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Ethical Dilemmas Posed in the Care of Obese Patients in the Emergency Department

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INTRODUCTION

Obesity is an epidemic that is about to overwhelm the economic and health care structures of society (Centers for Disease Control and Prevention, 2012). Obesity is emblematic of how society indulges a lack of self-control by the individual (Lawrence, 2004). Obesity is a complex medical condition that has roots in genetic, environmental and social exposures that should not be attributed lack of willpower any more than other diseases (Banja, 2004). Obesity leads to the stigmatization of patients and results in their isolation and discrimination in receiving health care (Puhl & Heuer, 2010).

None of the above statements are false, and, together, they summarize the ethical conundrum faced by physicians in caring for the obese. There is little doubt that the rising prevalence of obesity places an increasing number of adults and children at risk for chronic diseases that will be challenging to manage. According to the Centers for Disease Control and Prevention, more than one-third of all US adults and 17% of all US children are obese (Body Mass Index [BMI] $\geq$30) (Ogden, Carroll, Kit, & Flegal, 2012). As of 2008, the estimated cost of obesity related care in the US was $147 billion/year, up from $78.5 billion/year in 1998 (Finkelstein, Trogdon, Cohen, & Dietz, 2009). Together, these statistics express the burden that obesity related illness will place on patients and the health care system for the foreseeable future.

For emergency physicians, ethical dilemmas posed by the obesity epidemic are growing in both frequency and magnitude. The emergency department has been termed "the canary in the coal mine," the window through which the difficulties of the health care system become manifest (Venkat, 2004). In the case of obesity, the rising burden of obesity-related illness, the difficulties in diagnostically evaluating and treating obese patients and the access to care issues faced by obese patients all come to a head in the emergency department. If the emergency department remains the access point of last resort for patients in the US health care system, emergency physicians will continue to be confronted with caring for this challenging patient population with limitations in the types of equipment, diagnostic modalities and treatments feasibly available (Blomkalns & Silver, 2011).

The above limitations create a series of ethical dilemmas for emergency physicians and the facilities in which they practice. Among these are whether the same expectations for diagnosis and treatment can be maintained in the obese, and particularly the super obese (BMI$\geq$40), where typical diagnostic modalities in the ED may be unusable; whether there is an obligation of health care facilities to spend scarce resources on specialized equipment for a relatively small portion of

the patient population (super obese); whether there is a professional necessity for emergency physicians to have specialized knowledge in caring for the obese population; whether there is an obligation of centers that publicize their bariatric care to accept patients from smaller centers and, conversely, whether less specialized centers view themselves as having limitations in caring for the special needs of the obese and have protocols in place to transfer these patients to larger centers. In this article, we will present how current ethical paradigms can be used to frame approaches to these dilemmas and their resolution.

ETHICAL PARADIGMS FOR THE MANAGEMENT OF OBESE PATIENTS IN THE EMERGENCY DEPARTMENT

In evaluating how current ethical paradigms can help frame the obligations of emergency physicians in managing obese patients in the emergency department, it is important to understand that theoretical frameworks can often assume idealized circumstances. As all practicing emergency physicians understand, it is the rare clinical situation that follows a textbook description. Similarly, the application of ethical theory makes assumptions that may not fit the particular details of the case. What ethical paradigms can do is provide a thought process for evaluating how clinicians can manage difficult situations.

Principlism represents the most commonly discussed framework for evaluating ethical dilemmas at the bedside. The Four Principles approach enjoins physicians to respect patient autonomy, and to promote beneficence, non-maleficence, and justice. In the ED management of obese patients, all such principles apply, but the most challenging to unravel is the principle of justice. Justice involves both the obligation to fairly distribute scarce medical resources as well as the imperative to avoid discrimination and treat all patients with similar problems similarly. Emergency physicians regularly put this principle into practice through their clinical stabilization and evaluation of any patient who presents to their care. This is a recognized obligation under both professional codes of ethics promulgated by emergency medicine professional organizations and the federal EMTALA mandate, which requires any US emergency department and associated hospital to assess and stabilize a patient regardless of insurance status (American College of Emergency Physicians, 2011; Center for Medicare and Medicaid Services, 2012). While we may question the equity of providing such care in an unfunded manner, emergency physicians and emergency departments do publicly hold themselves as the final access point of care for all individuals regardless of status, a real life expression of the justice principle.

For obese patients, the justice principle would suggest that emergency physicians should not allow themselves to make judgments on the blameworthiness of

patients in their disease processes or, at a minimum, allow such judgments to affect the type and quality of care provided. However, that does not end the discussion of the justice principle's application in the emergency department as it also calls for responsible resource stewardship to allow all patients to be able to receive care. In the case of obese patients in the emergency department, this may cause emergency physicians to judge that they cannot do more than the minimum degree of stabilization (airway management for example) and not expend further resources to diagnose conditions that are either beyond the capabilities of their center or that may delay the evaluation of other patients whose conditions are more readily managed at that time. Examples of further resources that may be difficult to expect all physicians or centers to have access to or possess include radiologic imaging equipment and hospital beds with high weight limits, surgical instruments designed for the obese or specialty specific expertise on medical complications of the grossly overweight.

Consequentialism and Non-Consequentialism are ethical paradigms that evaluate the appropriateness of an action based on either its outcome for the former or whether it meets a universal standard of moral action for the latter. We would contend that their application to the question of how to treat obese patients in the emergency department is limited. By their nature, consequentialist and non-consequentialist theories are normative – whether an action ought to take place. There is little doubt that obese patients will be treated in this setting, but questions remain as to what extent and how far emergency physicians should go in preparing for these individuals. As such, these paradigms do not have as much to offer in addressing how emergency physicians can ethically treat obese patients.

Virtue theory addresses the ethical motivation and agency of the individual practitioner in their actions. In the case of emergency physicians, virtue theory would suggest that professional training imposes concomitant obligations to utilize that training to the benefit of patients (Larkin et al., 2009). Emergency physicians, by upholding the virtue of professionalism and their associated status in both the health care system and society as individuals capable of aiding patients in acute medical crises, would therefore have an obligation to have both the medical knowledge and professional skill to care for difficult patient populations such as the morbidly obese. Some examples of this specialized medical knowledge and professional skill that are specific to morbidly obese patients that all emergency physicians should possess include airway assessment and management, intravenous access, medication dosing/administration adjusted for weight and differential diagnoses of emergency conditions and how they are best assessed. It is an open question whether such professionalism and its correlative obligations should extend beyond the expectations of individual practitioners to a facility and its capabilities as well, as described above.

Finally, narrative and relationship theories call for ethical interactions to be evaluated based on the context, background and relative position of the individuals involved. As we have discussed above, obese patients face serious barriers to access in the health care system and are often treated adversely within society as a whole. Narrative and relationship ethical paradigms would therefore call for recognition of these prejudices and impediments in evaluating how emergency physicians should approach obese patients in the emergency department and conclude that more efforts should be expended to meet their health care needs.

APPLYING AN ETHICAL FRAMEWORK TO THE CARE OF OBESE PATIENTS IN THE EMERGENCY DEPARTMENT

For emergency physicians, an ethical approach to the care of the obese patient in the emergency department is unlikely to be governed by one paradigm or theory. Instead, we would advocate that a combination of virtue and relationship theories may be most applicable in resolving the commonly faced dilemmas that emergency physicians encounter with this patient population. Through the virtue prism of "professionalism," emergency physicians have a special role within the health care system to care for patients to the maximum ability of themselves and their facility regardless of socioeconomic status. Similarly, an understanding of the relationship the obese patient has to the health care system, facing common stereotyping as having a condition for which they are primarily to blame and limitations in access to health care resources, reinforces that the emergency department, as the access point of last resort for patients, should be prepared to care for the obese patient as it is for other vulnerable patient populations.

However, to state that virtue and relationship theories definitively answer the ethical dilemmas posed by care of the obese patient is simplistic. The reality is that emergency physicians, as hospital-based practitioners, are dependent on the larger organization in which they work. The capabilities of the hospital in which the emergency department resides may realistically limit how patients at the extremes of obesity (BMI$\geq$40) can be diagnostically evaluated and treated, as noted above. Similarly, consultant medical staff may not have the training or confidence to care for the extremely obese patient (McGee, 2011). For emergency physicians, the organizational structure in which they work may limit their ability to care for obese patients in a definitive manner.

This raises two questions. First, is there a basic skill set that all emergency physicians should have, as a mark of their professional status, to care for the obese patient? Second, is there a basic level of equipment and capability that all

hospitals should have to care for obese patients and support the obligations of their emergency physicians and department?

It is clear that caring for the obese patient is not merely a matter of scaling up existing treatment protocols based on weight. Whether in the area of airway management, medication dosing, risk assessment from injury or for complications derived from common disease processes, such as COPD or coronary artery disease, the medical care of the obese requires specialized knowledge and often additional equipment. However, if the professionalism of emergency physicians recommends knowledge of managing other patient populations who have unique and emerging requirements for care, such as transplant or aging trauma patients, it is likely that such an obligation extends to the obese as well (Venkat, 2011). Similarly, if one accepts the tenuous assumption that obesity is a self-inflicted condition, this would not abrogate the professional obligation to have knowledge of its complications any more than in other "self-inflicted" conditions, such as alcohol and drug abuse or smoking, for example (Sharkey & Gillam, 2010). Knowledge of the diagnostic requirements to assess disease processes in the obese is a minimum standard in return for professional status and recognition for all emergency physicians, even if the individual emergency physician is practicing in a setting where the application of that knowledge is limited.

For emergency physicians and the facilities in which they work, there is similarly a minimum ethical requirement, under a virtue theory framework of professionalism both at the individual and an institutional level, to be able to stabilize an obese patient in the emergency department. On a practical level, this may require specialized airway kit and knowledge of their application to airway management when a patient is significantly obese, the ability and tools to place intravenous access in obese patients whose anatomy may make this difficult, and monitoring and stretcher paraphernalia to comfortably examine and stabilize the morbidly obese individual. This is by no means an exhaustive list, and other items that likely fall in this category include appropriately sized chest tubes, pacing and defibrillating equipment and face masks for non-invasive ventilation. This represents a relatively modest economic investment in line with the professional and organizational ethical obligations placed on emergency physicians and hospitals that have emergency departments to be able to manage a critically ill patient to the point of transfer to a more capable center.

Yet the rising prevalence of obesity does not obligate emergency physicians and hospitals to be able to manage all obese patients throughout their clinical course. Beyond initial stabilization, it is an appropriate organizational ethical judgment for hospitals to determine that they do not wish to spend resources on equipment needed to care for the minority of patients with extreme obesity. Such judgments

acknowledge that not every hospital can care for every patient. Instead, the ethical obligation imposed by virtue and relationship theory is to care for patients, obese or otherwise, to the best of the medical staff's and facility's professional capabilities while avoiding value judgments on whether the individual being treated may be to blame for their condition.

That does not answer the question of how extremely obese patients can receive comprehensive health care where some hospitals and emergency physicians choose not to have the capability of doing so. The answer ethically may lie in the obligations imposed by professional expertise. With the explosive growth of bariatric surgery, a number of health care facilities have entered this field and hold themselves out as able to provide comprehensive care for patients with morbid obesity (Bagloo & Pomp, 2011). For emergency physicians at such hospitals, it is reasonable to expect that morbidly obese patients and their outpatient providers will expect that the emergency departments at these centers are equipped and staffed expertly to care for the spectrum of illness that can afflict these individuals. Similarly, an emergency department and a hospital that have a superior capability to care for the morbidly obese through a bariatrics program have a professional obligation under virtue theory to accept such patients from less capable facilities. In essence, a reasonable ethical framework under virtue theory is that if a facility and its staff claim professional expertise in caring for the obese, they have an obligation to accept such patients from less capable facilities and to have the specialized equipment to provide comprehensive care. This is analogous to the regionalization of care for patients with stroke or myocardial infarction who are transferred to centers with the most advanced capabilities with these conditions.

MEDICOLEGAL CONSIDERATIONS – THE STANDARD OF CARE

Overall, we would advocate an ethical framework based on virtue and relationship theory that emergency physicians and departments should be prepared based on medical expert knowledge and basic capabilities to stabilize the morbidly obese patient population. However, an ethical expectation of universal diagnostic and therapeutic capabilities seems unreasonable without a larger institutional commitment to care for the obese, perhaps exemplified by a bariatrics program.

Against this background and the growing prevalence of obesity, a related but separate issue is how the ethical position we are advocating may impact upon medicolegal considerations and the legal standard of care. In other words, should the standard of care in medical practice vary based on the relative complexities posed by a patient population? One issue that arises in discussing the care of a specialized patient population is whether the standard of care in medical practice should vary. For obese patients, this issue is particularly delicate. With the rising prevalence of

obesity in American society, the patient population with this condition is at a level where it may be assumed that caring for such individuals is routine and within the normal scope of practice of an emergency physician. On the other hand, super obesity (BMI≥40) is not nearly as prevalent, and as previously discussed, the equipment availability, procedural competency and knowledge of disease and treatment complexity may be different in the extremely obese population. Clearly, even if all of the necessary resources are present, difficulties in diagnosis and management may still arise from the known limitations of physical examination in the obese population (Garza, 2004). Together, the challenges posed by obesity to acute care may argue for a varying legal standard in diagnosis and management in the emergency department based on the capabilities put forth by the hospital (e.g., specialized bariatric surgery center of excellence or expertise versus no involvement with such a program).

Interestingly, there is little evidence that obesity contributes to malpractice claims against emergency physicians. A search of the WestLaw© database by the legal department of the institution of one of the authors did not reveal any reported court decisions on a malpractice case involving an emergency physician as the primary defendant where obesity was the defining patient characteristic. Similarly, a review in the surgical literature on the relationship between malpractice claims and obesity that evaluated all claims in the Physician Insurers Association of America database (1990-2009) reported that emergency medicine was grouped with 16 other specialties with a small number of payouts (<10% of all cases in the database) (Weber et al., 2013). No study, to our knowledge, has surveyed emergency physicians on whether they perceive the rising prevalence in obesity as a risk factor for generating malpractice claims. However, there is no doubt that performing a physical exam, doing an airway maneuver, performing a lumbar puncture, obtaining IV access, performing adequate CPR, and a host of other procedures and tests are more difficult when a patient is super-obese; hence, the risk of missing a diagnosis or at the very least delays to diagnosis and optimal treatment are very real.

Constraints on the standard of care are based on patient, physician, and ED resource factors. We would contend that the patient factor of super obesity is one possible constraint; similarly hospital and emergency staff who are not equipped to care for super obese patients cannot reasonably be held to the same standard as they would for a non-obese patient with an identical chief complaint. It is therefore impossible to define a singular medicolegal standard of care for all obese and non-obese ED patients alike. We would suggest a sliding standard that is sensitive to the fact that not all emergency physicians may be resourced to provide state of the art care for extremely obese patients, just as some may not be resourced to care for high levels of trauma or premature infants. While the rising

prevalence of obesity requires that emergency physicians have a minimum basic knowledge of the disease processes seen in this population and how to stabilize the obese patient, not all physicians and facilities can be expected to have all the resources, skills, and equipment to accommodate the breadth of diagnostic and treatment challenges when caring for patients with extreme obesity.

However, medical centers with a special mission to care for the obese, i.e., hospitals with specialized programs for bariatric surgery, and their emergency departments should be expected to be able to manage both the obese and the super obese requiring acute care. This likely extends to a willingness to accept in transfer patients who are beyond the capability of centers without this mission. Hospitals and their medical staff that hold themselves out as having a capability to care for bariatric surgical patients also will need to invest in equipment and training of their health care staff beyond physicians (nurses, radiology technicians, etc.) on the complex needs of this population.

CONCLUSION

The rising prevalence of morbidly obese patients creates professional and organizational ethical dilemmas for emergency physicians and the facilities in which they work. If emergency physicians contend that their occupation should embody the virtue of professionalism, then there is an obligation to have a knowledge and capability of stabilizing the acutely ill obese patient as they would for any other patient populations. Hospitals should support their emergency department staff by ensuring relevant equipment is available to manage obese patients until they can be transferred to more capable facilities. However, it is reasonable to expect that centers that claim expertise in the management of obesity through bariatric surgical programs should have a professional and organizational ethical obligation to accept extremely obese patients from hospitals and emergency departments who have chosen not to have such a capability. For emergency physicians who choose to exercise their professional skill at facilities which have expertise in bariatric care, there is a professional ethical obligation to have the knowledge and facility procedurally, supported by their institution and consultant staff, to provide definitive care to the morbidly obese.

REFERENCES

American College of Emergency Physicians. (2011). Code of Ethics for Emergency Physicians Retrieved January 29, 2014, from http://www.acep.org/content.aspx?id=29144

Centers for Disease Control and Prevention. (2012). Chronic Diseases and Health Promotion Retrieved April 27, 2013, from http://www.cdc.gov/chronicdisease/overview/index.htm

Centers for Medicare and Medicaid Services. (2012). Emergency Medical Treatment and Labor Act (EMTALA) Retrieved January 29, 2014, from http://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/EMTALA/

Bagloo, M., & Pomp, A. (2011). The Bariatric Surgery Patient. In A. Venkat (Ed.), *Challenging and Emerging Conditions in Emergency Medicine* (pp. 184-203). West Sussex, United Kingdom: Wiley-Blackwell.

Banja, J. (2004). Obesity, Responsibility, and Empathy. *Case Manager, 15*(6), 43-46.

Blomkalns, A., & Silver, D. (2011). The Obese Patient. In A. Venkat (Ed.), *Challenging and Emerging Conditions in Emergency Medicine* (pp. 204-227). West Sussex, United Kingdom: Wiley-Blackwell.

Finkelstein, E., Trogdon, J., Cohen, J., & Dietz, W. (2009). Annual Medical Spending Attributable to Obesity: Payer-And Service-Specific Estimates. *Health Affairs, 28*(5), w822-w831.

Garza, M. (2004). Obese patients offer big liability risks. *OB-Gyn Malpractice Prevention, 11*(11), 81-88.

Larkin, G., Iserson, K., Kassutto, Z., Freas, G., Delaney, K., Krimm, J., . . . Adams, J. (2009). Virtue in emergency medicine. *Acad Emerg Med, 16*(1), 51-55.

Lawrence, R. (2004). Framing Obesity: The Evolution of News Discourse on a Public Health Issue. *Int J Press Politics, 9*(3), 56-75.

McGee, G. (2011). Fat Chance Getting an Obstetrician in South Florida? Ethics and Discrimination in Obstetrics and Gynecology. *Am J Bioethics, 11*(6), 1-2.

Ogden, C., Carroll, M., Kit, B., & Flegal, K. (2012). Prevalence of Obesity in the United States, 2009-2010. *NCHS Data Brief, 82*, 1-8.

Puhl, R., & Heuer, C. (2010). Obesity Stigma: Important Considerations for Public Health. *Am J Publ Hlth, 100*(6), 1019-1028.

Sharkey, K., & Gillam, L. (2010). Should patients with self-inflicted illness receive lower priority in access to health care resources? Mapping out the debate. *J Med Ethics, 36*, 661-665.

Venkat, A. (2004, July 1). Health Insurance: canary in the mine, *Cincinnati Enquirer,* p. C10.

Venkat, A. (2011). Introduction. In A. Venkat (Ed.), *Challenging and Emerging Conditions in Emergency Medicine* (pp. 1-4). West Sussex, United Kingdom: Wiley-Blackwell.

Weber, C., Talbot, L., Geller, J., Kuo, M., Wai, P., & Kuo, P. (2013). Obesity and trends in malpractice claims for physicians and surgeons. *Surgery, 154*(2), 299-304.