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Emergency Medicine

Personal Narrative

Upcoming Issues of *Virtual Mentor*

March: Medical Residency
April: The Difficult Patient-Physician Relationship
May: Obstetrics and Gynecology
June: Caring for a Culturally Diverse Patient Population

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FROM THE EDITOR
Emergency Ethics
Audiey Kao, MD, PhD

In this issue of *Virtual Mentor (VM)*, we explore the complex, sometimes unique, ethical aspects of caring for patients in emergency medicine. As our regular readers know, *VM* has recently changed to a theme-based format, and, periodically, an issue of *VM* will focus on a given medical specialty. This editorial change is designed to highlight what is common and what is different about practicing medicine in various specialties. From a practical perspective, we hope this new format will be more user-friendly for students and teachers of medicine.

This month's *VM* issue provides our readers with a forum for exploring ethical challenges in emergency medicine. Often individuals treated in the emergency room do not have established histories with the physician. This lack of familiarity makes already difficult encounters—dealing with patients who want to leave AMA (against medical advice) or communicating with families about their deceased loved ones' desires to be organ donors—that much more challenging. At the same time, there are other patients who are all too familiar to emergency room physicians. Many of these patients use the ER as their source of primary care because they lack health insurance. These uncompensated ER "office visits" place significant cost burdens on hospitals. But ability or inability to pay cannot determine whether a person receives care in a potentially life-threatening situation; it is not consistent with medicine's tradition to provide charity care—and it is against the law.

Because of their unique obligations, emergency physicians wear "hats" that colleagues in other specialties usually do not. As front-line responders during disasters, ER physicians must triage and treat large numbers of the sick and injured. Sadly, future disasters may involve terrorist acts with biological agents. ER physicians will have to learn how to diagnose and manage diseases such as anthrax, and will soon have to decide, after weighing the risks and benefits, whether to get vaccinated for smallpox.

As physicians who frequently treat victims of domestic violence or child abuse, ER physicians are confronted with how to manage the social components of illness and trauma. Sometimes physicians are required to report suspected violence to the police or other authorities. With such reporting responsibilities, ER physicians' roles as trusted, non-judgmental caregivers to all, including victims and perpetrators, can come into conflict with their duty to the state.

ER physicians are depicted in popular TV dramas and filmed for reality shows. While the reality shows aim, in part, to educate the public, we must not allow the filming of vulnerable patients for commercial television to undermine our professional responsibility to protect patient privacy and confidentiality.

The learning objectives for this month's issue on emergency medicine are:

1. Understand the professionalism and ethics issues that are specific to, or more prevalent in, the emergency room setting.
2. Recognize the challenges presented by the absence of a patient-physician relationship.
3. Learn the obligations for providing emergency care to indigent and uninsured patients under EMTALA.
4. Understand the professional responsibility emergency physicians have to respond to disasters.
5. Understand emergency physicians' reporting responsibilities to law enforcement officials.

As always, I welcome your thoughts and suggestions about making *VM* better.

Audiey Kao, MD, PhD is the editor in chief of *Virtual Mentor*.

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CASE AND COMMENTARY
Does Patient Autonomy Outweigh Duty to Treat?
Commentary by Catherine A. Marco, MD

Case
Dr. Avery, a second-year emergency medicine resident, was on duty in a large urban hospital one night with 2 other residents, when a police officer escorted in a young man. The officer had found Scott Daley semi-conscious and with a cut on his head. When questioned by the officer, Mr. Daley had responded quickly, telling the officer that he had fallen. He then stood up and walked without difficulty. To be on the safe side, the officer decided that Mr. Daley should receive medical attention. Mr. Daley agreed.

Upon physical examination, Dr. Avery documented a minor laceration on Mr. Daley's forehead and some significant occipital swelling and tenderness. He appeared slightly intoxicated but was alert and aware. He understood the physician's questions and answered basic questions, such as his name, the location, and the date. However, he did not cooperate with more detailed questioning. He said that he had hit his head on the sidewalk and that it hurt. His pupils were equally round and reactive to light. There was no obvious evidence of intracranial bleeding, but Dr. Avery said she wanted to do a CT scan to be certain there was no skull fracture or intracranial bleeding.

At this suggestion, Mr. Daley became argumentative. He did not want any tests and did not want to spend any more time in the emergency room. He said he was fine. "Just give me some aspirin or something for the headache, and I'm outta here," he said. Because of the signs of head trauma and her difficulty in completing a detailed mental status exam, Dr. Avery did not want to let Mr. Daley leave the hospital before ruling out significant internal head injury. She attempted to explain the gravity of the situation, and risks of leaving without allowing her to complete diagnostic tests. The patient seemed inattentive and refused to cooperate with further questioning.

After reasoning with the patient for several minutes to no avail, Dr. Avery asked the other residents to help her convince the patient. They were equally unsuccessful, and the patient became increasingly agitated. He said that they were "ganging up on" him. He got up and started to leave. Dr. Avery could, of course, allow the patient to leave against medical advice. Given the possibility that he could have a life-threatening head injury, though, she contemplated whether to restrain him and complete the diagnostic work-up against his will.

Commentary
This interesting case depicts a scenario commonly encountered in emergency medicine. The fundamental question in this case is whether the patient possesses appropriate decisional capacity to make an important choice regarding refusal of medical care.

Some erroneously believe that decisional capacity (sometimes referred to as "competence") is an all-or-nothing phenomenon—either the patient has the capacity to consent to medical treatment or he does not. Unfortunately, the concept is not so simple.

Decisional capacity is based on the patient's ability to understand the choices, to deliberate about those choices, and to articulate his choice. Decisional capacity is dynamic—that is, a patient who had appropriate decisional capacity yesterday may not have it today. There are numerous reversible causes of impaired decisional capacity, including intoxication, hypoxia, sedation, stress, and many others. Every effort should be made to reverse potential impairments in capacity, to assure that the patient is making the most rational, autonomous choice. Level of needed capacity may also be decision-specific. For example, the physician may have a lower threshold for allowing a patient to refuse suturing a small laceration, than for allowing a patient to refuse admission for a myocardial infarction.

The medical evaluation of capacity can be challenging. On some level, we assess the capacity of every patient we see. For most patients, we presume that if they are able to give a rational history, cooperate with the medical evaluation, and appear to understand the treatment recommendations, they possess appropriate decisional capacity. Impaired capacity comes into question most often when patients refuse recommended medical treatment.

To evaluate decisional capacity appropriately, all reversible threats to capacity should be addressed. Patient goals and values should be assessed. Alternatives and consequences should be discussed, and the patient should demonstrate understanding of these elements. Family members may be helpful in determining mental status as compared to baseline. Standardized tests, such as the Mini-Mental Status Examination, may be helpful.

Another common misconception is that a signature on an "against medical advice" (AMA) form is sufficient to allow a patient to leave. In fact, informed refusal is a *process*, not merely a signature on an AMA form. The process should consist of determination of decisional capacity, delivery of information, including risks of refusing treatment, and documentation of the process.

In this particular case, the physician must make a judgment regarding decisional capacity. It is challenging because the patient exhibits some elements of capacity—he is awake, alert, and answers some questions appropriately. However, there is also evidence of impaired capacity. The patient appears somewhat intoxicated and

is somewhat uncooperative. He is unable (or unwilling) to cooperate with detailed questioning, which makes it impossible to ascertain whether he understands the risks of leaving against medical advice.

The significance of alcohol intoxication and its relationship to decisional capacity is controversial. Some believe that any intoxication renders a patient unable to make medical decisions. Others believe that intoxicated patients should be evaluated for appropriate capacity. In some cases, intoxicated patients are in fact able and willing to understand choices and the ramifications of those choices and to make an autonomous decision. A blood alcohol level is not necessary or sufficient to make a determination of appropriate decisional capacity. However, it may provide supporting evidence of impaired capacity. Certainly, alcohol intoxication is a "red flag," suggesting to the clinician possible impairment of capacity.

In cases where a complete evaluation of decisional capacity is not possible, it is reasonable to detain the patient until such an evaluation can be completed. Some options include explaining this simple fact to the patient. Often, when faced with the possibility of being physically or chemically restrained, the patient suddenly becomes more cooperative with answering questions. If the patient is able and willing to answer questions appropriately and understands the risks of leaving against medical advice, he should be allowed to leave. If he is not, he should be restrained until an appropriate evaluation of capacity can be completed.

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CASE AND COMMENTARY
Organ Donation: When Consent Confronts Refusal
Commentary by John C. Moskop, PhD

Case
Dr. Nichols is a third-year emergency medicine resident in a community teaching hospital. One Friday afternoon, while he was working in the emergency department, the desk operator sought him out and reported that an EMT unit was on its way in with a motor vehicle injury patient. A motorcyclist apparently hit a concrete median while taking a turn and was thrown from his bike. He had not been wearing a helmet. When the rescue squad arrived, the patient was not breathing. Life support measures were begun, and the patient was intubated in the field.

Dr. Nichols notified the trauma center on-call neurosurgeon about the incoming patient. When the patient, Derek Polaski, arrived, he was taken to the "crash" room. He had serious head injuries and was hypotensive. Dr. Nichols got a CT scan of the head to determine the extent of Mr. Polaski's injuries. The neurosurgeon arrived, performed a thorough neurologic examination, and looked at the CT scan. He reported to Dr. Nichols that Mr. Polaski was deeply comatose, lacked brain stem reflexes, and had no respiratory drive. He also pointed out that the CT scan showed massive brain injury and severe intracranial bleeding. The injuries were so severe that surgical intervention would be futile.

The neurosurgeon asked that Mr. Polaski be admitted to an ICU bed. When Dr. Nichols inquired about that, he was told that it would be several hours before an ICU bed would be available. The neurosurgeon reflected a moment, then asked that the patient remain in the ED. He explained that the patient was almost certainly brain dead. Ordinarily, he said, he would wait 24 hours before doing a repeat neurologic exam and pronouncing the patient dead. In this case, however, since both the cause and the extent of the brain injury were clearly established, he would return later in the afternoon, repeat the neurologic exam and, barring an unexpected change, pronounce the patient dead.

The neurosurgeon did return, performed the required examination, and pronounced the still-intubated patient dead at 6:20 PM, 4 hours after his arrival in the ED.

An ER orderly had informed Dr. Nichols that Mr. Polaski's driver's license indicated he wanted to be an organ donor. Dr. Nichols asked that the contact person for the organ retrieval team be notified. At 6:45, Mr. Polaski's wife arrived at the

ER, having been met at her door by 2 police officers when she arrived home from work.

It fell to Dr. Nichols to tell her about her husband's injuries and that he was brain dead. This was not easy. Mrs. Polaski hadn't seen her husband with his injuries (which sometimes makes it easier to believe the news); last she saw him he was perfectly fine. Dr. Nichols had to say more than once to her wide, disbelieving eyes, "Mrs. Polaski, your husband is brain dead." She didn't break down or cry.

It wasn't until the organ procurement coordinator from the Gift of Hope Organ Procurement Organization spoke to her about her husband's wish to donate his organs that Mrs. Polaski seemed to understand what was happening. The officer was kind, but he asked Mrs. Polaski to say her final good-bye to her husband and mentioned that the organ team could take Derek's body as soon as Mrs. Polaski "was comfortable" with them doing so. Mrs. Polaski was disbelieving and furious.

"What do you mean, he's dead?" she asked. "He's breathing. He's not cold or even pale. He's not dead."

"His brain is not functioning, Mrs. Polaski," Dr. Nichols stepped in to explain. "He can't breathe or do anything else on his own."

"Well, fine. Just leave him on that machine. He's not dead. I can see he's not dead. He doesn't look like dead people look. Don't touch him."

Dr. Nichols tried a couple more times to explain, but Mrs. Polaski said, "Even if he really does die, that doesn't mean you can cut him open and take his organs. I'm his wife. You have to give his body to me, and I don't want it all cut up and mutilated. I won't let you do it."

Dr. Nichols discovered that he was saying the same thing over and over—"your husband is dead and he wanted to help another person live by donating his organs." He could not bring himself to say, "We don't need your permission to take your husband's organs. We can take them on the basis of the signed intent to be an organ donor on his license."

Surprisingly, this was Dr. Nichols' first experience with an intended donor whose organs were satisfactory for transplant and whose family opposed the donation. Knowing that Mr. Polaski's organs were safely ventilated and perfused, Dr. Nichols tried to buy time. The team surgeon reassured Dr. Nichols that a signed donor card or driver's license served as a legal instrument (like a will) in their state. All 50 states, in fact, have adopted the 1987 Uniform Anatomical Gift Act, which established this guideline for organ procurement. Their own hospital policy quoted the state statute, the surgeon told Dr. Nichols, and protected physicians who retrieved organs over the objection of family members, as long as a signed donor card or license was present on the deceased. The hospital policy, however, did not

stipulate that physicians *must* override family members' objections. The policy stated that its physicians were free to act in response to circumstances that were "unique" to the case.

The hospital policy was similarly lenient regarding removal of brain-dead patients from ventilators. Under certain circumstances, such patients could be left on ventilators long enough for family members to arrive and see them. The length of time should not be "excessive," but, again, was left to the "judgment of the hospital's trusted physicians."

Dr. Nichols didn't want to give up on retrieving Mr. Polaski's organs, yet he doubted that a few hours—even 24—would change Mrs. Polaski's mind. It didn't seem right to do nothing. Mr. Polaski's interest and the interests of the potential donors who could receive his organs were on 1 side of the balance, with only Mrs. Polaski opposing them. Yet, here she was, the 1 person alive in front of him pressing her strong objection to the use of her husband's organs.

Commentary

In this case, Dr. Nichols confronts a difficult decision about organ procurement from a heart-beating cadaver donor. Fortunately for emergency physicians, such decisions do not often arise in the emergency department (ED), since most critically injured patients are swiftly transferred to an intensive care unit, where determination of brain death occurs after additional treatment efforts. Nevertheless, a large percentage of transplant organs are obtained from patients with severe trauma resulting in death. Many of these patients will receive initial care in the ED, and so emergency physicians should be familiar with policies and procedures for organ donation and procurement from cadaver donors.

Dr. Nichols clearly has a beneficent motive for his efforts to obtain Mr. Polaski's organs for transplantation. Moreover, Dr. Nichols has learned that Mr. Polaski had expressed his willingness to be an organ donor on his driver's license. The patient's wife, however, strenuously resists both the assertion that her husband is dead and the proposal that his organs be removed for transplantation.

The immediate question for Dr. Nichols, of course, is "How should I proceed?" Before we address that question, however, let's consider 2 prior questions. First, who should take the lead in communicating with Mrs. Polaski? Second, what role should Dr. Nichols, the emergency medicine resident, play in this process? In response to these "prior questions," let me state my position at the outset. I believe that informing Mrs. Polaski that her husband is dead and discussing the question of organ donation with her should be undertaken by different professionals and that Dr. Nichols should not play the lead role in either activity. These 2 activities should be separated to avoid any perception of a conflict of interest between caring for Mr. Polaski and using his organs to benefit other patients. Thus, the caregivers who diagnose and treat Mr. Polaski's condition should be clearly distinguishable from those who pursue organ procurement and transplantation.

The case states that "it fell to Dr. Nichols" to tell Mrs. Polaski about her husband's death, but it does not say why this is so. Information so sensitive and emotionally laden should, I believe, ordinarily be given by the physician who performed the required neurologic examinations establishing the diagnosis. Only this physician can provide specific answers to the wife's questions about how her husband's death was established. Moreover, this physician is likely to have a great deal more experience and expertise in communicating this particular information to family members than an emergency medicine resident. In the present case, the neurosurgeon might have been called away to another patient before Mrs. Polaski arrived at the ED. If that were the case, I believe that an attending emergency physician should have assumed this weighty disclosure responsibility, with Dr. Nichols' assistance. As described in the case, it appears that an organ procurement coordinator from the local organ procurement organization (OPO) did take the lead in discussing organ donation with Mrs. Polaski. This is appropriate, since the coordinator will have considerable experience in discussing this issue with family members and will be able to provide specific answers to questions Mrs. Polaski may have about the organ procurement and donation process. In many states, laws require that hospitals refer all potential donors to the local OPO for review and follow-up. Mrs. Polaski should also, of course, have access to Dr. Nichols or another member of her husband's care team to answer her questions about her husband's condition and treatment.

The case narrative does not include a detailed description of the caregivers' discussions with Mrs. Polaski, but 2 of the statements that are reported give cause for concern. First, Dr. Nichols is reported to say several times to Mrs. Polaski, "Your husband is brain dead." Many commentators recommend avoidance of the term 'brain dead', since it is widely misunderstood. Use of this term may suggest that there is a difference between "brain death" and death of the person, and thus allow family members like Mrs. Polaski to conclude that their loved one is not dead. Instead, Dr. Nichols, or preferably the neurosurgeon, should tell Mrs. Polaski that her husband is dead and explain that his death was established based on neurologic criteria, that is, irreversible loss of brain function.

Second, the organ procurement coordinator is reported to tell Mrs. Polaski that the organ team would "take Derek's body" as soon as she "was comfortable" with that. This statement may well have given Mrs. Polaski the mistaken idea that if she agreed to organ donation, she would permanently lose control of her husband's body. That might explain her later insistence that "you have to give his body to me, and I don't want it all cut up and mutilated." Instead, the organ procurement coordinator should have reassured Mrs. Polaski that she would retain control over her husband's body and that organ donation does not disfigure the body or interfere with an open casket funeral. A different approach to discussion of her husband's death and of the option of organ donation might have persuaded Mrs. Polaski to give her consent to donation.

Given the fact of her denial that her husband is dead and her objection to taking his organs for transplantation, however, should the organs be procured against her wishes? The decision to procure an organ is a responsibility of the OPO. A survey of the 61 US OPOs published in 2001 revealed widespread diversity in consent practices for cadaveric organ donation.[1] Despite this diversity, however, only 5 OPOs (8 percent) reported that they were likely to procure organs based on a person's wishes as indicated on a driver's license, if the next of kin objected to donation.

One might view most OPOs' reluctance to procure organs based on a person's driver's license as a violation of the person's moral right to donate. Or one might view this reluctance as recognition of the limits of this method for expressing one's wishes. Mr. Polaski's driver's license evidently expresses his general wish to be an organ donor. If, however, he could have foreseen the current situation, including his wife's shock, suffering, and inability to come to terms with his sudden death, would he still insist on immediate procurement of his organs despite her objections? Or would his concern for her well-being incline him to want her wishes to be honored, or, at least, want to give her more time to accept the fact of his sudden death? Time, and additional discussion, may help her to accept that fact and to carry out his wish to be an organ donor. Even if it does not, however, concern for her well-being offers a persuasive reason for sensitivity to Mrs. Polaski's wishes in this tragic situation.

References

1. Wendler D, Dickert N. The consent process for cadaveric organ procurement: how does it work? can it be improved? *JAMA*.2001;285:229-233.

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IN THE LITERATURE
ER Physicians and Police Collaboration
Swathi Arekapudi

The first stop for most victims of violence is their local emergency room. Of the 37 million visitors to emergency rooms in the United States in 1999, 7 percent had injuries related to intentional violence.[1] Certain kinds of violent acts, such as child abuse and dog bites must be reported to police in the US; in some states, physicians are required to report domestic violence and alcohol-related car accidents.[1, 2] Not all violent acts must be reported by emergency room personnel, however, and the police are often not notified.

In "Emergency Medicine and Police Collaboration to Prevent Community Violence," Jonathan Shepherd argues that much more could be done to stem violence in the community through a health services-criminal justice system collaboration.[3] Sheperd reasons that a stronger relationship between emergency room physicians and the police will lead to more investigations and, as a result, more convictions. Such an increase in investigations and convictions will act as a deterrent and lead to less community violence. There is some evidence that punishment deters future crime, including studies comparing the likelihood of conviction and the levels of violence between the United Kingdom and the US. One study Shepherd cites showed that an inverse correlation exists between the likelihood of conviction and the level of violence.[4]

Shepherd suggests that emergency room physicians can decrease community violence by facilitating increased rates of police reporting by, or on behalf of, the injured. In situations where the victim does not want to have the police involved, non-confidential material (such as where, when, and how the injury was inflicted) could be collected, aggregated, and distributed to the police. Such a process could yield information on previously unknown kinds of violence or provide specific locations where certain forms of violence are concentrated. This strategy has proved successful in some instances. Shepherd points out that the most frequently used weapon in the UK, bar glassware, was first identified from such information. Because of this data, glassware in the UK is now formed from toughened glass that reduces the risk of injury.

Epidemiologists studying criminal law have shown that laws can be effective means of addressing public health problems, such as violence. Shepherd points to a study that links laws requiring guns to be put in locked containers to fewer accidental shooting deaths in children.[5] In the emergency room, reporting of violence would

benefit the health of the community as well as the individual patient. Since half of all assault victims in the ER have been assaulted before, and most violent offenses are committed by a small proportion of offenders, intervening early would prevent much harm. In a Philadelphia study, 6 percent of chronic offenders accounted for 69 percent of all aggravated assaults, 71 percent of homicides, 73 percent of forcible rapes, and 82 percent of robberies.[6]

Shepherd argues that there are 4 types of barriers to reporting intentional violence in the emergency room: attitudinal, logistic, ethical, and legal. An attitudinal barrier is the position that violence prevention should not be the responsibility of medical professionals because this would allow the police force to divert some of the blame of the presence of crime to the medical establishment. There are additional worries that such collaboration indicates an "unacceptable medical paternalism."[6] Understandably, fewer attitudinal objections have been found among police. Instead, much of their concern stems from the fact that violence is not reported to them. Logistic barriers include the lack of facilities for patient reporting, an inability to record the circumstances of violence, poor communication with the police, and "the often exclusively health agenda" of emergency rooms.[7]

A study carried out in 5 emergency rooms in the UK illustrated ethical objections to increased reporting. Physicians opposed increased partnership with law enforcement for reasons of "patient confidentiality, maintaining a neutral stance in relation to issues of blame, and protecting the patient" (in decreasing order of importance). Reasons given for wanting to report violence were reducing risk to others, the severity of violent injuries, the use of weapons, and the vulnerability of the injured.[6]

There are potential benefits to increased collaboration between emergency departments and the police but also significant problems, many of which Shepherd sees more as obstacles to be overcome, such as the medicalization of violence and the effect such a position would have on the patient-physician relationship. Though the patient-physician relationship is different in the emergency room, physician reporting to the police will cause patients to distrust the health care system (especially if they are the perpetrators of violence) and perhaps fewer patients would go to the emergency room. California physicians who were surveyed expressed a strong aversion to such collaboration. If such mandatory reporting of abuse were instated, 64 percent of primary care physicians and 25 percent of ER physicians who responded would not comply because of concerns for patient safety, patient confidentiality, patient autonomy, and the integrity of the patient-physician relationship.[8]

Health care can be perceived as both a good in itself and as a gateway to other ends, in this case, the prevention of violence. A balance between the needs of the individual and those of the community allows medicine to serve its dual role, but where this balance lies is difficult to resolve. Shepherd leans towards a plan that places greater weight on the needs of the community than on confidentiality of

patient information. Wherever one believes this balancing point lies, whether favoring individual or community needs, that position will present difficulties and demand a defense.

Questions for Discussion

1. It is often noted that the patient-physician relationship is, at best, "attenuated" in emergency room encounters where, often, patient and physician are meeting for the first time. When does a patient-physician relationship start? Does the minimal relationship between patient and physician in the emergency room give the physician greater freedom to share patient information with police officers, even against the wishes of his or her patient?
2. How does the physician's role on behalf of public health differ from a police officer's role in the name of public protection?
3. Should physicians share accountability for community violence?
4. If a Shepherd-like plan were instated in an emergency department, how might that affect whether or not certain kinds of victims (such as those of domestic abuse, or those who are already on slippery legal footing) receive medical treatment?

References

1. Hargarten SW. Docs and cops: a collaborating or colliding partnership? *Ann Emer Med*. 2001;38:438-440.
2. Cole TB. What can we do about violence? *JAMA.* 1999;282:481-483.
3. Shepherd JP. Emergency medicine and police collaboration to prevent community violence. *Ann Emer Med*. 2001;38(4):430-437.
4. Shepherd, 432.
5. Cummings P, Grossman DC, Rivara FP, et al. State gun storage laws and childhood mortality due to firearms. *JAMA*. 1997;278:1084-1086.
6. Shepherd, 433.
7. Shepherd, 434
8. Cole, 482.

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HEALTH LAW

Equal Treatment for Emergency Room Patients

Kari Karsjens, JD

Ms Darcy Jones was 17 years old and pregnant with her first child. She had received prenatal care funded by a state program for indigent and adolescent expectant mothers. In July 2000, Ms Jones's records were turned over to her and her parents, and the Jones family was advised that Ms Jones could go to any hospital in the county to deliver her child.

On the afternoon of August 3, 2000, Ms Jones began to experience labor pains. At approximately 3:00 PM she went to the emergency room at County Memorial Hospital in her home county. Ms Jones provided copies of her medical records and, after initial processing by an ER nurse, she was taken to labor and delivery where Dr. David Duncan, a private obstetrician under contract with the hospital to perform obstetrical services in the ER, was to examine her.

Dr. Duncan scanned her medical records and realized she was an uninsured, indigent patient. Then, rather than perform a physical examination of Ms Jones, Dr. Duncan relied upon the notes of the nurse who had completed the preliminary exam. He concluded that her water had not broken and her membranes were intact. He did not verify these medical conclusions by performing an acidity test. He diagnosed Ms Jones as being in early latent labor. Dr. Duncan then instructed Ms Jones to drive to State University Medical Hospital, a facility 200 miles and 4 hours driving time away in another county to deliver her baby. He told her not to speed while driving there.

Dr. Duncan did not call the University Medical Hospital to alert them that Ms Jones was on her way. He did not write a transfer memo, listing in writing his reasons for deciding that the transfer's benefits outweighed the risks. He did not provide any medical treatment or perform any procedures to minimize the risks to Ms Jones and her baby, except for his instruction about not speeding.

At 4:00 PM, after hearing Dr. Duncan's instructions, Ms Jones was in a state of confusion, shock, and fear. She sat in the hospital ER hallway until 4:30 PM, when a nurse approached her and told her she should be on her way to the State University Medical Hospital. Ms Jones called her mother, who was outraged, and went to Eastern Legal Services to file a restraining order against Dr. Duncan. No legal action could be taken since the courthouse was closed, so Ms Jones called her boyfriend, who came to the hospital and picked her up. Borrowing a 24-year-old car

that was in bad condition, Ms Jones and her boyfriend departed for the State University Medical Hospital in the middle of the night. They arrived early on the morning of August 4. Ms Jones was not dilated to 3 cm, so the hospital sent her home to her own county hospital to deliver later that day. By this time, the federal court had issued a temporary restraining order, requiring Dr. Duncan to deliver Ms Jones's baby.

On August 5, Ms Jones's water broke and she returned to County Memorial Hospital where she was admitted. During delivery, Dr. Duncan administered oxytocin to speed her contractions, and engaged in a verbally abusive conversation with Ms Jones, denouncing her for involving lawyers and the courts and issuing a temporary restraining order against him. Ms Jones's baby was born with its umbilical cord wrapped around his neck, and it is likely the umbilical cord had been wrapped around the child for the entire period of these events.

Ms Jones brought a private EMTALA action against County Memorial Hospital for personal injury, emotional distress, and equitable relief. In addition, the Department of Health and Human Services (HHS) sought civil damages in the amount of $50,000 against Dr. Duncan, and $50,000 against County Memorial Hospital.

Discussion

EMTALA (Emergency Medical Treatment and Active Labor Act), 42 USC § 1395d (1986) aims to prevent instances of patient dumping and refusals to treat based on ability to pay. The law applies to all hospitals with emergency departments that have voluntarily chosen to participate in the Medicare program.

EMTALA requires all hospitals to provide a medical screening examination to anyone who presents at the emergency room, regardless of that person's ability to pay. The medical screening examination must be sufficient to determine whether an emergency medical condition exists. An emergency medical condition is one that includes acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to place the health of the individual (or, in the case of a pregnant woman with contractions, the life of the woman and her child) in serious jeopardy.

If it is determined that an emergency medical condition exists, then the emergency room MUST either:

- treat the patient until stabilized or,
- transfer the patient to another medical facility.

Repercussions for EMTALA violations include:

- patient lawsuit against the hospital under existing negligence standards,
- Department of Health and Human Services monetary penalties against the hospital and/or physician up to $50,000, and/or

- suspension or exclusion of the physician from the federal Medicare program.

Questions for Discussion

1. According to EMTALA requirements, what was Dr. Duncan's violation?
2. What actions could Dr. Duncan have taken to avoid violating EMTALA in this case? As a general rule, what action should *all* physicians who treat patients in the emergency room take to comply with EMTALA?
3. Because of the unique relationship between the emergency room patient and physician (ie, the acute nature of interaction and attenuated patient-physician relationship), it is often difficult for patients who have been injured or harmed in the ER to satisfy the necessary doctor-patient relationship upon which medical malpractice (negligence) cases are based. In the absence of this relationship, what standards should motivate physicians to treat all patients with equal care? That is to say, are the existing legal sanctions against physicians for malpractice (albeit limited for patients) enough to enforce ethical conduct in treating emergency room patients?

Subsequent Legal History

The aforementioned facts are taken from an actual case, *Owens v Nacogdoches County Hospital*. This 1990 case is one of the earliest to apply the "Patient Anti-Dumping" federal statute known as EMTALA. The facts in *Owens* depict a scenario that EMTALA was designed to prevent: a national scandal involving the "rejection of indigent patients in life threatening situations for economic reasons alone." As the court noted in *Owens*, "hospitals with emergency facilities cannot deny those facilities to the poor. They cannot shrug their shoulders and send children in rickety cars on 24-hour drives simply because they do not make the same money treating such children as they do for paying customers" (741 F Supp at 1281).

Additional facts are taken from *Burditt v HHS*. Federal courts have consistently reaffirmed the statutory authority of HHS to impose and enforce civil monetary fines of $50,000 *per violation* against *both* hospitals and physicians.

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STATE OF THE ART AND SCIENCE

Diagnosis and Management of Smallpox

Audiey Kao, MD, PhD

In 1980, the World Health Organization announced that smallpox had been eradicated. Smallpox vaccination was discontinued in the US in the early 1970s and worldwide in the early 1980s. It is hard to believe that one of the major public health achievements in human history may be undone by the reintroduction of smallpox through a bioterrorist attack. Given this possibility, emergency physicians are likely to be among the first health care professionals who will see patients infected with smallpox. Accurate diagnosis and proper management is critical to treating those already infected and limiting the spread of the disease in the community.

Diagnosing Smallpox

Smallpox can appear in 4 different forms: ordinary, modified, flat, or hemorrhagic. The latter 2 forms occur in patients with compromised immune systems, and the modified form occurs in previously vaccinated patients (those who are now roughly 30 years of age or older).

Physical Exam of the Skin

1. **Ordinary form**: skin lesions first appear on the buccal and pharnygeal mucosa then the face, forearms, and hands/palms. Over the next day, the rash spreads to the trunk, typically affecting the back more than the abdomen, and finally on the legs including the soles. Skin lesions in smallpox begin as macules and over the next couple of weeks progress to firm papules, then vesicles which soon become opaque and pustular. Around day 14, the pustules begin to dry up and crust over with development of a scab. These scabs separate with those on the palms and soles separating last.
2. **Modified form**: similar to the rash that appears in the ordinary form of smallpox, except that the progression from macule to scab is much faster (usually within 10 days).
3. **Flat form**: skin lesions develop slowly and become confluent and remain flat and soft. These lesions have a "velvety" appearance, and significant desquamation occurs. Unlike the ordinary form, these lesions never progress to the pustular stage.
4. **Hemorrhagic form**: this rare form of smallpox presents as skin petechiae and bleeding from the conjunctiva and mucous membranes.

Tips for Differentiating Smallpox from Chickenpox

Chickenpox	Smallpox
No or mild prodrome	Fever, cough, and headache are common
Skin lesions are in different stages of development, (macules>papules>vesicles>crust), with rapid evolution from macules to crust (<24 hours).	On any part of the body all the lesions are in the same stage of development, (eg, all are vesicles), slow evolution of lesions (each stage lasts 1-2 days).
Centripetal distribution with greatest concentration of lesions on the trunk; palms and soles are rarely involved.	Centrifugal distribution with greatest concentration on the face and distal extremities; lesions on palms and soles.

Managing Smallpox

- Patients with confirmed or suspected smallpox should be isolated. Local public health officials should be consulted before deciding on the most appropriate venue for medical isolation.

- Vaccination administered within 3-4 days post-exposure can prevent disease or severe illness.
- Medical care is generally supportive and treatment of complications such as:
    1. Hypovolemia and electrolyte imbalance (eg, hyponatremia, hypokalemia) due to fluid loss from skinlesions.
    2. Bacterial infections including skin abscesses, pneumonia, osteomyelitis, and septicemia.
    3. Corneal ulceration and/or keratitis.
    4. Gastrointestinal symptoms including nausea, vomiting, and diarrhea.
    5. Viral bronchitis and pneumonitis.
    6. Encephalitis which occurs in about 1 in every 500 cases of smallpox.

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POLICY FORUM

Resuscitating Privacy in Emergency Settings: AMA Policy Requires Patients' Consent before Filming

Faith Lagay, PhD

Since the trend toward reality TV in medicine took off around 1997, 30 or more emergency departments have invited film crews in for live taping.[1] Many physicians and administrators at participating hospitals are pleased with the results. The live taping, they say, counteracts the glamorized portrayals in dramas such as *ER* that create unrealistic expectations for survival and recovery from trauma. They argue that the reality shows—*Trauma, Paramedics, Hopkins 24/7*, and the like—educate the public and demystify the emergency department encounter.

Not all physicians agree. Medical ethics rests on the bedrock understanding that those who are sick are vulnerable. This fundamental truth gives rise to the ethical and professional standards governing patient privacy and confidentiality as well as to a gravity of purpose and conduct that suffuses the clinical interaction.

Some physicians believe that making an entertainment of actual clinical encounters violates these ethical and professional standards. The presence of non-medical team members, they claim, invades patient privacy, exploits the sick and dying, and could compromise clinicians' abilities to perform effectively.

One physician who felt strongly about the exploitation of critically ill or injured—and therefore vulnerable—individuals was Dr. Martin Fujimura, who campaigned for AMA policy on the issue. A family practitioner in Dayton, Ohio, Dr. Fujimura began his crusade to protect emergency patients in the fall of 1999. He penned letters to the Ohio State Medical Association, published an article for *In Confidence* magazine,[2] and wrote to the AMA's Council on Ethical and Judicial Affairs (CEJA) requesting that the AMA develop a policy to curtail the practice of filming. "I am particularly saddened," his letter stated, "by what I perceive as the exploitation of patients who need our care and protection the most, ie, the severely injured and the dying. How is it permissible to allow camera crews to film half-naked, dying patients (even teenagers and children) prior to obtaining consent?" he challenged.

In response to Dr. Fujimura's request, CEJA drafted a recommendation, which it presented it to the AMA House of Delegates at the June 2001 annual meeting. The recommendation was approved, adopted as AMA policy by the House, and became Opinion 5.045 of the AMA's *Code of Medical Ethics*.

Opinion 5.045 states that filming patients in health care settings for the purpose of commercial broadcast without consent is a violation of the patient's privacy.[3] Consent, says the policy, "is an ethical requirement for both initial filming and subsequent broadcast for public viewing." The opinion argues that, because filming cannot confer any therapeutic benefit to the patients, it is not worth the risk to patient privacy (and possibly well-being) that it entails. Therefore, "it is appropriate to limit filming to instances where the party being filmed can explicitly consent." Many trauma patients are unconscious or in distress too great to permit their giving informed consent. In such circumstances, the temptation is to allow the next of kin or other surrogate decision maker to provide consent. Opinion 5.045 says surrogate consent is not an acceptable substitute for patient consent. The role of such surrogates is to make decisions necessary for medical treatment or refusal of treatment. Consenting to or refusing to be filmed is not a medical treatment decision.

For most of the trauma and emergency room footage that has aired on television, patients' consent was received after the filming and before the broadcast. If patients did not consent, their portion of the film was not broadcast. But the filming itself had already violated their privacy. To understand why, it is necessary to differentiate between privacy and confidentiality. Patient *privacy* refers to the fact that patients have the right to be examined and observed only by those individuals involved in their medical care. AMA policy dictates that "physicians are ethically and legally required to protect the personal privacy and other legal rights of patients."[4] *Confidentiality*, on the other hand, refers to what happens afterward to information shared in private with the physician. Patient records and conversations fall under this protection and give sanctity to the patient-physician relationship. Information that is shared with the physician should not be disclosed to others, according to AMA policy on confidentiality, without the patient's consent or unless the disclosure can be "ethically and legally justified by overriding social considerations."[5] Examples of overriding social considerations include patient threats of harm to self or others from physical violence or communicable disease. Protection of privacy and confidentiality go hand-in-hand. If the patient-physician encounter is not private, confidentiality is far more difficult to secure.

Thus, unless a stationary camera is used or a health professional does the filming, the privacy of the clinical encounter is violated when filming takes place. Receiving consent for distributing the film after the fact avoids breaches of confidentiality but does nothing to undo the invasion of privacy. Breach of patient privacy is permissible only through expressed informed consent before filming.

It is important to recognize that, under Opinion 5.045, patients who are conscious and able to give consent may be filmed. Even here, though, the report that paved the way for the opinion warns that the time required for informing the patient fully about what the film crew may observe and record is time perhaps better spent on diagnosis and treatment.

One function of the AMA's Council on Ethical and Judicial Affairs is to receive physicians' ideas about ethical and professional dilemmas and funnel them to the House of Delegates for action. Any physician, any concerned individual, can bring a matter to the council's attention. Dr. Fujimura did so. His passion and persistence in seeking to protect vulnerable patients by ensuring privacy in the medical encounter stands as a testament to the power of advocacy.

References

1. Foubister V. Acting in the ER: participants in the documentary series "Trauma: Life in the ER" laud its educational value and positive portrayal of physicians. But critics have patient privacy concerns. *AMNew*s. March 27, 2000. Accessed January 15, 2003.
2. Fujimura MK. Private matters: lights! camera! trauma! Confidentiality and new media. *In Confidence*. 2000;8:4-5.
3. Opinion 5.045 Filming Patients in Health Care Settings. American Medical Association. *Code of Medical Ethics 2002-2003 Edition*. Chicago, IL: American Medical Association; 2002.
4. Opinion 5.04 Communications Media: Standards of Professional Responsibility. American Medical Association *Code of Medical Ethics 2002-2003 Edition*. Chicago, IL: American Medical Association; 2002.
5. Opinion 5.05 Confidentiality. American Medical Association. *Code of Medical Ethics 2002-2003 Edition*. Chicago, IL: American Medical Association; 2002.

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POLICY FORUM

Smallpox Vaccination: National Security and Individual Risk

Susanna Smith

Last year's dramatic season finale of *ER* brought smallpox into the living rooms of many Americans, highlighting the role of emergency physicians as first responders in the event of a bioterrorist attack.

Emergency physicians, more so than members of other specialties, are expected to respond to natural and man-made disasters in part because the Code of Ethics of the American College of Emergency Physicians (ACEP) puts forth a duty to respond to out-of-hospital emergencies and disasters as one of the central tenets of the emergency physician's relationship with society.[1]

The ACEP reacted to the fictional TV series, *ER*, suggesting in a press release that real-life physicians are not adequately trained to respond to a smallpox outbreak. This may soon change, and it will begin with physicians around the country receiving the smallpox vaccine.

In September 2002 the Centers for Disease Control and Prevention (CDC) released its most up-to-date Smallpox Response Plan and Guidelines.[2] These guidelines along with later supplements were set forth to serve as the basis for all states' emergency response plans in the event of an actual smallpox outbreak.

All US states and territories were then asked to submit their individual guidelines for responses to a bioterrorist attack, including plans to vaccinate emergency responders prior to an actual smallpox case. The CDC announced on December 12, 2002 that it would offer the smallpox vaccine in January 2003 to about 450,000 designated emergency responders based on the plans submitted by each state, and to the 500,000 military and other government personnel designated by the Departments of Defense and State. The Bush administration has said "emergency, health care workers and other personnel will be asked to *volunteer* to receive the smallpox vaccine" [emphasis added] as part of Smallpox Response Teams.[3] On January 24, 2003 this vaccination program "sputtered to a start" with 4 out of the 20 eligible doctors in Connecticut receiving the vaccine.[4]

According to recent teleconferences between the press, the CDC, and the Department of Health and Human Services (DHHS), the government expects to offer the vaccine to another group of about 10 million people made up of health care workers, police, firefighters, and other emergency responders in the spring of

2003. The vaccine will be made available to the public at large in 2004, or earlier for those who choose to enroll in clinical trials.

This will take place even in the absence of a single case of smallpox but amidst valid, thoughtful criticism. Various organizations (American Hospital Association, American Public Health Association, Institute of Medicine, ACEP, Service Employees International Union, American Federation of State, County and Municipal Employees) have raised a host of objections to the government's plans, which will directly affect emergency physicians.[5-8] The American Medical Association took a stance in favor of the June 2002 Advisory Committee on Immunization Practices' recommendations to the CDC to vaccinate a specific group of health care workers and emergency responders but has not voiced an opinion on the CDC and DHHS's current plan of staged, mass vaccination.[9] Of real concern to the public, and to health care workers especially, are the serious adverse reactions that, in the past, have affected 1,000 people for every million vaccinated. Another 14 to 52 people had life-threatening adverse reactions, with 1 or 2 deaths per 1 million people vaccinated.[10]

For a various reasons there will likely be more adverse reactions to the smallpox vaccine now than in the past. Because smallpox vaccination of the American public was discontinued in 1972, there is near-zero immunity to the vaccinia virus among today's unvaccinated population and an unknown residual immunity in previously vaccinated individuals.[11] More people today have contra-indications for the vaccine than in the past. There are more immuno-compromised individuals, (cancer patients, organ transplant recipients) including an estimated 300,000 people in the United States who do no know they are HIV-positive, and a higher incidence of eczema (another contraindication for the vaccine).[11]

In the face of possible mass vaccination over the next year, many groups have raised questions about compensation for individuals who receive the smallpox vaccine and experience mild to fatal adverse reactions.[5-7] Under section 304 of the Homeland Security Act, individuals can sue the federal government for compensation but they would have to prove negligence on the part of an individual or entity that administered the vaccine.[12] Outside of this narrow and unlikely case, doctors and others who receive the vaccine, experience adverse affects, and seek compensation will have to get assistance from their own health insurance plans and the state's workers' compensation plan.[12] Compensation will differ from state to state or from one insurance plan to another, and the payments will put an additional strain on already tight health insurance and state budgets.

Although the idea of a "no-fault" compensation fund like the Children's Vaccine Injury Fund has been suggested, the Secretary of the Department of Health and Human Services, Tommy Thompson, has said "there is no legislation being drafted or has ever been discussed" that offers broader federal compensation.

With a worrisome number of adverse reactions expected, the ACEP points out that "putting even a small number of MDs and RNs out of work on a short-to-middle-term basis without proper safeguards or compensation, could destabilize our entire emergency care system." Groups have asked for the government to offer reinforcement to the health care system and a more staggered vaccination plan, which would permit health care workers more time to recover from adverse reactions, minimizing understaffing crises in hospitals.[5-7] Thus far no such amendments to the federal plan have been made public.

Although the choice to receive the vaccine is voluntary and only advised by the government for the designated emergency responders, the question "how voluntary is voluntary" has been raised. Cheryl A. Peterson, RN, a senior policy fellow at American Nursing Association, suggests that being vaccinated might become a condition of employment in high-risk situations such as working in a major urban hospital emergency room.[13]

Will there be repercussions for doctors who refuse to receive the vaccine? Would a doctor have to disclose a reason for vaccine refusal, explaining, for example, that the doctor or a family member is HIV-positive, or undergoing chemotherapy, or just doesn't want to take the risk?

Although the IOM and many other professional health organizations support some type of precautionary smallpox vaccination plan, they are calling for more cautious and prudent decision making by the federal government. Many of their concerns are not being addressed as the CDC dodges questions from the press. In a recent teleconference, for instance, the CDC refused to talk about the number of hospitals that chose not to participate in the government's plan.

Dr. Julie Gerberding, director of the CDC, responded to concerns expressed in the recent IOM review of the CDC's plan by saying "we respect the input… but the point is the program needs to go forward."[14] When asked by *Los Angles Times'* reporter what was behind the recent pleas for a slower vaccination process, Dr. Gerberding responded "We do not appreciate a groundswell of requests to delay or stop this program…. This is an issue of homeland security and an issue of national defense."[14]

It is also an issue that has become highly politicized, with homeland security rhetoric usurping public health considerations. The IOM, an independent organization and a branch of the National Academy of Sciences, points out that the current safety monitoring arrangement for the vaccination program is made up of 2 government organizations, the CDC and the Department of Defense. Of particular concern is "a perception that the scientists overseeing the actual data on safety… are not actually independent of those setting or overseeing policy."[15]

The Bush administration appears to be moving ahead as planned. As of January 28, 2003, 35 states and 1 county had requested the shipment of the smallpox vaccine.

The CDC has already shipped out at least 98,600 doses.[16] It will now be up to emergency responders to decide whether to receive the vaccine for the public good, and at their own risk, without being told what the likelihood is of a smallpox attack. And doctors, many of them emergency physicians, will be among the first to make that difficult decision.

References

1. American College of Emergency Physicians. Code of ethics for emergency physicians. June 1997. Accessed January 22, 2003.
2. Centers for Disease Control and Prevention. *CDC Smallpox Response Plan and Guidelines* (Guides A-F plus Annex files 1-8). September 23, 2002. Accessed January 22, 2003.
3. Centers for Disease Control and Prevention. Protecting Americans: smallpox vaccination program. Accessed January 22, 2003.
4. Ornstein C, Goldman JJ, Lelyveld N. A slow beginning on smallpox; only four people are inoculated as the national effort gets underway in Connecticut. Unions resist, worried about side effects and compensation. *The Los Angeles Times*. January 25, 2003: A1.
5. American Hospital Association. Statement of the American Hospital Association before the Institute of Medicine Committee on Smallpox Vaccination Program Implementation on hospitals' views on the Federal Smallpox Vaccine Program. December 19, 2002. Accessed January 22, 2003.
6. American Public Health Association. APHA policy statement on smallpox vaccination. December 6, 2002. Accessed January 22, 2003.
7. Institute of Medicine. Review of the Centers for Disease Control and Prevention's smallpox vaccination program implementation- letter report # 1. January 17, 2003. Available at: http://www.nap.edu/books/NI000489/html/. Accessed January 22, 2003.
8. American Federation of State, County and Municipal Employees. AFSCME urges Bush to delay implementation of smallpox vaccination. January 16, 2003. Accessed January 22, 2003.
9. American Medical Association. AMA on government smallpox vaccination plan. December 13, 2002. Accessed January 30, 2003.
10. Centers for Disease Control and Prevention. Smallpox fact sheet: reactions after smallpox vaccination. Accessed January 22, 2003.
11. Neff JM, Lane JM, Fulginiti VA, Henderson DA. Contact vaccinia-transmission of vaccinia from smallpox vaccination. *JAMA.* 2002;288(15):1901-1905.
12. Centers for Disease Control and Prevention. CDC telebriefing transcript-update:smallpox educational activities and West Nile virus. December 19, 2002. Accessed January 22, 2003.
13. Maguire P. As the country gears up for smallpox vaccinations, physicians find themselves at the front lines. American College of Physicians-American Society of Internal Medicine. January 3, 2003. Accessed January 22, 2003.

14. Centers for Disease Control and Prevention. CDC telebriefing transcript-CDC smallpox vaccination update. January 17, 2003. Accessed January 22, 2003.
15. Institute of Medicine. Review of the Centers for Disease Control and Prevention's smallpox vaccination program implementation- letter report # 1. January 17, 2003:21. Available at: http://www.nap.edu/books/NI000489/html/. Accessed January 22, 2003.
16. Centers for Disease Control and Prevention. Smallpox vaccine shipment numbers. Accessed January 29, 2003.

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PERSONAL NARRATIVE

Prometheus Sits at Sunset on Saint Catherine Street

Chris Buckle

Paperweight snowflakes are swift to smother solitary footsteps.
They start in an alley like any other,
But end on a busy Saint Catherine Street corner.
That's where you sit, staring out to the street
On a heavy blanket wrapped round your feet,
Haloed in the light of the setting sun
Waiting, you fear, for the ravens to come.

The burden you carry lies deep inside,
An illness of mind that will not subside.
Your life is a chill, your soul gives it heat,
Your patience—a guide—that few can defeat.
It's patience, that cup your shaky hands hold,
That asks of the young what it begs of the old
Money that is, for that money will buy
Another day living life high and dry.

I gave to your cause an apple in lieu,
The apple we shared, our friendship it grew,
Sprung as it was from the iconoclasm you dared
Fed by the talk about god that we shared.
It was in these talks I learned of the weight,
That led your life to this surreal fate.
I learned of the ravens that day after day,
Come torture your mind, come caw your dismay.

Your thoughts came so fast and in so many ways,
That all I recall I must paraphrase –
You told me then and it stuck in my head -You said
Deranged Everywhere, Lucifer's Underlying Symbolism
Impairs Otherwise Natural Sentience

Inside your head these ideas collate,
Inside these ideas I wish I could see,
Instead all you show is a paperweight
Of a plastic Jesus with his arms spread free.

His eyes open wide as his arms touch the snow,
That swirls with strength when you give it a shake,
That lingers on him long after you slow,
That won't swirl at all when it's my turn to take.

Now snow falls on us as the night creeps in,
Whispers an end to visiting hours.
For isn't this just the broken asylum,
DeInStItUTiOnaLISm?
When cost cutting is the principal feat,
Time in the wards becomes time on the street,
When blankets not gowns are given to wear,
You still get a cup, to beg for your care.

From dusk until dawn, that's a cup you've worked in,
And its weight buys a scant supper.
Then back to the street and as night wears thin,
Comes hunger, a raven, to chew at your stomach.
And what of tomorrow? Same place, same pain
Same burden to face, you know shall repeat
Are delusions themselves an only escape,
Living like Prometheus on Saint Catherine Street?

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