The emergency physician (EP) provides care and takes medical decisions based on real-time evaluation of the patient’s history, physical findings and diagnostic studies. He/she needs a bulk of skills to treat a wide variety of injuries and illnesses in patients of all ages with differing way of thinking and religious, political, cultural, and personal beliefs. The principles of Emergency Medicine are simple questions that must be answered to provide effective care ("is this patient about to die?", what steps must be undertaken to stabilize the patient?", "what are the most potentially serious causes of the patient’s presentation?", and so on).

In the rush of providing effective response to emergency, EP work stands on sound medical knowledge, clinical guidelines, and personal experience. The fear of medical malpractice lawsuits has raised much attention also on the legal aspects of emergency care. Attention is concentrated on consent, psychiatric aspects, abandonment, privacy, but little attention has been payed to the moral and ethical aspects of the peculiar patient-doctor relationship in the Emergency ward. On the contrary, on top of the diagnostic and therapeutic challenges, EP faces questions such as "is my approach feasible, sound, appropriate, and accepted by the patient? Is such ambulance diversion ethically appropriate?" and so on that need preparedness.

Aim of this brief introduction is to provide key information on the basic bioethics principles that form the basement of the everyday clinical work in the Emergency Department, to which to refer in case of uncertainty.

Health Law and Bioethics: similarities and differences

In everyday clinical duties EP may believe that he/she is following the patients according to bioethics principles because the clinical practice is in accordance with health law, but this is not correct as bioethics and health laws have different origins and contents. Health Law and Bioethics are relatively young disciplines that emerged at the same time under the pressure of the human rights movements and alongside the implementation of a human rights approach into health care practice [1].

Ethics and law determine a normative framework of health care, but there are important differences in their shaping of the health care decision making. First, they differ in motivation. Motivation to follow moral rules is personal and it flows from deep beliefs and convictions based on cultural tradition, religious or philosophical views. Motivation to follow the law may be imposed by the fear of sanctions that are part of the law. Second, the law should be based on consensus and agreement, while moral positions and ethical evaluation of controversial issues may be dramatically different. Third, the legal point of view should provide clear normative standards of professional conduct based on a consensus seeking process, while the bioethical approach aims to raise questions on difficult health care choices and let the health care practitioner choose among different and competing moral scenarios [2].

There are also important distinctions between ethical principles and values in health care, on one hand, and written laws and regulations, on the other. Principles are moral guidelines that we consider we should follow, and values are the moral references in which we trust. They do not derive from written regulations, like biolaw. On the contrary, biolaw is based on written rules that dictate activities that are coherent with previously recognized principles and values [3].

The language of the law, with its emphasis on rights and individual autonomy, is an inapt tool to describe and resolve complex interactions and dilemmas in patient care [4]. When EP are confronted with difficult ethical dilemmas, they often turn to the law to answer the questions. However, law is just one factor to consider among many others, although it is important to know when and how the law applies to emergency medicine [5].

The bases of Bioethics in the Emergency Department

The Emergency Department is not an ideal place to reflect on difficult ethical issues [6]. However, EP should have a framework for ethical decision making that can be applied to the situation at hand, as ethical issues are likely to arise in emergency medical practice that involve legal factors as well. In this situation EP should consider the ethical issues first and then turn to the law for its contribution to guidance for action.

In 2004, the European Commission supported the European Hospital-based Bioethics Project (EHBMP) that brought together bioethics expertise from ten European countries (France, Germany, Italy, Lithuania, the Netherlands, Poland, Portugal, the Slovak Republic, Slovenia, and the United Kingdom) to promote extensive Bioethics education in hospitals throughout Europe. One of the outcomes of the project was a didactic book to which the interested reader may refer [7].
Autonomy, beneficence, non-maleficence, and justice are the key four principles that form the foundation of Bioethics. They were developed in the 1970s and rapidly took an important place in the field of Bioethics in USA [9]. They are known as the Big Four. More recently in Europe a similar effort to identify bioethical principles has been made by the working group of the Bioethics Principles in Bioethics and Biowork research project that were enclosed in the Barcelona Declaration [9]. They are again four and include autonomy, dignity, integrity and vulnerability.

EP activity should comply with the Big Four, but respect the patient autonomy is by far the most problematic one. Its main consequence is the obligation of ensuring appropriate informed consent to the health care, but there are many occasions in which autonomy is impaired by temporary or permanent diseases and disabilities, drug use, pain and so on. This implies that the question of autonomy should be addressed at any diagnostic and therapeutic step, continuously during care. It is not sufficient to identify a competent substitute decision maker, thus passing up the direct participation of the person.

The difficulty of respecting the principle of autonomy is testified by the fact that it was added to the Declaration of Geneva by the World Medical Association (WMA) only in 2017, almost seventy years after its first adoption [10]. The World Medical Association Declaration of Geneva outlines the professional duties of physicians and affirms the ethical principles of the global medical profession. The most notable difference between the previous version of the Declaration of Geneva and other key ethical documents, such as the WMA’s Declaration of Helsinki [11] and the Declaration of Taipei [12], was the lack of overt recognition of patient autonomy, previously guided by a paternalistic approach. Now at the beginning it reads “As a member of the medical profession: ... I will respect the autonomy and dignity of my patient...”.

Respect of autonomy in difficult situations

Beneficence, non-maleficence, and justice, that have been included in the Hippocratic oath for 2500 years (IV century bc), are easily understood by medical professionals and lay people. Yet, they may conflict with the newly added respect of patient’s autonomy.

Treating patients with respect requires doctors to accept the medical decisions of persons who are informed and acting freely. Individuals place different values on health, medical care, and risk. In most clinical settings, different goals and approaches are possible, outcomes are uncertain, and an intervention may cause both benefits and harms. Thus, it is not uncommon that competent, informed patients may refuse recommended interventions and choose among other reasonable alternatives.

Patients’ refusals of care may thwart their own goals or cause them serious harm. For example, a young man with asthma may refuse mechanical ventilation for reversible respiratory failure. Simply to accept such refusals, in the name of respecting autonomy, seems morally constricting. Physicians can elicit patients’ expectations and concerns, correct misunderstandings, and try to persuade them to accept beneficial therapies. If disagreements persist after discussions, the patient’s informed choices and view of his or her best interests should prevail. While refusing recommended care does not render a patient incompetent, it should lead the physician to probe further to ensure that the patient is able to make informed decisions.

To EP, this is certainly the most challenging bioethical task: how to convince the patient to accept a reasonable medical proposal, when its refusal may expose him or her to an unacceptable risk, while respecting autonomy, beneficence, non-maleficence and justice, that conflict in this case?

There is no simple solution, but some steps can be suggested. EP should, first, try to establish an empathic connection with the patient by developing rapport and agreeing on agenda, assess the patient’s response to illness and suffering, communicate to foster healing, use the power of touch, laugh a little. Second, it is mandatory to unravel the reasons of the refusal, to understand fear and hopes, explore past negative experiences, encourage any declaration of distrust, elicit, whenever possible, help and advice of relatives and friends, and offer consultation of a different professional in whom he/she may trust, before letting him/her leave the Emergency Room. Third, all these necessary efforts will be registered in the medical records together with their elicited effects.

REFERENCES