



American College of
Emergency Physicians®

ADVANCING EMERGENCY CARE 

POLICY STATEMENT

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Code of Ethics for Emergency Physicians

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I. PRINCIPLES OF ETHICS FOR EMERGENCY PHYSICIANS

The basic professional obligation of beneficent service to humanity is expressed in various physicians' oaths and codes of ethics. In addition to this general obligation, emergency physicians accept specific ethical obligations that arise out of the unique features of emergency medical practice. The principles listed below express fundamental moral responsibilities of emergency physicians.

1. Emergency physicians shall embrace patient welfare as their primary professional responsibility.
2. Emergency physicians shall respond promptly and expertly, without prejudice or partiality, to the need for emergency medical care.
3. Emergency physicians shall respect the rights and strive to promote the best interests of their patients, particularly the most vulnerable and those with impaired decision-making capacity.
4. Emergency physicians shall communicate truthfully with patients and secure their informed consent for treatment, unless the urgency of the patient's condition demands an immediate response or another established exception to obtaining informed consent applies.
5. Emergency physicians shall respect patient privacy and disclose confidential information only with consent of the patient or when required by an overriding duty such as the duty to protect others or to obey the law.
6. Emergency physicians shall deal fairly and honestly with colleagues and take appropriate action to protect patients from health care professionals who are impaired or incompetent, or who engage in fraud or deception.
7. Emergency physicians shall work cooperatively with others who care for, and about, emergency patients.
8. Emergency physicians shall engage in ongoing study to maintain the knowledge and skills necessary to provide high quality care for emergency patients.
9. Emergency physicians shall act as responsible stewards of the health care resources entrusted to them.
10. Emergency physicians shall support societal efforts to improve public health and safety, reduce the incidence of injury and illness, and secure equitable access to emergency and other basic health care for all.

II. ETHICS IN EMERGENCY MEDICINE: AN OVERVIEW

A. Ethical Foundations of Emergency Medicine

Although professional responsibilities have been a concern of physicians since antiquity, recent decades have seen dramatic growth of both professional and societal attention to moral issues in health care. This increased interest in biomedical ethics is a result of multiple factors, including technological advances, recognition of social inequities in medicine, easier patient access to medical information, efforts to provide health care to marginalized groups, and the persistently rising costs of health care. All these factors contribute to the significance, the complexity, and the urgency of moral questions in contemporary emergency medicine.

1. Moral pluralism

Emergency physicians can utilize a variety of sources for ethical guidance, including professional oaths and codes of ethics, cultural values, social norms embodied in the law, religious and philosophical moral traditions, clinical experience, practical reasoning skills, and professional role models. These sources claim moral authority, and together they can inspire

physicians to lead rich and committed moral lives. Problems arise, however, when different sources of moral guidance come into conflict. Numerous attempts have been made to propose and defend an overarching moral theory able to assess and prioritize moral claims from all their various sources. Lacking agreement on the primacy of any one of these theories, however, emergency physicians are left with multiple sources of moral guidance. The primary goal of bioethics is to help health care professionals and patients understand, interpret, and weigh competing moral values as they seek reasoned and defensible solutions to moral problems encountered in health care.

2. Moral challenges of emergency physicians

The unique setting and goals of emergency medicine give rise to a number of distinctive moral challenges, including the following:

- a. Patients often arrive at the emergency department (ED) with acute illnesses or injuries that require immediate care. In these emergent situations, emergency physicians have little time to gather additional data, consult with others, or deliberate about alternative treatments. Instead, there is a presumption for quick action guided by established treatment protocols.
- b. Patients in the ED often are unable to participate in decisions regarding their health care due to acute changes in their mental state. When patients lack decision-making capacity, emergency physicians cannot secure their informed consent to treatments.
- c. Emergency physicians typically have had no prior therapeutic relationship with their patients in the ED. Patients often arrive in the ED unscheduled, in crisis, and sometimes against their will. Thus, emergency physicians cannot rely on earned trust or on prior knowledge of the patient's condition, values, or wishes regarding medical treatment. The patient's willingness to seek emergency care and to trust the physician is based on institutional and professional assurances rather than on an established personal relationship.
- d. Emergency physicians typically practice in an institutional setting, the hospital ED, and in close working relationships with other physicians, nurses, emergency medical technicians, and other health care professionals. Thus, emergency physicians must understand and respect institutional regulations and inter-professional norms of conduct.
- e. In the United States, emergency physicians have a unique social role and responsibility to assess and treat patients who have no other ready access to care.
- f. Emergency physicians have a societal duty to render emergency aid outside their normal health care practice setting when they are able to provide an intervention that may save life or limb.
- g. By virtue of their broad expertise and training, emergency physicians are expected to be a resource for the community in out-of-hospital care, epidemic care, disaster management, toxicology, cardiopulmonary resuscitation, public health, injury control, and related areas.

All of these special circumstances shape the moral dimensions of emergency medical practice.

3. Virtues in emergency medicine

As noted above, the ED is a unique practice environment with distinctive moral challenges. To respond appropriately to these moral challenges, emergency physicians need knowledge of moral concepts, principles, and reasoning skills. Of equal importance, however, are praiseworthy attitudes, character traits, and dispositions, identified in ethical theory as *virtues*. The virtuous person is motivated to act in accordance with his or her moral beliefs and ideals, and he or she serves as a role model for others. It is therefore helpful to identify and promote the moral virtues needed by emergency physicians. Fostering these virtues can be a kind of moral vaccination against the ethical pitfalls inherent in emergency medical practice. Two

timeless virtues of Western thought have essential roles in emergency medicine today: *courage* and *justice*.

Courage is the ability to fulfill one's obligations despite personal risk or danger. The courageous physician advocates for patients against financial gatekeepers, demanding employers, interrogating police, inexperienced trainees, dismissive consultants, unconcerned families, and inquiring reporters, among others. Emergency physicians exhibit courage when they assume personal risk to provide steadfast care for all emergency patients, including those who are agitated, violent, infectious, and the like. Emergency physicians also exhibit courage when they speak out against conditions that compromise high quality patient care, including lack of PPE, inadequate nursing staffing, unreasonable expectations of patients seen per hour, and unreasonable expectations to admit patients.

Justice or fairness is the disposition to give each person what is due to him or her. Justice helps emergency physicians shepherd resources, make appropriate triage decisions, and employ therapeutic parsimony, refusing marginally beneficial care to some while guaranteeing a basic level of care for all others.

Additional significant virtues in the practice of emergency medicine are *vigilance*, *impartiality*, *trustworthiness*, and *resilience*.

Vigilance is perhaps the virtue most emblematic of emergency medicine. In no other specialty do physicians provide immediate assistance, at any time, for patients across the entire spectrum of medical conditions. Emergency physicians must be alert and prepared to meet unpredictable demands, despite the circadian disharmony that threatens personal wellness.

The virtuous emergency physician practices *impartiality* by giving emergency patients unconditional positive regard and treating them in an unbiased way. Impartiality is essential in emergency medicine, since ED patients can be impoverished, marginalized, or incapacitated, have limited health literacy, or hold value systems different from that of the physician. For example, emergency physicians must treat alleged perpetrators of violent crime with the same regard as victims. Emergency physicians must resist prejudice toward people of different races, creeds, customs, habits, and lifestyle preferences.

Another essential virtue of emergency physicians is *trustworthiness*. Because they are vulnerable, ED patients rely on emergency physicians to provide competent care for them, including truthful communication, respect for their treatment decisions and values, and protection of their personal health information. Emergency physician clinical investigators must also be trustworthy, so that patient-subjects can trust they will not be exploited for power, profit, or prestige.

Finally, emergency physicians require the virtue of *resilience* to remain composed, flexible, and competent in the midst of clinical chaos. A tired, overstressed ED staff needs elasticity, optimism, support, and cooperation to stave off cynicism, resignation, disillusionment, numbing and professional burnout.

Resilience enables emergency physicians to meet the challenges of difficult situations and to encourage others to do so also. Resilience enables recovery from change or misfortune. For example, it enables professionals to respond calmly to challenges from upset patients, bereft families, or dissatisfied coworkers. Resilient persons are hardy, curious, purposeful, and adaptable; they trust in their ability to influence the course of events. Maintaining flexibility

and coping with the typical circadian disharmony of emergency medical care is difficult, making the virtue of resilience essential.

B. The Emergency Physician-Patient Relationship

The physician-patient relationship is the moral center of medicine and the defining element in clinical ethics. The unique nature of emergency medical practice and the diversity of ED patients pose special moral challenges, as noted above. This section will rely on a prominent principle-based approach to bioethical theory to identify and describe emergency physician duties of beneficence, nonmaleficence, respect for autonomy, and justice.

1. Beneficence

Physicians assume a fundamental duty to serve the best interests of their patients by treating or preventing disease or injury and by informing patients about their conditions. Emergency physicians respond promptly to acute illnesses and injuries in order to prevent or minimize pain and suffering, loss of function, and loss of life. In pursuing these goals, emergency physicians serve the principle of beneficence, that is, they act for the benefit of their patients.

Emergency physicians' duty to provide beneficent care requires that they report for their shifts when medically able and treat all patients who present to the ED, unless caring for a patient poses significant risks to their own health or safety. Hospitals and health systems should take the necessary steps to mitigate risks to emergency physicians, but the physician's duty to care persists even when risks cannot be entirely mitigated.

To secure the benefits of health care, patients disclose sensitive personal information to their physicians and allow physicians access to their bodies for examination and treatment. Patients retain a strong interest, however, in protecting personal information from unauthorized disclosure and in preventing unnecessary intrusions on their physical privacy. Emergency physicians also respect the principle of beneficence, therefore, by protecting the privacy of their patients and the confidentiality of patient information. Personal information may only be disclosed when such disclosure is necessary to carry out a stronger conflicting duty, such as a duty to protect an identifiable third party from serious harm or to comply with a just law.

Telehealth and telemedicine offer new opportunities to provide beneficent care for patients. In their use of these modalities, however, emergency physicians must continue to prioritize patient interests, provide quality care, enable patients to make informed treatment choices, protect the confidentiality of patient information, and ensure continuity of care.

2. Nonmaleficence

At least as fundamental as the duty to benefit patients is the corresponding duty to refrain from inflicting harm. This duty, called the duty of nonmaleficence, is central to maintaining the emergency physician's integrity and the patient's trust. In contemporary emergency medical care, the potential for significant patient benefit is often inescapably linked with the potential for significant complications, side effects, or other harms. Emergency physicians cannot, therefore, avoid inflicting harms, but they can respect the principle of nonmaleficence by not initiating treatments likely to cause more harm than benefit, and by seeking always to maximize the benefits of treatment and to minimize the risk of harm. In order to protect patients from avoidable harm, physicians who lack appropriate training and experience in emergency

medicine should not misrepresent themselves as emergency physicians and should not practice without supervision in the ED or prehospital setting.

To achieve the beneficent goals of health care, and to minimize the harm of inappropriate behavior, laws, regulations, guidelines and institutional policies have established a variety of professional boundaries.

Widely recognized professional boundaries in health care include:

- a. *Civility boundaries* that direct physicians to employ social conventions of respectful speech and action in their relationships with patients and colleagues;
- b. *Personal boundaries* that require separation of personal and professional relationships, including prohibition of sexual contact between physicians and patients, and strict limits on treatment of physicians' family members;
- c. *Commercial boundaries* that protect patient interests by limiting or prohibiting physician practices that create financial conflicts of interest;
- d. *Inter-professional boundaries* that define the scope of practice or different health care disciplines and specify proper and improper interaction between professionals in different disciplines.

Egregious boundary violations, including commission of crimes of fraud and of moral turpitude, may be the subject of moral complaints and disciplinary action against ACEP members, including revocation of ACEP membership.

3. Respect for patient autonomy

Adult patients with decision-making capacity have a right to accept or refuse recommended health care, and physicians have a corresponding duty to respect their choices. This right is grounded in the moral principle of respect for patient autonomy and is recognized in the legal doctrine of informed consent. According to this doctrine, physicians must inform the patient with decision-making capacity about the nature of his or her medical condition, treatment alternatives, and their expected consequences, and then obtain the patient's voluntary consent to treatment.

These are, however, significant exceptions to the duty to obtain informed consent, as follows:

- a. If a patient lacks decision-making capacity, emergency physicians should respect reasonable decisions about the patient's treatment made by an appropriate surrogate decision maker. Emergency physicians should be adept at the determination of decision-making capacity and the identification of appropriate surrogate decision makers.
- b. Emergency physicians may treat without securing informed consent when immediate intervention is necessary to prevent death or serious harm to the patient. When the initiation of treatment can be delayed without serious harm, informed consent must be obtained. Even if all the information needed for an informed consent cannot be provided, emergency physicians should, to whatever extent time allows, inform the patient (or, if the patient lacks capacity, a surrogate) about the treatment they are providing.
- c. Patients may, for personal or cultural reasons, ask that information be given to family members, caregivers, or friends and that these third parties be allowed to make treatment choices for the patient. Patients may, if they wish, waive their right to informed consent or delegate decision-making authority for their care to others.
- d. The duty to obtain informed consent may be overridden when patient isolation or treatment is necessary to protect the public health or safety.

- e. The duty to obtain informed consent also may be modified or waived in a limited number of emergency medicine research studies where obtaining consent is not feasible, provided that these studies satisfy the values described in this Code of Ethics as well as the requirements of federal research regulations, including approval by appropriate review bodies.

To choose and act autonomously, patients need accurate information about their medical conditions and treatment options. Emergency physicians must therefore relay sufficient information to patients or their surrogate decision makers to enable them to make an informed choice among various diagnostic and treatment options. Emergency physicians, when speaking to patients and families, must not overstate their experience or abilities, or those of their colleagues or institution. They must not overstate the potential benefits or success rates of proposed treatments or research.

Significant moral issues may arise in the care of terminally ill patients. Emergency physicians should, for example, be willing to respect a terminally ill patient's wish to forgo life-prolonging treatment, as expressed in an advanced directive or by an authorized surrogate decision-maker. Emergency physicians should also honor portable medical orders, including Do Not Attempt Resuscitation (DNAR) orders and POLST orders. Emergency physicians should understand and facilitate institutional procedures for the determination of death by neurologic criteria and for the identification of organ donors.

4. Justice

In a broad sense, acting justly can be understood as acting with impartiality or fairness. In this sense, emergency physicians have a duty of justice to provide care to patients regardless of race, ethnicity, creed, gender, nationality, sexual orientation, or other irrelevant characteristics. In a more specific sense, justice refers to the equitable distribution of benefits and burdens within a community or society. In the United States, public policy has established a limited right of patients to receive evaluation and stabilizing treatment for emergency medical conditions in hospital EDs. This policy indirectly ascribes to emergency physicians a social responsibility to provide necessary emergency care to all patients, regardless of ability to pay. As noted in the Principles of Ethics for Emergency Physicians listed above, emergency physicians also have a duty in justice to act as responsible stewards of the health care resources entrusted to them. In making triage decisions, for example, emergency physicians allocate medical resources in order to maximize benefits without bias, minimize harm, and respect the rights of all patients.

C. The Emergency Physician's Relationships with Other Professionals

The practice of emergency medicine requires multidisciplinary cooperation and teamwork. Emergency physicians interact closely with a wide variety of other health care professionals, including emergency nurses, emergency medical technicians, and physicians from other specialties. General ethical principles governing these interactions include honesty, respect, appreciation of other professionals' perspectives and needs, and an overriding duty to provide beneficent patient care.

1. Relationships with other physicians

Emergency physicians must interact with other physicians to achieve their primary goal of benefitting patients. Channels of communication among physicians must remain open to optimize patient outcomes. Communication may, however, be delayed when a sick patient

requires immediate and definitive intervention before discussion with other physicians can take place. When practical, emergency physicians should cooperate with the patient's primary care physician to provide continuity of care that satisfies the needs of the patient and minimizes burdens to other health care professionals. Emergency physicians should support the development and implementation of systems that facilitate communication with primary care physicians, consultants, caregivers, and others involved in patient care.

On-call physicians, like emergency physicians, are morally obligated to provide timely and appropriate emergency medical care. Emergency physicians should strive to treat consultants fairly and to make care as efficient as possible. In choosing consultants, emergency physicians may be guided by primary care physicians, patients and institutional protocols. If multiple physicians work in the ED, each patient should have clearly identified physician who is responsible for his or her care. Transfer of this responsibility should be communicated clearly to the patient, family, caregivers, and staff and should be clearly documented in the patient's medical record. When a patient is discharged from the ED, there must be a clearly communicated transfer of responsibility to the admitting inpatient physician or follow-up outpatient physician.

Physicians with disabilities, injuries, or transmissible diseases such as HIV infection may practice emergency medicine if their conditions do not inhibit proper performance or constitute a threat of harm to patients or others.

The Principles of Ethics for Emergency Physicians also recognize a duty to take appropriate action to protect patients from health care professionals who are incompetent or impaired, or who engage in fraud or deception. Those actions may include reporting, peer review, measures to protect patients from substandard care, and mechanisms to assist physicians in addressing and overcoming deficiencies.

Corrective action may include internal discipline and remedial training. To provide adequate protection for patients, health care institutions should require appropriate remediation before the impaired physician returns to practice.

Whenever an emergency physician believes that a colleague or consulting physician is incompetent or impaired by drug use, alcohol, or psychiatric or medical conditions, he or she should first take necessary measures to protect patients from harm. He or she should also approach the colleague to communicate the concern and give the person an opportunity to seek assistance. If this does not promptly address the concern, he or she should report the impaired physician to the appropriate institutional and regulatory authorities. This should be done with discretion and sensitivity and with a clear intention to protect patients from harm and to help the impaired physician obtain treatment and progress toward recovery. Physicians who conscientiously fulfill this responsibility should be protected from adverse legal or financial consequences.

2. Relationships with nurses and other health care professionals

Although emergency physicians assume primary responsibility for patient care, emergency medicine is a team effort. For all of their patients, physicians must coordinate the efforts of nurses and other health care professionals. Emergency physicians and ED administrators should ensure that patients are aware of the license level and scope of practice of each clinician who is participating in their care. To make the most effective use of the specific skills and expertise of the various professionals practicing in EDs, all should participate in the design and implementation of ED care systems and protocols.

In the out-of-hospital setting, emergency medical technicians of all levels rely on and rightfully expect the cooperation and guidance of the emergency physicians with whom they work. Base-station command physicians and other emergency care professionals should strive to work harmoniously with prehospital personnel to optimize care for the patient. Patient-centered, nonjudgmental, open communication is an essential part of ethical medical command. Hospital and prehospital professionals must respect patient confidentiality and the dignity of all personnel involved.

While emergency physicians may have greater expertise in scientific and technical matters, they share responsibility with other health care professionals for making and carrying out moral choices. Physicians should therefore encourage involvement of other health care professionals when difficult moral issues arise.

3. Relationships with business and administration

Emergency physicians should advocate for emergency medical care as a fundamental right. Cooperation with experts in the management and administration of health care systems is essential for provision of efficient and cost-effective care, so that resources are available to provide care when it is needed. A central responsibility of physicians is to keep patient interests paramount in administrative and business decisions. The ability of emergency physicians to fulfill their fundamental responsibility to provide beneficial medical care for their patients depends, in turn, on basic societal responsibilities to establish and support an effective health care system.

Incentives from businesses, including for-profit and not-for-profit health care organizations and biomedical drug and equipment manufacturers, should not influence patient-centered clinical judgment. Gatekeeping activities that threaten patient safety are unethical, as are “gag clauses” in employment contracts that prevent physicians from informing patients about reasonable treatment alternatives. Physicians should not accept inappropriate gifts or other items from pharmaceutical, medical device, medical equipment, or biotechnology companies or their representatives.

Contractual relationships between emergency physicians and physician practice groups should be fair to all parties involved. Emergency medicine business practices must be transparently ethical, and emergency physician compensation should take into account both clinical and administrative services they provide. Disagreements arising from contractual arrangements should be arbitrated appropriately using a due process approach, whenever possible.

4. Relationships with students, trainees, and other learners

Emergency physicians practicing in academic settings have substantive moral responsibilities to medical students, trainees, out-of-hospital care personnel, and learners of all types. Learners depend on their clinical supervisors and professors to teach them both the moral and technical aspects of emergency medical practice. Practicing emergency physicians should serve as role models for ethical behavior in their relationships with patients, students, residents, fellows, and other health care professionals. In addition to positive duties to teach, supervise, and evaluate their trainees, academic physicians have negative duties to refrain from mistreatment, abuse, or coercion of those trainees.

Performance evaluations and letters of recommendation require careful, honest, and unbiased assessment of learners' strengths and weaknesses. In addition to mastering emergency medicine's essential skills and knowledge, emergency medicine residents and fellows should strive to understand and embrace their moral duties to patients, the profession, and society. Patient interests should not be compromised in the education process.

5. Relationships with the legal system as an expert witness

Expert witnesses are called on to assess the appropriateness of care provided by emergency physicians in matters of alleged medical malpractice and peer review. To assure that unbiased expert witness testimony is available to courts and panels that determine the applicable standard of care, emergency physicians with sufficient expertise should be encouraged to testify in these venues. Emergency physician expert witnesses should, at a minimum, be certified in emergency medicine by the American Board of Emergency Medicine (ABEM), the American Osteopathic Board of Emergency Medicine (AOBEM), or, in pediatric emergency medicine, by the American Board of Pediatrics (ABP), and who have been actively practicing clinical emergency medicine for at least three years prior to the date of the incident under review.

As an expert witness, the physician has a clear ethical responsibility to be objective, truthful, and impartial, evaluating cases on the basis of generally accepted practice standards. It is unethical to overstate one's opinions or credentials, to misrepresent maloccurrence as malpractice, to provide false testimony, or to invoke professional society memberships as prima facie evidence of expertise.

While reasonable compensation for a physician's time is ethically acceptable, physicians should not provide expert testimony solely for financial gain lest this unduly influence their testimony.

6. Relationships with the research community

Emergency physician investigators should abide by basic moral and legal principles contained in federal, institutional, and professional guidelines that govern research on human and animal subjects. Basic ethical requirements for research studies include appropriate study goals, a scientifically valid design, appropriate informed consent, confidentiality of records, and minimization of risks to subjects. Approval from appropriate institutional review boards is required, but it remains the responsibility of the investigator to protect the rights and welfare of patient-subjects. Federal regulations allow institutional review boards to grant a limited waiver of informed consent in specific emergency medicine research studies, where multiple other protections for patient-subjects are provided. It is imperative that data be collected carefully, interpreted correctly, and reported accurately; research misconduct and fraud are grounds for disciplinary action and loss of funding. Emergency physician investigators should follow responsible authorship practices; for example, all co-authors should actively participate in the study, including literature review, study design, data collection, data analysis, and manuscript preparation.

D. The Emergency Physician's Relationships with Society

1. The emergency physician and society

Emergency physicians owe duties not only to their patients, but also to the society in which they reside and practice. Though the emergency physician's duty to the patient is primary, it is not absolute. Emergency physician duties to the general public inform decision-making on a

daily basis; for example, emergency physicians have duties to allocate resources justly, oppose violence, and promote public health that sometimes transcend duties to individual patients. Emergency physicians should be active in legislative, regulatory, institutional, and educational pursuits that promote patient safety and quality emergency care.

2. Resource allocation and health care access: problems of justice

Both society and individual emergency physicians confront questions of justice in deciding how to distribute the benefits of health care and the burdens of financing that care among the various members of society. Emergency physicians routinely address these issues when they assign order of priority for treatment and choose appropriate diagnostic and treatment resources. In making these judgments, emergency physicians must attempt to reconcile the goals of equitable access to health care and just allocation of health care with the availability of resources and the need for cost containment.

3. Central tenets of the emergency physician's relationship with society

a. Access to emergency medical care is a fundamental right

As noted above, US public policy, as articulated in the federal Emergency Medical Treatment and Labor Act (EMTALA), has established access to emergency treatment as an individual right of all who seek and require it. Recognizing that emergency care makes a substantial contribution to personal well-being, emergency physicians endorse this right and support universal access to emergency care. Emergency physicians should not deny or delay emergency care on the basis of race, religion, sexual orientation, gender identity, ethnic background, social status, or ability to pay. Emergency physicians should act as advocates for the health needs of impoverished or marginalized patients, assisting them in finding appropriate care. This advocacy should include support for patient access to care for what a prudent layperson would reasonably perceive as an emergency medical condition. Society should support its establishment of a right to emergency care by providing adequate funding for all who need it.

When ED crowding limits access to care, morally defensible triage criteria should be used to determine priority for treatment.

Prehospital care is an essential societal good that emergency physicians, in conjunction with government, industry, health systems, and insurers must continue to make available to all members of society. Emergency medical technicians or paramedics should provide timely assessment of out-of-hospital patients. Decisions concerning transport to a medical facility should be made on the basis of medical need, patient preference, and the capacity of the facility to deal with medical problems.

b. Adequate inpatient and outpatient resources must be available to protect emergency patient interests

Patients requiring hospitalization for further care should not be denied access to an appropriate medical facility on the basis of financial considerations. Transfer to an appropriate accepting medical facility for financial reasons may be effected if a) the patient provides consent and b) there is no undue risk to the patient. Admission or transfer decisions should be made on the basis of the patient's best interest.

It is unethical for an emergency physician to participate in the transfer of an emergency patient to another medical facility unless the medical benefits reasonably expected from the provision of appropriate medical treatment at the receiving medical facility outweigh the risks of the transfer or unless a competent patient, or a legally responsible person acting on the patient's behalf, gives informed consent for the transfer. Emergency physicians should be knowledgeable about applicable federal and state laws regarding the transfer of patients between health care facilities.

Although emergency physicians bear primary responsibility for the care and disposition of their patients, on-call consultants should share equitably in the care of ED patients, including impoverished and/or marginalized patients. This may include an on-site evaluation by the consultant if requested by the emergency physician.

For patients who do not require immediate hospitalization but need medical follow-up, adequate outpatient medical resources should be available both to continue proper treatment of the patient's medical condition and to prevent the development of subsequent foreseeable emergencies resulting from the original medical problem.

c. Emergency physicians should promote prudent resource stewardship without compromising quality

Emergency physicians have an obligation to ensure that quality care is provided to all ED patients. Participation in quality assurance activities and peer review are important for assuring that patterns of inadequate care are detected and remedied. Participation in continuing education activities, including the development of scientifically-based practice guidelines, assists emergency physicians in providing quality care.

Emergency physicians should employ health care resources, including new technologies, on the basis of individual patient's medical and psychosocial needs and the appropriateness of the therapy as documented by medical literature. Diagnostic and therapeutic decisions should be made on the basis of potential risks and benefits of alternative treatments, including no treatment. Emergency physicians have an obligation to diagnose and treat patients in a cost-effective manner and must be knowledgeable about cost-effective strategies; but they should not allow cost containment to impede proper medical treatment of the patient.

The allocation of public resources to and within health care is necessarily a societal decision. In light of resource limitations and the lack of societal consensus on allocation issues, however, emergency physicians have dual obligations to honor patients' best medical interests and to serve as prudent stewards of health care resources.

d. Emergency physicians should respond to out-of-hospital emergencies and disasters.

Because of their unique expertise, emergency physicians have an ethical duty to respond to emergencies in the community if needed. This responsibility is buttressed by applicable Good Samaritan statutes that protect health care professionals from legal liability for good-faith efforts to render emergency medical treatment.

In a situation where the resources of a health care facility are overwhelmed by epidemic illness, mass casualties, or the victims of a natural or manmade disaster, the prudent emergency physician must make important triage decisions to benefit the greatest number

of potential survivors. When the numbers of patients and severity of their injuries overpower existing resources, triage decisions should classify patients according to both their need and their likelihood of survival. These triage decisions ideally should not be made by the same physician who would also be caring for the patient. The overriding principle should be to focus health care resources on those patients most likely to benefit and who have a reasonable probability of survival. Those patients with fatal injuries and those with minor injuries should be made as comfortable as possible while they await further medical assistance and treatment.

e. Emergency physicians should oppose violence.

Serving as a societal resource, emergency physicians have obligations to protect themselves, staff, and patients from violence and to teach EMS personnel under their supervision to do likewise. Hospitals have a duty to provide adequate numbers of trained security personnel to assure a safe environment. Ensuring safety may mean that patients who present a high risk of violence will lose some autonomy if they need to be restrained physically or chemically. Emergency physicians should ensure that restraints or medication are not used for punitive or vindictive reasons. Restraints are indicated only when there is a reasonable possibility that patients will harm themselves or others. The need for restraint of ED patients should frequently be reevaluated.

The emergency physician has an ethical duty to diagnose, treat, and properly refer suspected victims of abuse and neglect, including domestic partners, minors, and dependent adults, and to report domestic violence to appropriate authorities as required or permitted by law.

f. Emergency physicians should promote public health.

Emergency physicians advocate for public health in many ways, including the provision of basic health care for many uninsured patients. As a safety net both for patients who lack other resources of care and for victims of disaster, EDs provide needed care and assistance to many of the most vulnerable members of society. In times of disaster, pandemic, and other public health emergencies, EDs serve as the frontline against a constellation of medical and social ills.

Emergency physicians have first-hand knowledge of the grave harms caused by firearms, motor vehicles, alcohol, and other causes of preventable illness and injury. Inspired by this knowledge, emergency physicians should participate in efforts to advocate for and educate others about the potential of well-designed laws, programs, and policies to improve the overall health and safety of the public.

E. CONCLUSION

Serving patients effectively requires both scientific and technical competence, knowledge of what can be done, and moral competence, knowledge of what should be done. The technical emphasis of emergency medicine must be accompanied by a corresponding emphasis on character and careful moral reasoning, as emergency physicians increasingly confront difficult moral questions in clinical practice.

In the face of future uncertainties and challenges, ethics will remain central to the clinical practice of quality emergency medicine. Both technical and moral expertise can and should be nurtured

through advanced preparation and training. The time and information constraints inherent in emergency practice make reflection on fundamental ethical principles and values challenging. This *Code* is offered both for thoughtful consideration and as a resource when issues arise in clinical practice. The principles of emergency medical ethics identified herein may serve as a guide for practitioners and trainees. Through the process of moral reflection and deliberation, emergency physicians can make difficult and time-sensitive decisions based on a sound moral framework that respects and benefits patients, professionals, and society.

III. A COMPENDIUM OF ACEP POLICY STATEMENTS ON ETHICAL ISSUES

The policy statements listed in the Compendium section of the table of contents of this policy are available on ACEP's web site (<http://www.acep.org>).