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Article abstract

The complex health and social circumstances of living-at-risk, frequent users of emergency departments (aREDFUs) in the health jurisdictions of high-income countries, and the related, significant challenges posed for emergency departments and the health care providers working within them, are identified and explored in the paper. Ethical analyses of a set of relevant domains are performed, i.e., individual and relational autonomy considerations, relevant social construction and personal responsibility conceptions, patient welfare principles (beneficence, nonmaleficence, continuity of care), harm reduction methodologies and their applications, health equity, and justice considerations of the distributive, formal and social types. The outcomes of these analyses demonstrate that there are ethically compelling reasons for emergency departments to adopt an ethics-informed, policy-based approach to the longitudinal care and management of living-at-risk, frequent users of emergency departments. From a formal justice perspective, the development and uses of such an approach are justified by a demonstrable *relevant* difference between living-at-risk, frequent users of emergency departments and other persons and groups of patients who visit emergency departments. We propose an example of such a policy-based approach. Examples of possible, pragmatic applications of this approach, which help ensure that aREDFUs who present to the ED are managed in a fair and optimally consistent manner, are provided for the consideration of an urban emergency department's policymaking working group.

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An Ethics-informed, Policy-based Approach to the Management of Challenges Posed by Living-at-Risk, Frequent Users of Emergency Departments

Jeffrey Kirby[a], Lisbeth Witthoefft Nielsen[a]

Résumé

L'article identifie et explore les circonstances sanitaires et sociales complexes des personnes à risque qui fréquentent les services d'urgence dans les juridictions sanitaires des pays à revenu élevé, ainsi que les défis importants qui en découlent pour les services d'urgence et les prestataires de soins de santé qui y travaillent. Des analyses éthiques d'un ensemble de domaines pertinents sont effectuées, à savoir les considérations d'autonomie individuelle et relationnelle, les conceptions pertinentes de construction sociale et de responsabilité personnelle, les principes de bien-être du patient (bienfaisance, non-malfaisance, continuité des soins), les méthodologies de réduction des risques et leurs applications, l'équité en santé et les considérations de justice de type distributif, formel et social. Les résultats de ces analyses démontrent qu'il existe des raisons éthiques impérieuses pour que les services d'urgence adoptent une approche fondée sur l'éthique et les politiques en matière de soins longitudinaux et de gestion des personnes à risque qui fréquentent fréquemment les services d'urgence. Du point de vue de la justice formelle, le développement et l'utilisation d'une telle approche sont justifiés par une différence pertinente démontrable entre les utilisateurs fréquents à risque des services d'urgence et les autres personnes et groupes de patients qui visitent les services d'urgence. Des exemples d'applications pragmatiques possibles de cette approche, qui contribuent à garantir que les personnes à risque qui se présentent aux urgences sont prises en charge de manière équitable et parfaitement cohérente, sont soumis à l'examen du groupe de travail chargé de l'élaboration des politiques dans un service d'urgence urbain.

Mots-clés

vivre à risque, utilisateurs fréquents, services d'urgence, autonomie individuelle et relationnelle, construction sociale, responsabilité personnelle, justice sociale, équité en santé, réduction des méfaits

Abstract

The complex health and social circumstances of living-at-risk, frequent users of emergency departments (aREDFUs) in the health jurisdictions of high-income countries, and the related, significant challenges posed for emergency departments and the health care providers working within them, are identified and explored in the paper. Ethical analyses of a set of relevant domains are performed, i.e., individual and relational autonomy considerations, relevant social construction and personal responsibility conceptions, patient welfare principles (beneficence, nonmaleficence, continuity of care), harm reduction methodologies and their applications, health equity, and justice considerations of the distributive, formal and social types. The outcomes of these analyses demonstrate that there are ethically compelling reasons for emergency departments to adopt an ethics-informed, policy-based approach to the longitudinal care and management of living-at-risk, frequent users of emergency departments. From a formal justice perspective, the development and uses of such an approach are justified by a demonstrable *relevant* difference between living-at-risk, frequent users of emergency departments and other persons and groups of patients who visit emergency departments. We propose an example of such a policy-based approach. Examples of possible, pragmatic applications of this approach, which help ensure that aREDFUs who present to the ED are managed in a fair and optimally consistent manner, are provided for the consideration of an urban emergency department's policymaking working group.

Keywords

living-at-risk, frequent users, emergency departments, individual and relational autonomy, social construction, personal responsibility, social justice, health equity, harm reduction

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INTRODUCTION

Hospital administrators and health care providers working in the emergency departments (EDs) of high-income countries (HICs) are continually challenged by the frequent presentation for care of persons who are living at significant risk in the communities that acute care hospitals serve. The high frequency of presentations to the ED of this subset of the patient population is often influenced by the presence of longstanding patterns of nonadherence or under-adherence to treatment and follow-up recommendations for their physical, psychiatric, and substance use disorders (1). Living-at-risk emergency department frequent users (aREDFUs) often occupy ED beds and, in some cases, the inpatient beds of hospitals for medically inappropriate reasons for prolonged periods, e.g., because, once their acute health care need(s) is assessed and addressed, there is often nowhere to discharge them to in the community where they can receive appropriate home support or residential, long term care services (2,3). Other relevant indices of health care utilization, including the rate of hospital admissions and mortality rates, are known to be higher for aREDFUs than for patients who access EDs less often (1,2).

There is a lot of healthcare ethics at play in the complex health and associated social circumstances of persons living at risk who frequently visit EDs in HICs, and in how EDs, and the healthcare providers and staff who work within them, interact with,

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and respond to, these patients. Clinical ethics consultants and clinical ethics committees are sometimes called upon to assist in the management of significant ethical issues related to the delivery of health care to this patient subpopulation (4,5). From a narrow, distributive justice perspective, ED administrators and emergency department healthcare providers (EDHCPs) sometimes raise concerns and may express frustration about what they perceive to be the related, inappropriate use of emergency health care services (6).

In recent decades, hospital administrators and EDHCPs in HICs have attempted to manage the significant challenges posed by these patients in conventional ways. Many acute care hospitals have some experience with establishing and implementing a basic, case-management approach in circumstances where there is demonstrable over-use of ED services by patients (7,8). In urban, high-volume EDs, such case-management strategies – sometimes referred to as familiar faces programs – sometimes involve the initial assessment of the aREDFU by a group of EDHCPs and administrators during a meeting arranged for this purpose, and the subsequent assignment of a case manager who is responsible for monitoring and overseeing the person's subsequent use of ED services (9,7). These conventional case-management approaches flag ED visitors who require extra support, encourage multidisciplinary engagement, and may enhance communications and collaboration between the ED and relevant, community-based health and social supports.

However, there is often a lack of standardization of the process and procedures to be used, including those related to the longitudinal accessibility of EDHCPs to relevant health records, and, as such, EDs continue to be routinely challenged and burdened by the frequent presentations of this subset of patients. Further, there is little in the way of available, relevant research regarding the evaluation and related validation of trialed approaches to the management of aREDFUs (10). One randomized controlled study demonstrated that an implemented case management program for aREDFUs yielded a statistically significant and clinically appreciable reduction in the psychosocial problems of the participants, and another study indicated the possible, positive outcome of a reduction in alcohol and drug use (11,12). A study of the implementation of *compassionate contact* with homeless ED patients by trained volunteers in Toronto, Canada, resulted in a reported one-third reduction in the number of return ED visits within one month (13).

In this paper, relevant ethics lenses applicable to the significant challenges posed by aREDFUs in HIC health jurisdictions are identified, explored, and analyzed. The outcomes of these analyses demonstrate that there are compelling reasons for EDs to adopt an ethics-informed, policy-based approach to the longitudinal care and management of aREDFUs that is as fair and consistent as possible. From a formal justice perspective, the development and uses of such an approach are justified by a demonstrably *relevant* difference between aREDFUs and other persons and groups of patients who visit the ED (as described later in the paper).

In this paper, we employ a comprehensive ethical analysis methodology, which is used to inform meso-level health policy development in circumstances such as these where the domain, matters, or issues covered by the policy have important ethical elements and dimensions (14). With this objective in mind, the paper begins with a robust ethical analysis of the complex health and associated social circumstances of aREDFUs. The following, relevant ethics domains and lenses are explored and analyzed: individual and relational autonomy considerations, relevant social construction and personal responsibility conceptions, patient welfare principles (beneficence, nonmaleficence, continuity of care), harm reduction methodologies and their applications, health equity, and justice considerations of the distributive, formal and social types. Based on these analyses, an ethics-informed, policy-based approach to the care and management of aREDFUs by EDs is proposed. This approach consists of the development of a meso-level health policy by an ED, through the deliberative engagement of identified, core stakeholders and relevant resource persons, that guides the practical establishment and implementation of individualized care and management plans for aREDFUs. The intended outcomes of the implementation of such an ethics-informed, policy-based approach include: enhancing social justice (by paying appropriate, targeted attention to the health and social needs of members of disadvantaged social groups), promoting distributive justice (through fairer use of limited health resources), providing more comprehensive, community-based care to marginalized health-care-receivers, reducing the workload and psychological and moral distress of EDHCPs, and enhancing health equity (by improving access to emergency care for persons who present to EDs with appropriate, urgent health care needs).

We recognize that the social group constituted by EDFUs is heterogenous and, for the purposes of the paper, we have intentionally narrowed the focus of our ethical analysis and the proposed, policy-based approach, to the subset of emergency department frequent users who live at risk in the communities that EDs serve, and who experience the significant health and social challenges that are described in the next section of the paper. The paper's scope of consideration does not include the circumstances of 1) EDFUs where psychiatric and capacity assessments during their ED visits reveal clinical features that warrant involuntary, psychiatric hospitalization or the triggering of a health-professional *duty to warn*, and 2) EDFUs who agree to placement in long-term care facilities after their acute health care needs have been addressed in the ED or other hospital settings. And, of particular note, the paper does not address the circumstances of EDFUs who are not living at significant risk in the community, including those who periodically visit the ED to meet their routine care needs because of such factors as lack of access to community-based health care providers or social services. Further, the paper does not provide an ethical analysis of the longstanding, deeply entrenched, social determinants of health and the systemic healthcare delivery issues that underlie, and contribute to, the overuse of EDs by persons who live at risk in HIC communities.

COMMON HEALTH AND SOCIAL CHALLENGES OF FREQUENT ED USERS

aREDFUs typically experience forms of significant social vulnerability, i.e., unemployment, poverty, and the absence or paucity of pragmatic social supports such as regularly engaged family members, friends, and advocates (1,3). They often are homeless or have an insecure residential status (15). Many aREDFUs suffer from significant psychiatric disorders of the severe and persistent mental illness type, including untreated or inadequately managed psychotic disorders such as schizophrenia and chronic delusional disorder, bipolar mood disorders, personality disorders of asocial, obstructive, schizoid, borderline and mixed types, and various, severe types of anxiety disorders (1,3). They also frequently suffer from significant, chronic, physical health conditions such as inadequately managed chronic obstructive pulmonary disease, diabetes, essential hypertension, congestive heart failure, and hepatic dysfunction. Another common comorbidity is substance use disorder of various types including single substance or mixed alcohol, opioid, and psychostimulant use (1,16). aREDFUs typically present for care to EDs with exacerbations of their psychiatric or physical conditions. They may also sometimes visit EDs for primarily social reasons, e.g., when the weather becomes less suited to being outdoors or when they lose their tenuously held residential accommodations in the community because of such factors as shelter closures or evictions by landlords due to their disruptive behaviours – e.g., verbal or physical obstruction, aggression or hoarding – that pose a health and/or safety risk or because landlords find them challenging or inconvenient to manage.

MORAL DISTRESS AND ED HEALTH CARE PROVIDER RESPONSE TO AREDFUS

The experience of moral distress by EDHCPs as it relates to their engagements with, and responses to, living-at-risk EDFUs is relevant to the topic under consideration. As articulated by Moskop et al., moral distress is “the painful, psychological disequilibrium [that] clinicians experience when … constraints prevent them from pursuing what they believe to be the morally-right course of action” (17, p.359). Research performed over the last three decades (primarily in the academic nursing domain) has revealed that moral distress has significant implications for HCP recruitment, satisfaction, and retention (18). Healthcare providers (HCPs) who experience sustained moral distress frequently end up leaving their jobs because of related burnout and health professional attrition (19). Wolf et al. comment that the underlying causative or predisposing factors for moral distress are environment and system-driven, and that this experiential, professional phenomenon tends to occur in “a high-acuity, high-demand, technical environment with insufficient resources [to meet the existing health care demands]” (20, p.37).

In HIC ED settings, EDHCPs may experience moral distress because of their perception that the occupation of ED beds by aREDFUs compromises their ability to provide high-quality care to patients with urgent acute-care needs, which they believe to be their primary professional obligation. Further, EDHCPs may have strong opinions that the treatment of aREDFUs for non-urgent needs is morally wrong in the sense that it constitutes a misuse or misallocation of limited health resources. The development and implementation of an ethics-informed, policy-based approach that supports EDHCPs who professionally engage with aREDFUs and incorporates a relevant, educational component (such as that described in the final section of this paper), is a viable strategy to mitigate moral distress in the ED workplace.

RELEVANT ETHICS DOMAINS/LENSES

Individual and relational autonomy

Autonomy considerations play an important role in the circumstances of aREDFUs and their relationships to EDs and health organizations as a whole. In most liberal democracies, consistent with the wide acceptance and privileging of the fundamental ethical principle of *respect for persons* (as actualized through promotion and support of individual autonomy), all capable persons are acknowledged to have the right to make meaningful decisions about their health care and treatment and about other important matters related to their personal, social lives. Residents of HICs are provided with considerable latitude in their freedom to make choices about where they access health care and where they live because of society’s commitment to a relevant negative right, e.g., the right to not be interfered with in the pursuit of one’s chosen life plans. Once they present for care in EDs, persons with decision-making capacity have some discretion as to the forms of health care and treatment they receive from among those that are offered by attending EDHCPs. aREDFUs and other persons presenting for care do not have a recognized positive right to receive all the treatments that they desire and request, but in some liberal democracies, based on the person’s acute health care needs, EDHCPs are obliged to offer them an array of available treatment options that fall within the customary practices of EDs within their health jurisdiction – or, stated another way, that fall within the existing, accepted, standards of care for that healthcare delivery setting. The scope of recommended treatments that capable EDFUs can autonomously refuse is only limited by the determination of their attending physician(s) / nurse practitioner(s) that, by the refusal of such care, they are posing a danger to themselves or others or, in some jurisdictions, a determination that, without patient adherence to a recommended treatment(s) and intervention(s), they are at significant, imminent risk of deterioration in their psychiatric status.

This theoretical account of the personal freedoms of persons is misleading in the challenging, real-life circumstances of aREDFUs. Despite the obligation of attending EDHCPs in some ED settings to offer the scope of treatments and interventions that fall within the customary practices of EDs, many of these care options cannot be effectively accessed in a sustained manner by aREDFUs because of associated requirements for what many of these patients simply do not have, including 1) functional, healing environments, including viable housing and nutritional arrangements, 2) adequate financial resources, and 3) the support and assistance of allies such as family members and engaged friends.

The ethical and social science conception of *relational autonomy* is useful in recognizing and understanding this reality. Critical feminist theorists have argued in compelling, theoretical ways that autonomy, as actually practiced by persons in society, has important relational elements and is a product of social relations. A person is not an autonomous, decision-making *island*. Instead, they are situated within a dynamic web of relationships such that the making of a decision by one person, i.e., the pulling of a strand of the relational web, can significantly affect the choices, decision-making, and life circumstances of persons situated at other loci within the web (21). Average- to high-functioning members of society are typically dependent on significant others within their relational webs if they are to pursue meaningful, productive lives and actualize their chosen life goals. For the varied reasons articulated earlier in the paper, many aREDFUs do not have such functional, relational webs. They are often cut off from family and former friend supports while living physically and relationally isolated lives in the community. Moreover, aREDFUs typically lack meaningful connections with professional support persons and agencies that are located within their communities to provide specific forms of pragmatic assistance. This is a particular vulnerability for persons with severe and persistent mental illness, given the historical failure of many HIC health jurisdictions to augment existing and develop new community-based services for this subset of the population after the deinstitutionalization movement of the late 20th century. This vulnerability is also negatively shaped by chronically low allocations of healthcare resources to fund community-based and in-hospital mental health care services, despite the demonstrably high, legitimate needs for such services in HICs (22).

Social construction and personal responsibility

The social science conception of *social construction* is another useful lens through which to analyze the lived circumstances of aREDFUs. Social construction “is a conceptual framework that emphasizes the cultural and historical aspects of phenomena widely thought to be exclusively natural” (23, p.567). Social constructionists draw a distinction between a disease, i.e., the biological health condition, and illness, i.e., the social meaning of the health condition. A social construction analysis demonstrates “how the meaning and experience of illness is shaped by cultural and social systems”, including the state of medical knowledge and the existence of significant power differentials (p.567).

Persons, including aREDFUs, who suffer from stigmatized illnesses, such as HIV disease and psychiatric disorders of the severe and persistent type, often experientially inhabit shrunken day-to-day worlds in which a great deal of their energy is consumed by dealing with their illness-states and other people’s discriminatory responses to these states. They are frequently cut off from many of the features of conventional life that are taken for granted by others, e.g., being gainfully employed, spending time with family members, socializing with friends, and moving around freely.

Given socially constructed elements of their highly challenged life circumstances, many aREDFUs do not have enough practical knowledge or social agency to be considered blameworthy or to be reasonably held accountable for their less-than-optimal health care, residential circumstances, and other life choices (24). For example, for persons with severe and persistent mental illness who live on the streets or in shelters, their smoking of cigarettes may not be fully autonomous, as smoking behaviour is a part of the culture of living with chronic, serious psychiatric conditions in insecure environments, and it is known that the consumption of nicotine may reduce hallucinatory experiences in persons with psychotic disorders (25).

Other health-related actions known to be associated with poor health outcomes about which aREDFUs have inadequate knowledge, and over which they often have sub-optimal control, are nutritional choices and the use of alcohol and illegal drugs. It is not uncommon for aREDFUs to have: 1) strong, genetically-based family histories of alcohol and drug addiction, and 2) the lived experiences of growing up in social circumstances characterized by significant alcohol- or drug-use-related dysfunction (26,27). In the context of the challenging lived experiences of many aREDFUs, moral notions such as culpability, bad intent, and causal moral responsibility have little practical meaning or application.

It is important for attending EDHCPs, when deciding how to communicate and interact with aREDFUs, to take into consideration the reality of the social construction of some components of chronic physical and psychiatric illnesses, and the related lack of full, personal responsibility of many of these patients for their sub-optimal health statuses and frequent visits to EDs. With this awareness, EDHCPs can acknowledge their biases and challenge any existing conscious or subconscious discriminatory attitudes that they have toward aREDFUs (28). This also has the potential to constructively mitigate the experiential frustration and attitudinal negativity that is sometimes experienced by EDHCPs in their regular interactions with aREDFUs.

EDHCPs, health administrators, and public funders may also wish to reconsider their tendency to assume that the unhealthy behaviours of aREDFUs are very costly to the healthcare system in terms of the related misallocation of limited health resources. As Peter Ubel (1997) comments, “…any attempt to base allocation on personal responsibility is impossibly entangled with our social judgments about the desirability of [health-related behaviours]” (26, p.344). Moreover, it is known that, because of premature mortality outcomes and the fact that the health demands of persons typically escalate in late old age, costs to the health care system over a lifetime are often reduced for persons with health-related behaviours and addictions, such as smoking and the overconsumption of alcohol, as compared with the lifetime costs that accrue for persons who do not have such (socially-constructed, at least in part) behaviours (24,29).

Patient welfare principles and harm reduction

The *patient welfare* principles of beneficence and nonmaleficence are of relevance to the management of aREDFUs by EDs and acute-care health organizations. From the perspective of beneficence and duty of care, EDHCPs are obliged to offer therapeutic benefits to patients and, additionally, to provide compassionate, nonjudgmental, dignity-promoting, and culturally safe care to all persons who present to EDs. At a minimum, this entails an assessment of the patient's presenting health care need(s). In some HIC health jurisdictions, as indicated in an earlier subsection of the paper, there is also an obligation to offer treatments that fall within the scope of the existing, accepted standard of care for the presenting healthcare condition(s).

The principle of beneficence requires that HCPs and health organizations provide continuity of care to their patients (22). It is widely accepted that HCPs, who have existing therapeutic relationships with patients, have an obligation to continue to provide healthcare and treatment services within their professional purview or to refer their patients to (an)other, appropriate HCP(s) as per the mechanisms established by their relevant professional regulatory body. The continued provision of beneficent care to patients is typically actualized and promoted through the development and maintenance of functional, therapeutic relationships. In the context of the provision of emergent care, it is typically not possible for individual EDHCPs and patients to form such full, therapeutic relationships. However, the ED itself, as an organizational-care entity, can decide to offer consistent, beneficent care to aREDFUs through the development and implementation of a policy-based approach to the care and management of such patients in as optimal a manner as possible.

It is recognized that EDHCPs, as agents of beneficence, are currently stretched to the breaking point because of the challenges posed by Covid-19 and other circulating, infective respiratory conditions. Some of the non-constructive, burnout-related behaviours exhibited by EDHCPs in their responses to aREDFUs result from the untenable circumstances in which EDHCPs are expected to provide optimal care. The policy-based approach that is proposed later in the paper takes into account the significant health resource and other constraints experienced by EDHCPs and the EDs in which they work.

From the perspective of nonmaleficence, it is widely acknowledged that HCPs and health organizations are obliged to do as little as possible harm to persons who present for care. What follows from this responsibility in the context of providing care to aREDFUs in EDs is not as straightforward as avoiding unnecessary treatments and minimizing patients' experiences of treatment-related side effects and potential complications. Decisions about how EDs and EDHCPs operationalize nonmaleficence need to take into meaningful consideration the typical complex circumstances of this subset of the patient population. *Harm reduction* is "a conceptual framework and set of practices" (15, p.130) that is designed to take into account such challenges and to manage the health and associated social needs of these patients in as optimal a manner as possible. Harm reduction is applicable in circumstances where: 1) it is recognized that the unhealthy actions and behaviours of individuals cannot be eliminated or effectively mitigated, and/or 2) efforts to prohibit these actions/behaviours could result in worse harms and burdens to the affected individuals than the continuation of them, and/or 3) prohibitive enforcement would interfere too much with the autonomous decision making and self-governance of persons who are members of liberal democracies (30,31). An example of circumstances that may warrant the adoption of a harm reduction approach is the use of illicit, intravenous substances in the community, which is difficult to control in HICs when it is not coupled with overt, illegal behaviours such as major theft and drug trafficking. The related prevalence of significant harms, such as the acquisition and transmission of HIV and hepatitis C, and high overdose-related mortality, can be effectively reduced by providing intravenous substance users with sterile drug administration supplies in the relatively safe, drug delivery setting of a supervised overdose prevention site. Additionally, clinicians and theorists have begun to advocate for the use of harm reduction strategies in the management of psychiatric patients – such as persons with chronic, disabling mental health conditions, including treatment-refractory mood disorders and severe and enduring anorexia nervosa – where the goals of treatment have been appropriately modified to the sustaining or enhancing of patient-chosen, quality-of-life elements rather than to the possible achievement of symptom-free recovery (32,33).

Other harm reduction strategies focus on housing. Access to housing is often a barrier for persons with severe and persistent mental illnesses and comorbid substance use disorders. As described by Padgett, Gulcur, and Tsemberis (34), housing programs typically call for abstinence from substance use. However, by tying access to housing with demonstrated adherence to successful, abstinence-based treatment for substance abuse, the individual's right to make voluntary life choices is compromised. Harm reduction approaches, such as 'Housing First', prioritize housing as a fundamental human right that is crucial to a person's health. These authors advocate for a type of "supported housing" that separates treatment for substance use from housing, considering the former optional and the latter "a fundamental need and human right" (34, p.75). In doing so, such innovative housing programs actualize a form of harm reduction that supports and promotes individual autonomy in health and social decision-making.

A theoretical account of harm reduction provided by Daniel Weinstock has some useful elements for consideration in the development of a policy-based approach to effectively pragmatize the ethical principle of nonmaleficence (30). Weinstock describes one of two main forms of harm reduction as "deliberative harm reduction" (p.321), grounded in what he calls "the fact of reasonable disagreement" about relevant underlying, first-order values and principles (p.317). It also concerns, and pays attention to, how these values and principles should inform the development of macro- and meso-level health and social policies that guide the management of the unhealthy behaviours and practices of some societal members. Rather than society making a typically unsuccessful attempt to prohibit a behaviour that is considered unhealthy or morally wrong, Weinstock advocates for the use of a form of deliberative engagement of relevant core stakeholders that provides a non-judgmental,

collaborative means to develop relevant policies that are as optimal and fair as possible. Resultant policies meaningfully instantiate respect for the views and positions of all participants despite the high likelihood of residual disagreement. A deliberative engagement methodology of a similar but more structured type is proposed as an important feature of the proposed ethics-informed, policy-based approach to the care and management of aREDFUs described in the next section of the paper.

Justice and health equity considerations

Considerations of *health equity* and distributive, formal, and social *justice* are of relevance to the development and implementation of a fair approach to the management of aREDFUs by EDs, EDHCPs, and health organizations. From the perspective of distributive justice, it is recognized that the frequent accessing of ED care by the subset of the general population made up of aREDFUs constitutes an over-consumption of limited, publicly funded, healthcare resources in HICs with socialized medicine arrangements. In HIC health jurisdictions with privately funded health care systems, this overuse also puts significant financial strain on acute care hospitals, given that persons without private health insurance in these jurisdictions often have a legal right to receive health care assessment and treatment services in ED settings (3,7).

Current conversations among EDHCPs and ED administrators regarding the frequent use of EDs by some patients tend to focus on distributive justice considerations in a particular way – the major problem posed by EDFUs is their purported significant drain on the limited health resources of hospitals and, more broadly, health care systems (6). There is, of course, some truth to this claim. In health jurisdictions where there are insufficient health resources to meet all the health needs of residents, as is the case in most if not all HICs, the overuse of treatment services by a subset of the patient population presents an *opportunity cost* to the more equitable allocation of available health resources. As mentioned earlier in the paper, this is not as clear cut as it is usually presented, as persons with significant, chronic health conditions attributable to health-related behaviours such as chronic smoking and substance use frequently die young – their lifetime use of collective health resources is often less than that of those who maintain healthier lifestyles. Also, in reality, a reduction in the use of EDs by aREDFUs can only really save the healthcare system money if the overuse of services by aREDFUs is of such a magnitude in a particular hospital setting that the number of ED treatment beds and the related complement of EDHCPs and other staff could be reduced if clinical care circumstances were different — i.e., if all patients are making ED visits at the same frequency as the existing majority of persons presenting for emergent care to the hospital.

Health equity is a related consideration that speaks to, and concerns, the access to care of patients with healthcare needs beyond addressing traditional distribution considerations. All persons with legitimate healthcare needs within a given health jurisdiction should have equitable access to available, appropriate healthcare services. It is recognized, in the typical HIC circumstances of limited health resources, that the occupation of ED beds and, in some cases, in-patient hospital beds by EDFUs whose health and social care could be effectively delivered elsewhere, e.g., in the community, reduces the access of other persons with emergent and in-hospital care needs to these essential health services.

It is important to recognize that distributive justice and health equity are only two of the relevant justice-related lenses to apply in the circumstances of aREDFUs. Formal justice, usually attributed to Aristotle, requires that individuals and groups of persons be treated the same unless a *relevant* difference can be demonstrated that justifies their different treatment. As applied to persons who access EDs for health care, aREDFUs should be treated the same as those who visit on a less frequent basis unless there is a *relevant* difference between these two groups of ED patients. In terms of the previously cited obligations of EDHCPs and healthcare organizations to respect patient autonomy and to actualize patient welfare principles, an obvious, *relevant* difference(s) does not appear to exist. However, the overuse of ED services, a limited health resource, by aREDFUs, as compared to the less frequent and more appropriate use of ED services by the majority of patients who present for emergency care, does appear to constitute enough of a *relevant* difference between the two groups of ED patients to justify the development and implementation of an ethics-informed, policy-based approach to the care and management of aREDFUs in HIC EDs.

The lens of social justice is of particular relevance to the circumstances of many aREDFUs. Social scientists and critical feminist theorists have argued in compelling ways that forces of systemic domination and oppression work together to significantly limit the options of members of historically marginalized and otherwise disadvantaged social groups (21). Iris Marion Young's conceptualization of democratic cultural pluralism is particularly helpful in identifying which social groups are significantly disadvantaged in HICs. Young specifies five categories or *faces of oppression*, i.e., exploitation, marginalization, powerlessness, cultural imperialism, and violence (35). She considers the lived experience of each of these five categories to be a sufficient condition for social group oppression. Many aREDFUs, e.g., persons with severe and persistent mental illness, homeless or insecurely-housed persons, and chronic substance users, qualify as members of disadvantaged social groups by virtue of their common experience of one or more of these *faces of oppression* – in particular, in the health and social context under consideration, those of marginalization, powerlessness, and violence. The recognition and acknowledgment that a social group is significantly disadvantaged within a liberal democratic society places a social-justice-related obligation on those persons and organizational agents who professionally interact with such groups to pay particular attention to the meeting of their healthcare and associated social needs. In addition to the development by EDs and health organizations of care and management approaches that comprehensively and consistently address the healthcare needs and social complexity of aREDFUs, it is important – from a social justice and participatory-democracy perspective – to ensure that members of disadvantaged social groups are meaningfully engaged in the development and implementation of macro- and meso-level health policies that directly affect them.

DEVELOPING AND IMPLEMENTING AN ETHICS-INFORMED, POLICY-BASED CARE AND MANAGEMENT PLAN

Proposed optimal features of an ethics-informed, policy-based approach

Based on the outcomes of the previous ethics analyses, the following optimal elements of a policy-based approach to the care and management of aREDFUs in HIC health jurisdictions are proposed:

- Promotion of the fragile, challenged autonomy interests of aREDFUs by providing pragmatic support to their health-related decision making and by augmenting over time, as possible, their impoverished, relational webs.
- Fostering of nonjudgmental, accepting communications and interactions with aREDFUs where the negative biases and attitudes EDHCPs are uncovered, acknowledged and consciously modified.
- Provision of beneficent, appropriate care that is compassionate, dignity-promoting and culturally safe.
- Mitigation over time, where possible, of the existing injustices and inequities experienced by aREDFUs.
- Prudent, fair/just use of limited health resources.
- Use of well-thought-out, appropriate harm reduction strategies.
- Encouragement of meaningful aREDFU engagement in the initial establishment, and subsequent 'living', of ethics-informed care and management plans.
- Promotion of constructive, sustained, functional relationships of EDs (and the EDHCPs working within them) with aREDFUs.

Examples of the pragmatic application of these optimal features in real-world HIC ED settings are provided below.

Recommended use of a deliberative engagement, policy development process

Relevant, meso-level health policies should be developed by HIC EDs to guide the establishment and maintenance of care and management plans for aREDFUs. There is a socially just and pragmatic methodology for developing health policies with strong ethics elements (and constructively handling the significant, organizational-ethics challenges of health organizations) that fosters the collaborative identification of the multiple obligations and responsibilities that arise in complex healthcare delivery circumstances (22). It uses a structured, deliberative engagement approach that is inclusive and stakeholder-driven in nature. This methodology is influenced by the academic insights of Iris Marion Young, who contends that members of the sociocultural and vocational groups that are anticipated to be directly affected by a health policy's outcomes should have the opportunity to participate directly in the policy-making deliberations. In addition, it recognizes that the developers of health policies should be obliged to demonstrate that the interests and perspectives of core stakeholders have been meaningfully considered (35). Policy making of this deliberative sort is meaningfully informed by collaboratively chosen, task-specific, substantive principles and values that aim to 1) assist in the normative framing and interpretation of relevant policy matters and issues, and 2) act as values- and principles-based criteria for making collaborative decisions during the development of policy content. Typically, the concurrent application of these substantive principles and values, which are not lexically ordered in terms of their moral or practical importance, leads to tensions that need to be identified, and competing obligations to be carefully weighed and balanced by policymakers. Another feature of this methodology is the intentional use of deliberative dialogue to collectively develop optimal arguments on all sides of relevant policy or organizational ethics issues, consistent with the *principle of charity* in philosophical discourse. With skilled facilitation, participants can learn to assist their colleagues in the elucidation and strengthening of arguments that are opposed to their own intuitions and positions.

In the considered context of an ED's development of a policy to guide the care and management of aREDFUs, it is proposed that a policy development working group be established that consists of identified core stakeholders and relevant resource persons. Working group members in the policy-making context under consideration would, ideally, include an ED physician, nurse practitioner, direct care nurse, social worker, an administrative lead, an aREDFU where possible (or a former aREDFU), a family member of an aREDFU, a professional member of a community-based support service, a trained advocate for members of marginalized social groups, an Indigenous health professional, and where available, consultants in psychiatry, addictions, health care ethics, and health law.

The eventual implementation of such a meso-level health policy in the considered context, which has been collaboratively developed by relevant core stakeholders and informed by the collective consideration of chosen substantive principles and values, will help ensure that aREDFUs who present to the ED are managed in a fair and optimally consistent manner. This, in turn, mitigates the negative consequences of the possible actions of EDHCPs and ED health administrators who (understandably) may have subconscious biases against members of this challenging subset of the patient population.

Examples of relevant substantive principles and values[1] that could be considered by working group members in this health policy development context include:

- Individual and relational autonomy
- Health equity
- Justice:
    - Traditional-distributive
    - Formal
    - Social
- Patient welfare principles:
    - Beneficence and duty of care
    - Non-abandonment and continuity of care
    - Nonmaleficence
    - Harm reduction
- Efficiency and utility
- Sustainability

Early in the policy development process, it is useful for working group members to collaboratively write descriptions of their chosen substantive principles and values, which can be referenced throughout the policy-making deliberations. Two examples of such principle and value descriptions are:

> *Health equity* – the obligation of healthcare providers and organizations to identify and eliminate or mitigate unfair disparities among individuals and sociocultural groups in their opportunities for health and their access to appropriate healthcare treatments and interventions.
>
> *Efficiency/utility* – the responsibility of healthcare organizations to pursue and accomplish desired health-related activities with an optimally-efficient expenditure of limited resources such as public funds and staff time. Respect for the principle of efficiency in the modern health care context requires that organizational decision-makers pay careful attention to the delivery of health care services in intentional, strategically-integrated ways.

Ideally, the progressive development of policy content by the working group is guided and structured by a facilitator who: 1) has experience in the use of the methodology, 2) is generally knowledgeable about health care delivery systems in the relevant health jurisdiction, and 3) has a pragmatic understanding of, and sensitivity to, the reasons and ways in which persons with significant, chronic psychiatric and physical health conditions are typically not well *heard* by health care providers who engage with them.

Although the topics and issues that arise during the development of a relevant, ethics-informed, meso-level policy will vary depending on the location and funding statuses (i.e., public or private) of the EDs in differently-situated HIC health jurisdictions, considerable attention will likely need to be paid to the establishment of constructive strategies to deal with challenges related to aREDFUs' common experiences of severe and persistent mental illness, chronic substance use, and entrenched behavioural patterns of nonadherence to treatment and follow-up recommendations. In doing so, the fundamental, competing obligations of EDs and the EDHCPs working within them to on one hand, respect and promote the autonomy and equity interests of capable aREDFUs as much as possible, and, on the other hand, protect, and do as little as possible harm to, these patients (and EDs/EDHCPs) will require careful consideration.

Examples of the pragmatic application of an ethics-informed, policy-based approach

Potential ways for members of an ED's policy development working group to pragmatize an ethics-informed approach to the care and management of aREDFUs in a meso-level health policy can be imagined, including: 1) program coordination, 2) development of individual care and management plans, 3) healthcare provider and staff education, and 4) standardized program management

1. Program coordination

The initial communication with a capable aREDFU in the ED concerning the establishment of a care and management program is crucial. It is suggested that in urban, high-volume EDs, a program coordinator be appointed. This could be practically achieved (without health-system cost-amplification) through the expansion of the duties of an ED's social worker who, by the nature of their work, is a member of the circle-of-care of ED patients. The program coordinator (during regular, weekday hours) or a program-trained, other EDHCP (at other times) starts a conversation, as soon as possible during the aREDFU's next visit to the ED, after their frequent-user status has been identified. This initial approach, and all subsequent communications with the aREDFU, should be respectful and non-judgmental in tone and content to intentionally build and sustain trust and to establish and maintain, as much as possible, functional rapport with the aREDFU. This requires that the program coordinator and program-trained EDHCPs be aware and cognizant (though pre-education/training and professional support) of their own

[1] As described previously, these substantive principles and values are not lexically ordered, and any competing obligations arising from consideration of them require collaborative weighing and balancing by members of the policy development working group.

relevant subconscious biases when communicating with the aREDFU. The goal of the initial approach to the aREDFU is the setting up of a meeting of the program coordinator with the EDFU at their community residence, if such a housing arrangement exists, or in the ED to discuss the establishment of a care and management plan. The aREDFU is informed that an advocate of their choosing, e.g., an engaged family member or friend, may participate in this meeting.

If the aREDFU does not actively oppose the development of the plan but does not show up for the scheduled meeting, the program coordinator or a program-trained EDHCP attempts to meet with the EDFU during their next visit to the ED. If the aREDFU actively opposes the establishment of a plan or is cognitively impaired (e.g., by acute psychiatric illness and/or an active substance use disorder) when they are approached for this purpose in the ED, the plan is established by the program coordinator without the initial, direct input of the aREDFU. The content of the care and management plan may be informed by documented, relevant health and social information already contained in the health record and, 2) (as consented to by the aREDFU) information obtained through communication with a family member or friend, as available and willing (see subsequent comment re. a suggested approach to achieve this).

For those aREDFUs who are willing to engage in the development of a care and management plan, the program coordinator or program-trained EDHCP enters into a discussion with them that includes information-gathering about the following suggested elements:

- aREDFU-perceived, significant health conditions
    - Physical health
    - Mental health
- Existing social supports, if any
- Existing community supports, if any
    - Health-related
    - Social
    - Other
- Housing status
- Substance use status
- Established, historical pattern regarding adherence to recommended treatments and follow-up

A care and management plan is then developed with the capable aREDFU that actively addresses the challenges and issues that are identified during the intake component of the initial meeting or that are contained in the aREDFU's health record or that are obtained through the consented-to seeking of collateral information.

2. Development of individual care and management plans

A few examples of the content of the proposed care and management plans can be envisaged.

Patient education – significant differences or divergencies between the aREDFU's perception of their health conditions and the health record evidence of their health status are identified and discussed, as appropriate. Patient education may also include conversations with the patient about 1) the inappropriate use of EDs for routine health concerns that can be adequately addressed elsewhere, and 2) the appropriate use of EDs for emergent exacerbations of their chronic health conditions.

Social support – if the aREDFU lacks functional, personal family and friend supports, an offer could be made for the program coordinator to reach out in an exploratory way to a former, core family member or friend to determine whether some form of constructive support or an advocacy-type relationship can be restored.

Housing – if the aREDFU is homeless or insecurely housed, an offer could be made for the program coordinator to establish contact with a local Housing First Program (or equivalent organization) to explore alternative housing options for the patient.

Partnering with relevant, community-based health delivery services – if the aREDFU has an active, significant psychiatric disorder for which they are not being actively treated and followed by an appropriate mental health care practitioner, an offer could be made regarding the setting-up of an appointment for the aREDFU in a local psychiatric outpatient department or with a local Mobile Outreach Street Health (MOSH) program. If the aREDFU has an active, significant substance use disorder, the aREDFU's goals concerning abstinence-based treatment or the possible use of appropriate harm reduction strategies could be explored. For example, if a drug-injecting substance user is not interested in, or ready for, abstinence-focused intervention and support, but is willing to make some efforts to maintain or enhance their health safety and quality of life through harm reduction, information about and referrals regarding available local community-based services such as free drug supply distribution and supervised injection and overdose protection sites could be provided. For persons with chronic, treatment-refractory alcohol use disorder who are homeless or insecurely housed, admission to a shelter or transitional residence that has a Managed Alcohol Program could be considered (18). If the aREDFU has a historical pattern of non-adherence to recommended treatment and follow-up care, engagement in collaborative strategies to support their adherence could be offered. For example, if the aREDFU has an active, psychotic mental illness(es) and provides informed consent to be treated with prescribed, regular antipsychotic medication, an appointment could be arranged with the local psychiatric outpatient clinic or MOSH regarding the regular, monthly administration of intramuscular, depot injections of antipsychotic medication(s) in the

community. Also, in these circumstances, the care and management plan could, as consented to by the patient, include a provision for the confirmed dates of administration of the intramuscular, antipsychotic injection to be shared between the outpatient psychiatric clinic or MOSH and the ED, so that missed dosages can be administered during ED visits.

Establishment of limited care and management plans – for those aREDFUs who are opposed to the establishment of a care and management plan or who do not follow through with any suggested assistance offered by the program coordinator over a sustained period, a limited type of plan could be established by the program coordinator. Such plans focus on the practicalities of appropriate assessment and care that are to be consistently provided to the aREDFU in terms of standard investigations and treatments during their (anticipated-in-type) presentations to the ED. If the aREDFU has demonstrated a longstanding, intractable pattern of non-adherence to recommendations, the care and management plan could provide guidance to attending EDHCPs that further in-hospital specialist and community-based service referrals are not to be arranged for the aREDFU during ED visits to facilitate the fair and prudent use of limited health and social service resources in the health organization and community. The implementation of such a (limited in content and scope) plan for the EDFU could indirectly promote and enhance the delivery of health and social services to other local patients (in the form of improving their access to these resources). As such, limited care and management plans for aREDFUs would promote the distributive justice and health equity interests of other, non-EDFU patients, and help alleviate or mitigate the psychological and moral distress of EDHCPs, hospital-based specialty consultants, and community-based health and social service providers (36).

3. Healthcare provider and staff education

Members of the policy development working group may also wish to incorporate a relevant educational component for EDHCPs and other ED staff into the established meso-level health policy (36). This could take the form of the program coordinator setting up, and actively facilitating, constructive group dialogue during a series of flexible education or information sessions held during times when EDHCPs and staff meet informally for coffee, meals, etc. Examples of some appropriate topics which could be addressed during these sessions are the social construction of illness and related personal responsibility considerations regarding marginalized patients, challenges in supporting autonomous decision making in the ED, prioritizing social justice and health equity in the delivery of emergency health care, harm-reduction strategies appropriate for employment in collaboration with aREDFUs, relevant community-based supports, management of the psychological and moral distress of EDHCPs treating aREDFUs and other challenging patients, and advocacy initiatives for ED patients who are members of diverse and heterogeneous, disadvantaged social groups.

4. Standardized program management

An electronic, standardized form containing all the practical elements of the established, individualized care and management plan should be available on the aREDFU's health record with a built-in, non-discriminatory mechanism to draw it to the attention of attending EDHCPs and the program coordinator or a program-trained EDHCP when an identified aREDFU presents to the ED. The specific responsibilities of different attending EDHCPs – e.g., physicians / nurse practitioners, direct-care nurses, social workers, the program coordinator, and program-trained EDHCPs – are spelled out within the care and management plan in a clear, optimally accessible way. The program-related actions of EDHCPs taken during the ED visits of aREDFUs are recorded in an attached, electronic, progress-notes section of the form with a built-in mechanism for the program coordinator and program-trained EDHCPs to be notified of newly added content (if they were not present and engaged during the aREDFU's ED visit).

CONCLUSION

Relevant ethics approaches applicable to the significant challenges posed by living-at-risk, frequent users of emergency departments in HIC health jurisdictions are identified, explored, and analyzed in this paper. The outcomes of these analyses demonstrate that there are compelling reasons for EDs to adopt an ethics-informed, policy-based approach to the longitudinal care and management of living-at-risk, frequent users of emergency departments. Examples of possible, pragmatic components of such an approach are provided for the consideration of an ED policy working group, consisting of core stakeholders and relevant resource persons, that is tasked to develop a meso-level health policy through the use of a socially just, deliberative engagement methodology.

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