
Ethical decision-making in practice: A triage decision

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The experience I would like to discuss occurred three years ago and it impacted me greatly, prompting me to question my decision-making processes surrounding it. I initially believed it to be a purely clinical decision, but reflection suggested that it may be equally an ethical one. I am interested in seeing how the two processes work together and wanted to see if I would have altered my decision after examining it from an ethical framework.

At the time, I worked in the busy emergency department of a community hospital (I suppose that “busy emergency department” is redundant; they are all busy these days). The department was in the process of a complete renovation and, for the previous few months, we had been trying to cope with approximately 75% of our regular number of stretchers and considerably less space. Waiting times were being extended for all acutely ill patients for up to five hours.

I was assigned to the triage desk for four hours on a Saturday evening. Approximately half of the stretchers in emergency were filled with admitted patients for whom there would be no ward beds until at least the following day, and all the other stretchers were in use. The nurse going off shift gave me a report regarding a patient who was registering at that time, who had overdosed on Tylenol roughly six hours prior to her arrival. At that moment, a middle-aged woman presented at my desk with midsternal chest pain, radiating to her left shoulder for the past two hours.

Both women had the potential for severe negative consequences with delayed treatment. A bed became available in 15 minutes, and I gave it to the younger woman, who quickly received treatment. The woman with chest pain was not taken into the department for another 90 minutes, and did, in fact, have an anterior myocardial infarction.

My first step in this process was to identify the actual problem from an ethical perspective. I had two patients who

both needed prompt access to the emergency department. Due to limited resources, I had to place a higher priority of care on one or the other. These were my only two alternatives available; to prioritize neither was not an ethical option.

This could be classified as an ethical dilemma since it is not solvable, but resolvable. However, Wocial (1996) goes on to describe my conflict in terms of moral distress:

Moral distress occurs when a person is prevented from acting on their individual conscience to exercise their moral choice. In this case, one believes they know the right thing to do, but power structures, such as institutional constraints, prevent them from acting on their moral choices (p. 152).

Both alternatives are equally undesirable, but I believe I did have some influence over this decision, and wanted to explore the decision I made in terms of my own values.

Because this type of resource allocation problem is becoming more frequent, I wanted to be certain I was practising from a “good” ethical standpoint.

Two of my personal values that come into play here are those of health and fairness. These are both in accordance with the Canadian Nurses Association Code of Ethics (1999), and are a central part of my ethical decision-making. Rodney and Starzomski (1993) state: “The moral agency of health care professionals is enshrined in the high standards of behaviour demanded by specialized knowledge and skills. Traditionally, professional morality is viewed as protecting the individual patient interests and enhancing the status of the profession” (p. 25). I also value my skills and knowledge as a professional, and believe I have a moral duty to my patients.

In gathering information, I began with these nursing skills, knowledge, and clinical reasoning. Although patients presenting with overdoses frequently overstate the amounts they took, the symptoms the young woman displayed indicated that she was probably telling the truth about swallowing 50 tablets. I knew that she would require medication very soon to prevent liver damage,

plus her level of consciousness was decreasing. The older woman had pain which could very well have been pain of cardiac origin. She had no cardiac or gastrointestinal history, and her vital signs were within normal limits.

I chose not to use a utilitarian framework for this discussion. Its emphasis is on the consequences of the action, and since this is a retrospective exercise, I know that both patients recovered from their illnesses. It is more the duties and responsibilities to patients that I wished to explore, and how they relate to my own values. In using the deontological perspective, I will examine the dilemma from each of the four principles: autonomy, beneficence, nonmaleficence, and justice.

In reflecting on the principle of autonomy, I discovered that although I gave each of them ongoing information, it might not have been complete enough for them to make fully autonomous choices. The younger woman's level of consciousness may have interfered with her ability to understand the consequences of what I was telling her. I accepted her consent as implicit by the fact that she stayed for treatment. The second patient, although informed of the potential wait, was not given alternatives. I could have told her she could go to another facility, but I did not believe that to be in her best interests. This may have been paternalism on my part, but there were also risks in giving her that choice. If she had gone elsewhere, would she have been treated more quickly? Might she have suffered a cardiac arrest en route? I do not believe I could have answered those questions for her, so I did not give her that choice.

Nonmaleficence is the principle I struggled with the most. There was potential for doing harm to each patient by choosing the other. I believed that I had a duty to provide safe and optimal care to **both** patients, but the context in which I was working prohibited that. I will discuss context more thoroughly later. Here was where my moral distress lay; my own personal and professional values of being able to help my patients to maintain their health conflicted with the needs of the entire department. Storch (1992) discusses the concept of the nurse having multiple obligations "to patients, to families, to physicians, to colleagues, and to employing institutions"(p. 261). I certainly felt the weight of these differing obligations; to my two patients, the other ones in the waiting room, those being treated in the department, as well as to the already-overworked staff.

The question became "did I do harm?". Unfortunately, I have no way of knowing how much my patient's infarct extended while she was waiting. I certainly caused her distress, although I checked with her frequently to keep her informed and to reassess to the best of my limited ability.

The principle of beneficence, I believe, was upheld. I did not refuse treatment, in fact I did my best to accelerate it for both patients. I reassured them and provided opportunity for questions and information, in order to care for them as best I could.

Justice was the principle I most wanted to examine. Did I base my choice on my own personal values, or professional ones? There are different aspects to this principle that need to be looked at, beginning with the concept of distribution according to effort or merit. Both patients actively sought treatment. My personal moral belief of the sanctity of life was certainly in the back of my mind regarding a young woman who would attempt to take her own life. However, I recognize that my professional ethic to care for someone in such distress overrode that. She was certainly responsible for the health predicament she was now experiencing....or was she? I did not have enough information on her background to be able to judge that; i.e., did she have a longstanding mental illness? Nor did I have enough background on the older woman to base my decision on this. Was she a smoker or an alcoholic? On reflection, I cannot honestly say that I have **never** taken this difference into account, but it was not a factor in this instance. Nor did I base it on either's actual or potential social contribution. This seems irrelevant to my nursing practice.

Equal-share distribution was probably more in the minds of my patients than mine. Although in Canada we pride ourselves on the concept of universality, the current constraints on the system make this difficult to maintain. I see this frequently in the emergency, where patients' expectations of how we can care for them are so very different from our realities. For example, it is no longer feasible to keep someone in hospital for investigation of gall bladder disease. These are now being done as outpatients, despite the pain that they are having. Both of my patients ultimately received an equal share of care and treatment, but perhaps not as quickly as they expected.

The distribution according to need is difficult, both clinically and ethically, to examine. Both my patients and myself agreed that they needed to be seen by a physician. However, as Maddox (1998) states, "this is complicated by the fact that individuals may perceive their need differently than their health providers or health plans. When providers advocate for an individual, the professional justification of need may be conflicted" (p. 6). The dilemma occurred when I tried to establish whose need was greater. This conflicted with my own need to advocate for both patients. In this instance, I believe I looked at it from a "distance-ethic" perspective. McGillivray describes it this way:

In cases of conflict, the overriding principle is determined by relevant data specific to each case from a position of impartiality, observing four criteria: 1) the moral objective must be realistic, 2) no morally preferable alternative is available, 3) the least infringement possible must be sought, and 4) the agent must act to minimize the effects of infringement (p. 2).

It is from this framework that I believe I actually made my decision for this dilemma. The moral objective was to address the health needs of both my patients within the

constraints of the department. The morally preferable alternative of having both patients seen immediately was not available. My data collection told me that the young girl had a high likelihood of severe liver damage if not treated very soon. The older woman may have been cardiac, but also may have been gastrointestinal by her symptoms. With my limited information, my clinical judgment was that she was the more stable of the two, hopefully causing the least infringement. I attempted to minimize the effects of the wait with frequent reassurance and reassessment.

Although the process of “close-up” ethics would appear to be the gold standard for nursing care, its emotional nature makes this type of resource allocation decision more difficult. I was aware of the need to avoid the chaos that would ensue by acting on everyone’s individual values, and also governed by my obligations to all the patients who were directly or indirectly in my care. I was also cognizant of the needs and values of my colleagues. The “society” that I was acting for was the emergency (and the whole institution), and the patients and staff who were a part of it that shift. I responded to both patients in a compassionate manner by honestly outlining my constraints, and explaining how I would do my best for each of them. By doing this, I was also fostering a trusting relationship. By using my knowledge and skills, I acted in a competent manner in accordance with the code of ethics, and maintained the best care possible in the circumstances.


The context of this dilemma is probably its major component. The limitations of the department created a situation where I was unable to act on what I thought was right. The understaffing, renovation of the department resulting in fewer available stretchers, and an increase in the number of acutely ill patients that shift all played an important role at the organizational level. The societal belief that we are all entitled to health care on demand is an example of the context at the macro level. Although I value access to health care when it is needed, I understand that realities and expectations may be different, and this creates a conflict for me.

The micro context is more difficult to examine. I had an equal duty to each patient, and my relationship to each was the same. Because that relationship was limited by my triage role, I had little knowledge of each patient’s personal context regarding their illness. The older woman was fearful, which may have added to her symptoms and/or outcome. Did she have relatives who had died from heart attacks? Had she had prior negative experiences in hospital? Due to her drowsiness, I was unable to gain much context from the young woman, either. I did not know if she had asked to come to hospital, or was found by friends and brought there without explicit consent. Was this a reaction to a stressful event, or the result of a longstanding depression? Although I do not believe these pieces of information

would have ultimately changed my decision, they could have improved my care for them in the interim while I was waiting for a bed.

In trying not to look at this problem retrospectively, I recognize that my decision could have had a negative impact on either patient. If my personal values regarding suicide had weighed more heavily, this young lady might have sustained irreversible liver damage. I could also have considered the younger woman’s potential for societal contribution, as opposed to the older one’s. If I was a less experienced practitioner, I might have delayed the older woman’s treatment even longer, based on her lack of cardiac history or associated symptoms. Alternatively, if I had taken the older woman in first, her outcome (decreased pain, quicker reperfusion) might have actually improved her outcome.

Using the deontological approach has proved difficult in this problem, because outcome is clearly an important aspect. When determining the allocation of limited resources for these two patients, I found that, from this framework, either would have been essentially an ethical decision. It gave me little direction as to which would be the better of the two choices. However, it did allow me to examine my own moral and ethical beliefs, and understand how they affected the decision that I made. It is clear now that this was not only a clinical decision, but also an ethical one. After looking at all of the perspectives in this discussion, I believe I would not change the decision I made. However, I still resent the context that made this decision necessary.

The pressures of limited resources in the hospitals are not going to go away soon and, therefore, need to be examined from an ethical “eye” by all nurses. Changes will have to be made at all levels, micro, meso, and macro, and nurses have a huge responsibility in this. Sometimes, though, there are no “right” answers, and I believe that with the guidance of resources like the code of ethics, we can only make the best of the choices that are open to us. 

References

- Canadian Nurses Association. (1999). **Code of Ethics for Registered Nurses**. Ottawa, ON: Author.
- MacGillivray, J. (1994). Allocating Health Care Resources [Electronic version]. **Bioethics Bulletin**, 6(4), 1-5. Retrieved March 15, 2001 from <http://www.ualberta.ca/~ethics/bb6-4res.htm>
- Maddox, P.J. (1998, December 31). Administrative Ethics and the Allocation of Scarce Resources [Electronic version]. **Journal of Issues in Nursing**, 1-13. Retrieved March 15, 2001 from <http://www.nursingworld.org/ojin/topic8-5.htm>
- Omery, A. (1989). Values, moral reasoning, and ethics. **Nursing Clinics of North America**, 24(2), 499-508.
- Rodney, P., & Starzomski, R. (1993). Constraint on the moral agency of nurses. **Canadian Nurse**, 89(9), 23-26.
- Storch, J. (1992). Ethical Issues. **Canadian Nursing Faces the Future: Development and Change** (2nd ed.). 259-270
- Wocial, L.D. (1996). Achieving collaboration in ethical decision-making: Strategies for nurses in clinical practice. **Dimensions of Critical Care Nursing**, 15(3), 150-159.