

## CONCEPTS

## The Practice of Emergency Medicine

# The role of hospital ethics committees in emergency medicine practice

Eileen F. Baker MD, PhD<sup>1,2</sup> | Joel M. Geiderman MD<sup>3</sup> | Chadd K. Kraus DO, DrPH<sup>4</sup> |  
 Rebecca Goett MD<sup>5</sup>

<sup>1</sup> University of Toledo College of Medicine and Life Sciences, Toledo, Ohio, USA

<sup>2</sup> Inc, Riverwood Emergency Services, Perrysburg, Ohio, USA

<sup>3</sup> Emergency Medicine, Department of Emergency Medicine, Ruth and Harry Roman Emergency Department, Cedars-Sinai Medical Center, Los Angeles, California, USA

<sup>4</sup> Emergency Medicine, Geisinger Medical Center, Danville, Pennsylvania, USA

<sup>5</sup> Emergency and Palliative Medicine, Rutgers New Jersey Medical School, Newark, New Jersey, USA

**Correspondence**

Eileen Baker, MD, PhD, University of Toledo College of Medicine and Life Sciences, Toledo, Ohio, USA.

Email: [uhemsdoc@earthlink.net](mailto:uhemsdoc@earthlink.net)

**Funding and support:** By *JACEP Open* policy, all authors are required to disclose any and all commercial, financial, and other relationships in any way related to the subject of this article as per ICMJE conflict of interest guidelines (see [www.icmje.org](http://www.icmje.org)). The authors have stated that no such relationships exist.

**Abstract**

Emergency physicians face real-time ethical dilemmas that may occur at any hour of the day or night. Hospital ethics committees and ethics consultation services are not always able to provide immediate responses to emergency physicians' consultation requests. When faced with an emergent dilemma, emergency physicians sometimes rely on risk management or hospital counsel to answer legal questions, but may be better served by real-time ethics consultation. When other resources are not immediately available, emergency physicians should feel confident in making timely decisions, guided by basic principles of medical ethics. We make the following recommendations: (1) availability of a member of the hospital ethics committee to provide in-person or telephonic consultation concurrent with patient care; (2) appointment to the hospital ethics committee of an emergency physician who is familiar with bioethical principles and is available for consultation when other ethics consultants are not; and (3) development of educational tools by professional societies or similar organizations to assist emergency physicians in making reasoned and defensible clinical ethics decisions.

**KEYWORDS**

emergency medicine ethics, ethical dilemmas, ethics committee, ethics consultation, ethics policy, hospital policy, risk management

**1 | INTRODUCTION****1.1 | Case 1**

A 78-year-old woman presents to the emergency department (ED) late Sunday night with a complaint of lower abdominal pain. Her temperature is 39°C, pulse is 110 beats/min, and the rest of her vital signs are normal. Her clinic chart documents "early dementia" in her problem list. Her abdominal exam reveals bilateral lower quadrant tender-

ness without rebound. Her urinalysis is normal, and white blood cell count is 11,500 cells per liter. She becomes agitated because she has waited for 3 hours to be seen and does not want to wait for a computed tomography (CT) scan or evaluation by a consultant physician. She dresses haphazardly and demands to go home. She is estranged from her family but has a physician son in Hawaii who cannot be reached. You are a first-year attending physician caring for her and do not know whether to let her leave in this situation. What are your options?

Supervising Editor: Catherine A. Marco, MD.

This is an open access article under the terms of the [Creative Commons Attribution-NonCommercial-NoDerivs](https://creativecommons.org/licenses/by-nc-nd/4.0/) License, which permits use and distribution in any medium, provided the original work is properly cited, the use is non-commercial and no modifications or adaptations are made.

© 2020 The Authors. *JACEP Open* published by Wiley Periodicals LLC on behalf of the American College of Emergency Physicians.

## 1.2 | Case 2

A 25-year-old man arrives unconscious with shallow breathing. The electronic medical record reveals that he is on methadone. He is given naloxone and awakens to tell you that he has injected heroin today and occasionally uses marijuana and alprazolam. Twenty minutes later he loses consciousness again and awakens after being given another dose of naloxone. Another 20 minutes after waking up he is dressed and wants to leave the ED. You are not sure if he should be restrained and forced to remain in the ED.

## 1.3 | Case 3

An 82-year-old man arrives from a skilled nursing facility with a blood pressure of 60/40 mm Hg and rapid breathing. He is not able to communicate, but he is sent with what appears to be a properly executed Physician Orders for Life Sustaining Treatment (POLST) form with the box selected that says no cardiopulmonary resuscitation (CPR). Another box indicates "comfort measures only." His daughter arrives, demands to know exactly what is wrong with him, and wants "everything done." You are not sure what to do.

## 1.4 | Case 4

During the COVID-19 pandemic, you have just intubated a 70-year-old man in your ED, who shows ground-glass opacities on chest x-ray. A rapid COVID-19 test confirms the diagnosis. Your ICU team informs you that this patient will take the last ventilator available in your hospital. Half an hour later, while awaiting the ICU bed, an ambulance crew calls in reporting that they are en route with a 61-year-old female who has been intubated for severe angioedema. There are no known COVID-19 risk factors for this patient. You cannot divert the ambulance, as you are the tertiary receiving facility, and all outlying facilities are similarly resource-depleted. How should you manage this situation? Who should get the ventilator?

These cases are examples of the real-time dilemmas that emergency physicians frequently encounter. Such situations are not necessarily unique to the ED, but represent dilemmas that emergency physicians face, often suddenly and at any hour. Emergency physicians are accustomed to making quick medical decisions and to taking action. When ethical questions arise, traditional channels, such as hospital ethics committees or ethics consultation services, may not be available. At times, emergency physicians may be able to rely on the hospital's risk management department or legal counsel to answer questions. However, those resources might also not be available in the immediate situation.

We describe the traditional role of hospital ethics committees and ethics consultation services, review the limitations of those groups in providing guidance to the emergency physician with bedside ethical dilemmas, and propose measures to address those limitations. Recognizing that real-time hospital ethics committee consultations may not

be available in all situations, we suggest that emergency physicians should be familiar with the basic principles of medical ethics. These can help guide the physician's actions, when a situation cannot wait for a formal ethics consultation or a decision proposed after a discussion by the hospital ethics committee. We recommend the following: (1) availability of a member of the hospital's ethics committee to provide consultation concurrent with patient care; (2) appointment to the hospital ethics committee of an emergency physician who is familiar with bioethical principles and is available for consultation when other ethics consultants are not; (3) development of educational tools by professional societies or similar organizations to assist emergency physicians in making cogent clinical ethics decisions; and (4) that the creation of guidelines and protocols for rationing in pandemic situations be done by appropriately constituted task forces or committees (including the ethics committee) and approved by the institution's governing body in advance and not at the bedside for a given patient.

## 2 | A BRIEF HISTORY OF HOSPITAL ETHICS COMMITTEES

In the United States, hospital ethics committees developed in the second half of the 20th century with the rapid evolution of medical technologies, including the development of hemodialysis, the advent of organ transplantation, and the proliferation of critical care units.<sup>1,2</sup> One of the first and perhaps most well-known ethics committees was in Seattle in 1962, after pioneering physician Belding Scribner developed the first dialysis unit at Swedish Hospital.<sup>2</sup> To decide who would be eligible for this scarce resource, the committee used criteria that included a candidate's age, sex, occupation, marital status, education, dependents, income, and net worth, past performance and future potential. When the LIFE magazine published an account of this, it set forth a firestorm of controversy and the committee was infamously dubbed "The God Committee."<sup>2</sup> This resulted in further examination of the role of ethics committees.

By the 1980s ethics committees were present in 60% of US hospitals, and by the 1990s the number was 90%.<sup>2</sup> Today, nearly every hospital has a hospital ethics committee and/or an ethics consultation service, including all US hospitals with 400 beds or more, all federal hospitals, and all teaching hospitals. Such bodies have become the "primary mechanism to address ethical issues in patient care."<sup>2,3</sup> Today, hospital ethics committees and ethics consultation services are sophisticated, with membership that often includes physicians, other clinical staff, including nurses, respiratory therapists, case managers, and social workers, professional bioethicists, chaplains, clergy, and patient and community representatives.<sup>3,4</sup> Regional hospital ethics committees sometimes serve multiple institutions, often within a single hospital system. Tele-ethics programs have been initiated in many countries, with a variety of staffing structures to assist when local resources are not available.<sup>5</sup>

### 3 | RESPONSIBILITIES OF HOSPITAL ETHICS COMMITTEES

Hospital ethics committees are “a body of persons established by a hospital or health care institution and assigned to consider, debate, study, take action on, or report on ethical issues that arise in patient care.”<sup>6,7</sup> Hospital ethics committees empower patients, families, clinicians, hospitals, and health systems to “address ethical issues that arise in patient care and facilitate sound decision making that respects participants’ values, concerns, and interests.”<sup>8</sup> Hospital ethics committees develop policies, advance education, and provide ethics consultations, usually via a smaller expert group.<sup>5,9</sup> In short, hospital ethics committees exist to share responsibility for difficult decisions,<sup>1</sup> for the benefit of patients, physicians, and institutions.<sup>10</sup>

Hospital ethics committees generally report to administrative leadership or the board of directors of the institution. These deliberative bodies have a presence in nearly all hospitals in the United States and play a unique role in large and tertiary facilities where acuity and medical complexity make ethical quandaries a frequent occurrence.<sup>1</sup> Hospital ethics committees have historically played a central role in dispute resolution, particularly focused on issues of futility and end-of-life decision making in critical care settings such as ICUs. This work often takes place in a time and space separate from the clinical setting. For example, in the case of a patient with a prolonged stay in the ICU, and with a variety of treatment decisions to be made, there might be protracted discussions with the care team, the family, and other stakeholders to reach agreement. Moderating and assisting with this consultation is a primary function of hospital ethics committees. However, these discussions are not usually undertaken at the bedside or in an acutely time-sensitive way.

Finally, while separate entities, some hospital ethics committees also serve the institution in risk management activities, interpreting and carrying out relevant laws, regulations, and statutes, and in priority setting of the use of limited resources. There has been less clarity around the risk management function of hospital ethics committees and whether hospital ethics committees should play any role at all in risk management, although many institutions use hospital ethics committees in this capacity.<sup>11,12</sup>

### 4 | ETHICS CONSULTATIONS IN THE HOSPITAL

Hospital ethics committees usually have scheduled meetings, frequently once a month, to discuss cases, plan upcoming ethical educational events, and create and oversee the implementation of ethics-related policies within their institutions. Hospital ethics committees might also meet on an ad-hoc basis. Between formal meetings, ethics consultations take place within the hospital or other clinical areas, sometimes with one or several hospital ethics committee members participating in the consultation. The hospital ethics committee chair, along with the members on the ethics consultation service coordinate consultations and make recommendations to the clinical care teams on a rolling basis. Hospital ethics committee members sometimes also

bring specific cases to the entire hospital ethics committee during scheduled meetings or discussion or to review for additional recommendations.

Although ethics consultations can take place in any clinical setting, in most hospitals they occur within the ICU. This is due, in part, to the fact that scheduled consultations may be more convenient for treatment teams and consultants, during regular business hours. Critically ill patients have complex plans of care, frequently complicated by psychosocial or religious issues. Patients often have protracted ICU stays, permitting an ethics consultation to take place over several days. Nevertheless, care plans can be developed in the ED, which may preclude the need for in-patient consultations. It is not unusual for patients and families to find difficulty sorting out their wishes when an emergency occurs. Lack of timely availability of ethics consultants presents an obstacle for emergency physicians.

Ethics consultations are usually initiated because the clinical team wants input and guidance regarding next courses of action, recommendations on stopping non-beneficial treatments or continuing aggressive care. Sometimes consultants help with matters of moral distress on the part of caregivers. By helping to clarify ethical issues and values, facilitating discussion, and providing expertise and educational resources, ethics consultants aim to promote respect for the values, needs, and interests of all participants, especially when there is disagreement or uncertainty about treatment decisions.<sup>13</sup> Ethics consultations cover a wide variety of topics, such as informed consent, appropriate appointment of health proxies, patient privacy issues, public safety, and provider interaction with local officials and media. Although ethics consultants make suggestions and recommendations to help guide appropriate actions, care teams are not required to follow them.

Hospital ethics committees typically are comprised of members from a wide variety of health care professions and medical specialties, yet emergency physicians are not always members. Some hospital ethics committee members may be unfamiliar with the unique environment of the ED, including time constraints and the absence of an ongoing therapeutic relationship with the patient and family that create a different dynamic for ethics consultations for patients in the ED.

### 5 | OBTAINING ETHICS CONSULTATIONS

In most institutions, anyone involved in the care of a patient can request an ethics consultation. This open door policy is designed so that providers, staff, patients, and families can seek assistance with an ethical issue or dilemmas at will to reduce moral distress of staff and clinical teams, ease the burden on families, and to assist institutions.

The hospital operator often has a pager or contact information for the hospital ethics committee or ethics consultation service. The person who responds may be the head of the hospital ethics committee or another member of the ethics consultation service. Unfortunately, in most places a rapid response can be obtained only during

regular business hours. This has clear implications for emergency physicians attempting to resolve time-sensitive ethical dilemmas in the ED.

Ethics consultants usually ask for information about the patient's medical condition and the ethics question that the ethics consultant is confronting.<sup>14</sup> Certain issues, such as hospital policy questions, may be initiated or handled over the phone whereas more complex issues often require in-person support. For ethics consultation requests regarding patients in the ED, ED leadership should also be available by telephone to help guide decisions.

In cases where ethical issues exist and the patient is going to be admitted, requesting an ethics consultation can be helpful. An ethics consultation initiated in the ED might not have enough time to address all the patient's and provider's concerns, but it can still serve an important role in patient care. The trajectory of care is sometimes established in the ED.<sup>15,16</sup> Ethics consultations can help prepare teams for future care discussions or advise on next steps to address the complexity of the patient's care.

Engaging the hospital ethics committee for patients in the ED can help to develop the skills and working relationships to understand the nuances of and approach to ethical challenges in the ED better. Ethics programs should discuss the consultation processes with the ED leadership to clarify when and how ethics team members will be available for an ED consult, by phone or in person. Improved awareness of the unique ethical challenges faced in the ED can result in better and more proactive approaches to meeting the needs of all stakeholders.

In times of scarce resources, including during pandemics, having guidelines and processes in place prior to individual patient encounters serves to minimize, or eliminate the need for the individual emergency physician to ration care according to her or his individual opinions. Hospital ethics committees should have a role in developing such protocols in consultation with stakeholders including emergency physicians.

## 6 | WHEN ETHICS CONSULTATION IS NOT AVAILABLE: THE 2-MINUTE DRILL

In American football, "the 2-minute drill" is vernacular for a play-calling strategy implemented when the time is running out and the team has to make practiced decisions. Using this analogy, 2-minute drills exist in the ED for cardiac arrest, seizures, anaphylaxis, and other conditions. Similarly, the emergency physician should be equipped to address the ethical challenges described in the cases at the beginning of this article. No answer will be perfect or reached with universal agreement; however, a logical approach should be taken. In the absence of hospital ethics committees, consultation services, or legal and administrative resources, emergency physicians should have their own practiced strategies in place to resolve anticipated time-sensitive ethical dilemmas. The emergency physician should be familiar with POLST and other advance care planning documents, with state statutes that identify surrogate decision makers for patients who lack decision making capacity, as well as with core principles and guidelines of medical ethics. The

emergency physician should apply the relevant decision making strategies and document the rationale for those decisions in the chart. Communicating providers' reasoning and decision making will help other providers understand the plan of care in the ED and the next steps in management.

## 7 | RECOMMENDATIONS FOR THE FUTURE

When faced with an emergent ethical dilemma, emergency physicians need to make rapid and morally defensible clinical judgments, relying on their skills as clinicians, patient advocates, and educators. The hospital's risk management department might be available to address legal questions. Physicians, however, may be better served by colleagues who can provide contemporaneous ethics consultation.

With this in mind, emergency physicians should be encouraged to participate in their institutions' hospital ethics committee. Educating colleagues about ED care can help them to appreciate the special circumstances that restrict emergency physicians' options, including time constraints, resource limitations, and unfamiliarity with a given patient's history and values. Highlighting the need for timely consultation can prompt the development and use of prospective strategies for making morally defensible treatment decisions in emergent situations. We make the following recommendations, recognizing that some of these will require the combined efforts of leaders, educators, and administrators from local hospitals and institutions, as well as our national organizations:

1. availability of a member of the hospital ethics committee or ethics consultation service to provide consultation for ED patients concurrent with patient care;
2. appointment to the hospital ethics committee of an emergency physician who is familiar with bioethical principles and is available for consultation when other ethics consultants are not;
3. development of educational tools by professional societies or similar organizations to assist emergency physicians in making cogent clinical ethics decisions; and
4. that the creation of guidelines and protocols for rationing in pandemic situations be done by appropriately constituted task forces or committees (including the ethics committee) and approved by the institution's governing body in advance and not at the bedside for a given patient.

## 8 | CONCLUSION

The real-time demands of the ED make immediate access to ethics consultation difficult if not impossible. When emergency physicians face ethical dilemmas, they should request consultation, but they should also familiarize themselves with strategies to facilitate prompt ethical decision making. Involvement of emergency physicians with hospital ethics committees may foster greater understanding of the unique ethical challenges in the ED and create more effective relationships with

hospital ethics committees and ethics consultation services. The overarching goal should be a team approach to optimize the quality of moral decision making in the ED, including access to ethics consultation services for ED patients.

### CONFLICTS OF INTEREST

The authors declare no conflicts of interest.

### REFERENCES

1. Tapper EB. Consults for conflict: the history of ethics consultation. *Proc (Baylor Univ Med Cent)*. 2013;26(4):417-22.
2. Aulisio MP. Why did hospital ethics committees emerge in the US? *AMA J Ethics*. 2016;18(5):546-553.
3. Courtwright A, Jurchak M. The evolution of American Hospital Ethics Committees: a systematic review. *J Clin Ethics*. 2016;27(4):322-340.
4. Larcher V. Role of clinical ethics committees. *Arch Dis Child*. 1999;81(2):104-106.
5. Subramanian, S, Pamplin, JC, Hravnak, M, et al. Tele-critical care: an update from the Society of Critical Care Medicine Tele-ICU Committee. *Crit Care Med*. 2020;48(4):553-561.
6. Hajibabae F, Joolae S, Cheraghi MA, Salari P, Rodney P. Hospital/clinical ethics committees' notion: an overview. *J Med Ethics Hist Med*. 2016;9:17.
7. Powell LT. Hospital ethics committees and the future of health care decision making. *Hosp Mater Manage Q*. 1998;20(1):82-90.
8. American Medical Association (AMA) Ethics Committees in Health Care Institutions. Code of Medical Ethics Opinion 10.7. Available at: <https://www.ama-assn.org/delivering-care/ethics/ethics-committees-health-care-institutions>. Accessed February 5, 2020.
9. Aulisio MP, Arnold RM. Role of ethics committee: helping to address value conflicts or uncertainties. *Chest*. 2008;134(2):417-424.
10. McLean SAM. What and who are clinical ethics committees for? *J Med Ethics*. 2007;33(9):497-500.
11. McGee GE, Spanogle JP, Caplan AL. Successes and Failures of Hospital Ethics Committees: a national survey of ethics committee chairs. *Camb Q Healthc Ethics*. 2002;11(1):87-93.
12. Annas G, Grodin M. Hospital ethics committees, consultants, and courts. *AMA J Ethics*. 2016;18(5):554-59.
13. Ethics Consultations: Code of Medical Ethics Opinion 10.7.1. *AMA: Ethics*. <https://www.ama-assn.org/delivering-care/ethics/ethics-consultations>. Accessed February 5, 2020.
14. Lamba S, Quest TE, Weissman D. #298 Palliative Care Consultation in the Emergency Department. *Palliative Care Network of Wisconsin: Fast Facts and Concepts*. 2015. <https://www.mypcnow.org/fast-fact/palliative-care-consultation-in-the-emergency-department/>. Accessed February 5, 2020.
15. Penrod JD, Deb P, Dellenbaugh C, et al. Hospital-based palliative care consultation: effects on hospital cost. *J Palliat Med*. 2010;13(8):973-979.
16. Rosenberg M, Rosenberg L. Integrated model of palliative care in the emergency department. *West J Emerg Med*. 2013;14(6):633-636.

**How to cite this article:** Baker EF, Geiderman JM, Kraus CK, Goett R, the Ethics Committee of the American College of Emergency Physicians. The role of hospital ethics committees in emergency medicine practice. *JACEP Open*. 2020;1:403-407. <https://doi.org/10.1002/emp2.12136>