPAA) and carved out exceptions (mandatory reporting) to this stricture. With the advent of minimally secure electronic medical records, the ability to maintain patient confidentiality has become even more difficult.

Note that privacy, often confused with but related to confidentiality, is a patient’s right to sufficient physical and auditory isolation such that he or she cannot be seen or heard by others during interactions with medical personnel.

Truth Telling

Truth telling remains a somewhat controversial virtue within the medical community. While many champion absolute honesty to the patient, honesty must be tempered with sensitivity and compassion; it should not equate to brutality. In recent years, poor role models, a lack of training in interpersonal interactions, and bad experiences may have diminished the perception of truth telling as a physician virtue. There are multiple tales of the champions of absolute fidelity who, nevertheless, were appalled by their own physician’s lack of sensitivity when relating unfavorable medical news to them [28].

The degree to which physicians fail to disclose the truth varies with the circumstances. When failure to disclose the truth will do physical harm to the patient, such as in the infamous Tuskegee experiments on patients known to have syphilis, it is not only immoral but also probably illegal to withhold the information. Likewise, if failure to disclose information is strictly for the physician’s benefit, such as telling a patient who calls in the middle of the night to “take two aspirins and call in the morning,” although there is a strong suspicion of serious disease, there are serious ethical and legal deficits in the clinician’s behavior. The issues become somewhat murkier when truth telling involves a third party, such as a sex partner who the patient has exposed to an infectious disease [29].

The following cases demonstrate two scenarios involving this principle that commonly occurs with ED hematology-oncology patients. The first deals with relating a probable diagnosis to a woman in a strong communitarian culture. The second deals with death notification, emphasizing the need for strong communication skills and sensitivity.

Truth Telling (Fidelity) and Communitarianism: Diagnosis Notification

A 54-year-old Hispanic woman came to the ED with her family because of a persistent cough and poor health for at least several weeks. Before the patient could be examined or any tests could be done, the patient’s husband intercepted the emergency physician and told him that if the patient had a lifethreatening disease, she was not to be told because “she didn’t want to know.” The adult children agreed. The evaluation showed that the woman had a hard new breast lump, honeycomb lesions, and multiple pulmonary nodules consistent with cancer. The physician had a policy to tell the truth to all his patients but believed that the family might be accurate in their assessment.

Many patients come from cultures that embrace communitarianism, rather than autonomy. Communitarianism stresses the interactions between group members, which may be just the family, but may also include elders, religious figures, or the entire tribe, group, or community. In this case, the family implied that the patient was part of such a culture.

Doing good in these cases often means respecting the patient’s personal or cultural desire not to be explicitly informed about a serious disease. This is the norm for many Asians (particularly Japanese), Hispanics, and Native Americans. The enormity of this information (and slight possibility of error in this case), coupled with the minimal physician-patient relationship established in the ED, might also suggest that, at least at this stage, stating the presumed “diagnosis” could be avoided.

The question for the physician is, how much does the patient want to know? The best way to find out is to ask her both what she wants to know and, if she does not want to know anything, with whom does she want the physician to speak. If she wants the information, the physician is obligated to gently tell her what he knows about her illness, including the next steps in the diagnostic process. If she designates someone else to receive this information, this fully complies with the patient autonomy principle and should be followed.

Truth Telling (Fidelity): Survivor Notification

Nowhere in emergency medicine is truth telling with sensitivity more important than when the clinician must deliver the news of a death, which is often an emotional blow, precipitating life crises, and forever altering the survivors’ world. Emergency physicians must repeatedly do death notification as part of their daily work.

Excellent communication skills represent the basis for correctly delivering tragic news to survivors. Directness, truth, consistency, and clarity are the key factors in delivering information about a sudden, unexpected death—and complying with the virtue of fidelity. Perceptive survivors can easily tell which notifiers care and which are only “going through the motions” [30, 31].

Poor clinician-patient communication disappoints both the patients and clinicians. Often, this failure is due to clinicians:

- Using highly technical language.
- Not showing appropriate concern for problems voiced by patients.
- Not pausing sufficiently to listen.
- Not verifying that the listener has gotten the information presented.
- A generally impersonal approach to the interaction, including their manner of speech [32].

Delivering the news about sudden unexpected death provokes strong emotions in both the notifier and survivors. Communication is improved if the notifier acknowledges those emotions, being prepared to vocalize and demonstrate their sadness and to recognize and acknowledge it in the survivors. Using the voice to communicate does not always mean talking. In some instances, para-verbal behavior is what is called for. These sounds, such as mmmmm, ahhhh, or mhmmm, are often sufficient to show that a person is listening and understands, particularly if they are accompanied by appropriate nonverbal cues, such as nodding the head.

It often takes imagination to put oneself in the position of a grieving survivor, especially when wide cultural or age differences exist. Even if you cannot learn to empathize with survivors, you can learn to behave appropriately, speak correctly, and assist them in their time of grief. Imagination, studying people, advance planning, or taking the lead from experienced mentors is the only way to successfully perform this necessary, but tragic task [30, 31].

References

1. American College of Emergency Physicians Ethics Committee. Code of ethics for emergency physicians. Dallas, TX: ACEP; 1997.
2. Iserson KV. Principles of medical ethics. In: Marco C, Schears R, editors. Clinical ethics in emergency medicine. Cambridge: Cambridge University Press; 2015.
3. Iserson KV, Heine C. Bioethics. In: Marx JA, Hockberger RS, Walls RM, editors. Rosen’s emergency medicine: concepts and clinical practice. 7th ed. Philadelphia, PA: Mosby; 2013. p. e33–46.
4. Larkin GLL, Iserson KV, Kassutto Z, Freas G, Delaney K, Krimm J, et al. Virtue in emergency medicine. Acad Emerg Med. 2009;16:51–5.
5. Pirkei Avot 2:5 (Book of Principles) 200–220 AD.
6. Iserson KV. Ethical principles—emergency medicine. Emerg Med Clin North Am. 2006;24(3):513–45.
7. Arras JD. A method in search of a purpose: the internal morality of medicine. J Med Phil. 2001;26:643–62.
8. Kuczewski M. Methods of bioethics: the four principles approach, casuistry, communitarianism. http://www-hsc.usc.edu/~mbernste/tae.methods.kuczewski.html.
9. Beauchamp TL, Childress JF. Principles of biomedical ethics. 1st ed. New York, NY: Oxford University Press; 1979.
10. Iserson KV, Biros M, Holliman CJ. Ethics of international emergency medicine. Acad Emerg Med. 2012;19:683–92.
11. Schloendorff v Society of New York Hospital, 105 NE 92, 93, 1914.
12. Drane JF. Competency to give an informed consent. JAMA. 1984;252(7):925–7.
13. Iserson KV. The three faces of “yes”: consent for emergency department procedures. Am J Bioethics. 2007;12:42–5.
14. Iserson KV. A simplified prehospital advance directive law: Arizona’s approach. Ann Emerg Med. 1993;22(11):1703–10.
15. Iserson KV. Nonstandard advance directives: a pseudoethical dilemma. J Trauma. 1998;44(1):139–42.
16. Iserson KV. The rapid ethical decision-making model: critical medical interventions in resource-poor environments. Camb Q Healthc Ethics. 2011;20(1):108–14.
17. Iserson KV, Sanders AB, Mathieu DR, editors. Ethics in emergency medicine. 2nd ed. Tucson, AZ: Galen Press, Ltd; 1995.
18. Iserson KV, Goffin F, Markham JJ. The future functions of ethics committees. HEC Forum. 1989;1(2):63–76.
19. Iserson KV. Withholding and withdrawing medical treatment: an emergency medicine perspective. Ann Emerg Med. 1996;28(1):51–5.
20. Boisaubin EV, Lynch GR, Dresser R. Hypercalcemia of advanced malignancy: decision making and the quality of death. Am J Med Sci. 1991;301:314–8.
21. Popularized by Dr. Edward Livingston Trudeau (1848–1915), but also cited as a 15th century folk saying.
22. Spivey WH, Abramson NS, Iserson KV, MacKay CR, Cohen MP. Informed consent for biomedical research in acute care medicine. Ann Emerg Med. 1991;20:1251–65.
23. Iserson KV. Has emergency medicine research benefited patients? An ethical question. Sci Eng Ethics. 2007;13:289–95.
24. Iserson KV. Physician ethics in human research: the role of medical publications. Ann Emerg Med. 1990;19:828.
25. Bounes V et al. Quality of publications in emergency medicine. Am J Emerg Med. 2013;31:297.
26. Landesman BM. Physician attitudes toward patients. In: Iserson KV, Sanders AB, Mathieu DR, et al., editors. Ethics in emergency medicine. 2nd ed. Tucson, AZ: Galen Press, Ltd; 1995. p. 350–7.
27. Moskop JC, Iserson KV. Triage in medicine—part II: underlying values and principles. Ann Emerg Med. 2007;49(3):282–7.
28. Kubler-Ross E. On death and dying. New York, NY: Macmillan; 1969.
29. Novack DH, Detering BJ, Arnold R, et al. Physicians' attitudes toward using deception to resolve difficult ethical problems. JAMA. 1989;261:2980–5.
30. Iserson KV. Grave words: notifying survivors about sudden unexpected deaths. Tucson, AZ: Galen Press, Ltd.; 1999.
31. Iserson KV. Pocket protocols: notifying survivors about sudden unexpected deaths. Tucson, AZ: Galen Press, Ltd.; 1999.
32. Korsch BM, Negrete VF. Doctor-patient communication. Sci Am. 1972;227:66–74.