

# CONSENT, CONFIDENTIALITY AND ALLERGY IN THE EMERGENCY DEPARTMENT

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*'There's a good reason – many, in fact – that the television drama "ER" has been a runaway hit for 8 years. The emergency room is a crucible for the medical encounter. Life-threatening illness and trauma are more likely to appear here than in the office or clinic, hence, decisions often must be made quickly. Patients' physical distress and fear push them to extremes of behaviour. Crisis, fear, strange behaviour, and the opportunity for heroic success or failure – the elements on which drama and melodrama thrive – are commonplace in the emergency room or emergency "department", as the expanded service in most hospitals is now more properly known.*

*It makes sense that these high-pressure conditions turn up the heat on the patient-physician interaction also. The personalities of individual patient and physician and the range of personal, social, and professional expectations that each brings to the interaction always have the potential to turn the medical encounter into a difficult one; they are almost certain to do so in the emergency department where patients are frequently hostile, angry, combative, or abusive if special care is not taken to avoid potential problems.'*<sup>1</sup>

## WHAT IS UNIQUE ABOUT EMERGENCY MEDICINE?

**E**mergency medicine (EM) is a relatively new specialty in South Africa, but already EM physicians have made a tremendous difference to the standard and quality of care that patients receive – in both the public and private sectors. The unique emergency department (ED) setting lends itself to a number of ethical dilemmas. Iserson maintains: 'Deep reflection is not typically part of emergency medicine practice.'<sup>2</sup> He then quotes Michael:

'Emergency medicine is comprised of disciplined practice of routines and guidelines under conditions of uncertainty, pressure and time limits. More than any other medical area, emergency physicians learn to act 'automatically', faster than the speed of philosophical thinking.'<sup>3</sup>

EM doctors have a completely different relationship with their patients compared to primary care practitioners.<sup>2</sup> Some of these differences include:

- the acuity and mode of presentation;
- the type of illness or condition with which the patient presents;
- the limited time within which an assessment has to be made;
- the urgency of the management, and
- the poor control that the doctor has over the ED environment.<sup>2</sup>

The patient and the doctor are usually not known to each other, so that there is no established doctor–patient relationship. The patient may actually be there against her wishes, having been brought in by family or ambulance services. By the very nature of the reason for the presentation at the ED, the patient may be anxious or in distress.<sup>1,4</sup>

Important ethical considerations in the ED include:

- consent and decision-making in a situation in which the patient may not be fully autonomous or not autonomous at all;
- patient confidentiality;
- withholding and withdrawing life-sustaining treatment;
- advance directives and living wills, and
- resource constraints.<sup>2,4</sup>

I discuss the issues of consent and confidentiality as they pertain to patients presenting to the ED, using two cases to illustrate the challenges.

## INFORMED CONSENT FOR A CHILD IN THE ED

Kevin, a nine-year-old boy, was diagnosed with hereditary angioedema (HAE), but is not on any prophylaxis. He has been very well and asymptomatic up to now. He joins his uncle, Steven, on a fishing trip. Kevin develops dyspnoea and difficulty breathing, and his uncle takes him to the ED. On arrival at the ED, Kevin is cyanosed and has severe

airway obstruction. Steven informs Dr Msiza, the doctor on duty in the ED, of a family history of HAE. Dr Msiza has previously treated a patient with HAE and is aware of the HAE card available on the website of the Allergy Society of South Africa in which the emergency treatment of an acute event is detailed. She attempts to intubate Kevin, while at the same time administering adrenaline, corticosteroids and antihistamines, and urgently ordering fresh frozen plasma (FFP). She is unable to intubate Kevin, as he has already developed severe pharyngeal and laryngeal oedema. The only option is to perform a cricothyrotomy – a procedure she has never performed before. As Kevin is a child, she requires parental consent. The only family member present is his uncle, and the potentially life-saving procedure is required urgently; there is no time to contact Kevin's parents.<sup>5,6</sup>

### INFORMED CONSENT AND DECISION-MAKING IN THE ED

The principle of respect for autonomy underpins the requirement for informed consent in healthcare. Patients have the right to be involved in making decisions regarding their own healthcare and should be given all the relevant information to enable them to make a decision. Informed consent implies being able to choose between different treatments as well as being able to refuse treatment.<sup>7</sup> The fundamental elements of the process of informed consent are threshold, information and consent elements. The threshold elements include the capacity to understand the information provided, and the voluntariness of the decision-making process. The information elements are disclosure, recommendation of a treatment plan and understanding of both the information provided and the recommendation. The consent elements include a decision in favour of a treatment plan and its authorisation.<sup>8</sup>

In the latest edition of *Principles of Biomedical Ethics*, Beauchamp and Childress discuss two different views of 'informed consent' as they currently appear in the literature.<sup>8</sup> The first view is that informed consent is 'an individual's *autonomous authorisation* of a medical intervention or of participation in research'. In this sense the patient must voluntarily *authorise* the doctor to do something after being informed of the plan. In the second view

'informed consent refers to *conformity to the social rules of consent* that require professionals to obtain legally or institutionally valid consent from patients or subjects before proceeding with diagnostic, therapeutic, or research procedures'.

In this interpretation informed consent is merely an institutional requirement whereby the doctor has to inform patients of the potential risks of a treatment or procedure. Beauchamp and Childress acknowledge that the first sense of informed consent may well impose unreasonable demands on the doctor, but they believe it should serve as

'the benchmark for the moral adequacy of institutional rules of consent'. The practical application of this requirement is what would be considered reasonable in a particular situation.

The ED is no different from any other healthcare environment in that the doctor has a duty to obtain informed consent from the patient for any procedure or treatment. In obtaining informed consent, the EM doctor should provide sufficient information for the patient to be able to make an informed choice, but should not overstate the potential benefits of a proposed course of treatment.<sup>9</sup> Should the patient not have the capacity to make a decision, a surrogate should be consulted, if time permits. Trauma, intake of drugs and/or alcohol, and medical conditions all impact negatively on the patient's decision-making ability. This incapacity may be temporary and, if a delay in commencing treatment will not result in harm, informed consent should be sought. However, life-and-death emergencies or serious illness or trauma necessitate urgent intervention, and in these situations EM doctors may proceed without consent.<sup>4,9</sup> The exception to obtaining informed consent applies only to the emergency situation at hand and does not permit other, non-essential, treatment without consent.<sup>10</sup> Explicit refusal of treatment by a patient who has the capacity to make decisions should be respected.

These guidelines are in accordance with the legal requirements of the National Health Act 61 of 2003, Chapter 2, section 7:

'If any delay in the provision of the health service to the user might result in his or her death or irreversible damage to his or her health and the patient has not refused such treatment, treatment must be provided.'<sup>11</sup>

The EM doctor should be aware of who constitutes an appropriate surrogate decision-maker. In terms of South African legislation, the hierarchy of surrogate decision-makers are, in order, the patient's spouse or partner, parent, grandparent, adult child, or brother or sister.<sup>11</sup>

Another exception to the obligation to obtain informed consent is if it is in the interests of public health, so that the individual patient's autonomy is overridden and treatment instituted in order to protect others.<sup>9,12</sup>

What about children in the ED? Children older than 12 years are able to give consent for medical treatment, providing they have the maturity and capacity to do so, but they need parental or legal guardian consent for surgical procedures. Children under the age of 12 years who can understand the treatment to be provided should assent to that treatment, but consent has to be provided by the parent, legal guardian or caregiver.<sup>13,14</sup> Parental or legal guardian consent is required for surgical treatment. A child over the age of 12 years may refuse treatment, but

obviously the urgency and gravity of the situation will affect how this is managed by the ED team.

Kevin presented with acute life-threatening airway obstruction and has not responded to the emergency medical treatment. Fatal laryngeal oedema has been described as a result of HAE<sup>5,6</sup> and a surgical airway is essential. Legally, his parents would be the designated decision-makers as Kevin is only nine years old, but they are not present to give consent. Kevin's uncle, Steven, should be informed that he needs an urgent surgical airway. The surgical airway should proceed urgently without consent. If an ED physician who is more experienced than Dr Msiza is available to perform the cricothyrotomy, he should perform it. Failing this, Dr Msiza should carry out the procedure in Kevin's best interests (in accordance with the principle of beneficence).

### CONFIDENTIALITY AND THE ADULT WITH HIV IN THE ED

Sara, a 27-year-old, HIV-infected woman, presents to the ED with an acute hypersensitivity reaction to her anti-retroviral drugs. When asked which medication she is currently taking, Sara refuses to disclose the information to Dr Jansen, the ED physician, as she first wants assurance that everything she tells the doctor will be regarded as confidential, will not be reflected in her medical notes and will not reach her family. Not even her husband is aware of her HIV diagnosis.

### CONFIDENTIALITY IN THE ED

The obligation of confidentiality in medicine forms one of the fundamentals of the doctor–patient trust relationship, that is, the obligation not to disclose medical information about the patient to others without her consent. The Hippocratic Oath emphasised the importance of patient confidentiality and the Declaration of Geneva includes the statement, 'I will respect the secrets that are confided in me, even after the patient has died.'<sup>15</sup> In terms of the provisions of the National Health Act 61 of 2003, all patients have a right to confidentiality.<sup>16</sup> A doctor may disclose medical information about a patient only with their consent and, in the case of a minor below the age of 12 years, with the written consent of the parent or guardian. In the case of a deceased person, the written consent of the next of kin or the executor of the deceased's estate is required. Other permissible breaches of confidentiality may occur in terms of a statutory provision; on the instructions of a court of law; or if it is in the public interest – for example, a notifiable or infectious disease or where a patient may pose a danger to someone else.<sup>17</sup>

In modern medical practice respecting patient confidentiality has become difficult, with widely accessible electronic patient and laboratory records and large healthcare teams, particularly in public-sector hospitals. In teaching hospitals large numbers of students also have access to patients'

information. Unintentional breaches of confidentiality are common when discussing patients with interesting signs or diagnoses, often in hospital corridors, canteens or lifts. Patients' hospital folders or other records are left lying around in wards. Patients' names and diagnoses are written on nurses' and doctors' handover lists. Computer screens are left open with confidential information displayed for all to see.

In the ED confidentiality may be difficult to preserve, given the physical environment, the acuity of the patient's medical condition, and multiple team members who may be involved in the patient's care. The ED is

'typically a public, crowded environment in which many people are present, including multiple patients, physicians (attending physicians, consultants and residents), nurses, emergency medical technicians, students, family, friends, law enforcement officers, and others'.<sup>12</sup>

ED patients frequently present with distressing medical conditions for which privacy is essential, but it is precisely under these circumstances that privacy and confidentiality are difficult to maintain:

'Semi-open wards, congested hallways, and a fishbowl atmosphere provide little or no physical privacy and limited opportunities to communicate personal information confidentially.'<sup>12</sup>

Sara is reluctant to disclose information about her HIV status and drug treatment as she fears it will become known to her family. It is essential for the treating team to know which drugs she is currently taking as this will influence her future management, and Dr Jansen will have to try to explain to her how important this is. He may be able to access other sources of information to ascertain her treatment history. Dr Jansen will also have to inform the other staff in the ED about Sara's request for confidentiality, and the fact that she has not disclosed her HIV status to her family. One dilemma facing Dr Jansen is the potential risk of HIV to Sara's husband: Does he have a duty to warn him? This will entail breaching Sara's confidentiality against her express wishes. Many factors will influence his decision, such as whether Sara's husband is HIV-negative and therefore at risk of becoming infected, and whether disclosing Sara's status will entail safety concerns for her when her husband finds out about her status. The guidelines of both the South African Medical Association and the Health Professions Council of South Africa advise that the patient should preferably disclose to the partner, but that the doctor may disclose under certain circumstances, but only after having informed the patient of the intention to do so and having ascertained that the disclosure does not put the patient at additional risk.<sup>11</sup>

Preserving confidentiality in the ED includes securing

patient folders and records so that only authorised personnel have access to them. Computerised records should be password-protected and not left open on the screen for all to see. This also applies to laboratory results and imaging.<sup>18</sup> Only those healthcare professionals involved in the patient's care should have access to the patient's medical information. Telephonic requests for information about patients in the ED should be managed judiciously. Disclosure of private information about patients in the ED, even if they are public figures, is not acceptable.<sup>18</sup>

The use of social media platforms to share patient information and images must be managed carefully. Sometimes this is done to solicit an opinion from another specialist. Ideally, encrypted software should be used and the images and information deleted as soon as they are no longer required.

## CONCLUSION

The ED constitutes a unique environment with challenging

doctor–patient relationships. The EM doctor has to have a broad knowledge of medical, surgical and traumatic conditions as well as technical expertise in a wide range of procedures. In addition, the EM physician has to understand the difficult ethical, moral and legal dilemmas that may arise in the ED. As the Code of Ethics for Emergency Physicians of the American College of Emergency Physicians states:

'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.'<sup>19</sup>

## DECLARATION OF CONFLICT OF INTEREST

The author declares no conflict of interest with respect to the content of this article.

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