

# Ethical Challenges in Emergency Medical Services

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This paper was approved by the Executive Committee of the National Association of EMS Physicians, 13 September 1992.

Published in *Prehospital and Disaster Medicine*, April-June, 1993

These views expressed are those of the NAEMSP and do not necessarily reflect those of the United States Air Force.

## Introduction

Over the past 20 years, the field of prehospital medicine has undergone impressive growth. As the body of knowledge continues to grow, as more technology is introduced, and as research defines and refines the uniqueness of prehospital emergency medical care, the challenges of the prehospital setting are becoming more than operational and medical. Efficient response, appropriate care, and safe, expeditious transport are the expectant fundamental components of prehospital care. However, more and more prehospital providers are facing challenging ethical dilemmas.

The prehospital provider must frequently interact and negotiate with reluctant patients, counsel those patients who ask for advice or refuse care, address requests for limitation of resuscitation, assume some degree of personal risk in the care of agitated, uncooperative, or infectious patients,

deal with social and psychiatric challenges, and respond to a variety of unusual requests which may not be medical in nature. Each of these situations presents potential ethical conflicts.

There are three fundamental ethical premises that guide prehospital medical care. The principle of justice implies that the system be fair and equitable. The principle of beneficence requires that actions and intentions are in the best interest of the patient. Respect for patient autonomy dictates that the requests of the patient are honored and nothing is done which is contrary to the wishes of the patient<sup>1</sup> These philosophical principles are the underpinnings of the discussion that follows.

Formal training alone does not prepare the prehospital provider to deal with ethical situations. Many learn by experience; some are guided by well-defined policy. Appropriate resolution of ethical dilemmas in prehospital care is promoted when those who provide and those who direct prehospital care are educated and sensitive to ethical conflicts which may arise. This statement outlines several ethical issues which are prominent in the prehospital setting, and proposes a course for further deliberation. Before specific ethical issues are discussed, the relationship between ethics and the law must be clarified.

### **The Relationship Between Ethics And Law**

Emergency medical services must look to the law for guidance when developing methods to honor advance directives to limit resuscitation or to implement policy regarding involuntary transport of dangerous patients. However, legal guidance does not provide the answer to every difficulty that may arise. There are many situations in the prehospital setting that have not been addressed by statute or case law. In addition, statutes may vary substantially between states. Ethical theory should set a universally applicable standard. Also, the law may be ambiguous, so no clear guidance is offered, or it might be very specific, applying only to cases with substantially similar circumstances. The law also does not address the breadth of ethical imperatives which obligate emergency medical services. Finally, the law may not reflect ethical behavior. For example, case law has stated that a person who knows how to swim has no legal obligation to rescue a drowning child. While the law is limited in its ability to provide universal guidance and direction, ethical analysis should provide a framework for determining moral duty, obligation and conduct.

Similarly, ethical analysis does not substitute for appropriate legal guidance. When dealing with dilemmas, when initiating policy and protocols, or when updating existing procedures, informed legal advice is mandatory. An

attorney familiar with prehospital challenges and well-versed in relevant statutory and case law, will help to define legally acceptable actions.

### **The EMS Ethical Obligation**

When an emergency medical services (EMS) system holds itself out to the community as an emergency response network, it is assuming an important ethical obligation. It has the duty to respond regardless of the patient's income or social position. Care must not be limited unfairly to any specific group or class of people. Financial concerns do dictate the resources available, and often set the community level of prehospital care. Financial limitations do not necessarily present an ethical dilemma. The duty of the system is to uphold those standards that it sets for itself; whether the services are basic or advanced, they must be medically acceptable.

Emergency medical services often set priorities of care or classify certain calls as "non-emergencies." Patients with minimal illnesses may not be transported, or may have transport delayed. This rationale or triage of care must be based only upon medical indication and well-defined protocols. These efforts are appropriate because they allow the system to be fluid and accessible to critically ill or injured patients. These allocation decisions must not be arbitrary, and must not penalize any group unfairly. When planned appropriately, EMS might be regarded as one of the most fair of health care institutions. Emergency medical service policies must remain equitable and just.

### **Prehospital Ethical Issues**

#### *Limiting Resuscitation Efforts*

Emergency medical services should be available to all persons in need, including terminally ill patients who need to be transported to the hospital for palliative care. Prehospital care providers require a means to honor patient directives to limit intubation and avoid application of cardiopulmonary resuscitation (CPR). This issue often presents a complex problem. Requests to limit resuscitation will confront the provider in many forms. Written Do-Not-Resuscitate (DNR) orders, living wills, clear and unequivocal family requests, and a relative's impulsively expressed reservations about life support will be encountered. Acceptable directives must guarantee that withholding resuscitation would reflect the informed wishes of competent patients.

Reliable mechanisms have been developed by some EMS systems to identify patients in the prehospital setting who do not want to be resuscitated<sup>3</sup> These

constructs allow recognizable, consistent, legally accepted, written statements to be used as valid indication that the patient wishes to have no CPR or intubation at the time of cardiac arrest. The goal is to minimize ambiguity and maximize patient autonomy. Such documents must be familiar to the emergency medical service, be easily recognizable to the prehospital care provider, and be specific in regard to the interventions to be withheld. Extensive written lists should be avoided, since the time to read, interpret, determine the applicability, and decide on a course of action threatens appropriate care. There can be no delay or question when such directives are presented. Importantly, legal counsel must be involved with the development of any prehospital DNR system, since state laws regarding this issue vary widely. Some states have passed statutes to authorize prehospital orders to limit resuscitation.

Verbal requests by relatives cannot be accepted. When ordinary verbal requests are made, it is not clear that they may represent the informed decision of the patient. An exception to this rule exists when the relative holds a durable power of attorney to make health care decisions. The person who holds power of attorney for health care decisions has a duty to base decisions on the patient's values and wishes; the decision-maker must assess what the patient would have wanted. As a legally recognized proxy decision-maker for the patient, this person may request that resuscitation should be withheld. Based on this direction, resuscitation ethically can be withheld. This might present confusion for the prehospital care providers who may have little experience in dealing with these situations or may be unsure if the decision has been well thought out. Even a legally designated proxy decision-maker may make impulsive requests that are not carefully thought through. Prehospital care providers should not enter into what may be a complicated and uncomfortable discussion regarding health care options and questions of the legitimacy of withholding resuscitation. At the time of crisis in the prehospital setting, such discussions are not appropriate. If there is any doubt about the legitimacy or authority of a request to withhold resuscitation, appropriate resuscitation maneuvers must be initiated. If the authority is clear and the emergency medical service acknowledges such directives, there is no ethical reason that they could not be accepted. Optimal communication is facilitated through a written "no CPR/no intubation" order which is familiar and acceptable to the prehospital care provider. Acceptable written advance directives should be standardized and promoted by the emergency medical service.

Blanket policies which mandate that all patients must undergo resuscitation are not appropriate. Patients should have a mechanism to express their wishes to have CPR and/or intubation withheld. Emergency medical services must work with legal counsel and state agencies to develop appropriate

mechanisms to honor advance directives in the prehospital setting. Written "no CPR/no intubation" orders should detail the patient's name, signature, date of the order, diagnosis, "no CPR/ no intubation" specification, and personal physician's name and signature. Further ethical guidelines should be developed to assist emergency medical services who wish to develop prehospital DNR policies<sup>4</sup>.

"Dead on Arrival" (DOA) policies specify those patients who should not undergo resuscitation attempts, because the effort would be futile. While the medical criteria which define futility must be discussed from a scientific point of view, the ethical implications are evident. Prehospital care providers may be biased regarding age, underlying illness, or other factors which may or may not suggest futility. In general, age, medical history, social position, or patient vices should not determine whether resuscitation is initiated. The values and attitudes of the prehospital care provider must not enter into such decisions. The decision to determine that a patient is "dead on arrival" must be made on firm scientific grounds. In those medical conditions which have been scientifically accepted as futile, resuscitation should not be carried out. Strict criteria, education, and appropriate supervision and review must be part of a DOA policy. Continued research should define further those situations where "DOA" determination are medically appropriate.

### *Informed Consent*

Patients will express preferences and voice demands regarding interventions and hospital destination. They will refuse care, refuse elements of care, prefer transport without interventions, or prefer interventions without transport. Protocols and policies should be developed to deal with these circumstances. The provider must be trained to deal with these difficult circumstances, while respecting both the patient's autonomy and the obligation of beneficence.

The prehospital care provider operates, as does the physician, only at the request and with the consent of the patient. This is complicated particularly in the prehospital setting when the patient may not have been the one to call for assistance, but is confronted with providers who are eager to intervene. Prehospital care practitioners must respect patient autonomy. Nothing can be done to a patient without the patient's consent, whether this consent is explicit or implied. Prehospital care providers comfortably operate under implied consent when patients request and cooperate in the care. The emergency rule, or consent applied by law, presumes that consent is offered if the patient is unable to express it because of illness or injury. In these cases, treatment must proceed when prompt intervention is necessary to prevent loss of life or disability. True informed consent requires that the

patient participate in the decision-making with a full understanding of the risks and benefits of treatment as well as the risks of lack of treatment<sup>5</sup>. The ideal of informed consent is difficult to achieve in the typical prehospital setting. Nevertheless, in the routine of prehospital emergency medicine, when appropriate care is provided in the best interests of the patient without patient objection, no ethical dilemma is present.

A dilemma may arise when a patient refuses to consent to care. The competent patient's wishes must be honored: it only is with the patient's permission that care is rendered. However, patients in acute medical crisis might lack the ability to make reasoned judgments regarding their care. Withholding care based on a patient's impulsive refusal would not serve the patient's interests. Patients with intracranial injury, drug or alcohol intoxication, metabolic derangements, or mental illness might offer unreasoned refusals of care. Conversely, patients with dementia, mental retardation, or drug or alcohol intoxication may offer valid, autonomous decisions (i.e., a decision made with an appropriate understanding of the facts, risks, and benefits that are consistent with their personal values). Sometimes, it is difficult to know when a prehospital patient's refusal represents an informed decision. Transport and emergency department evaluation must be encouraged if the patient is at risk of harm. A patient may refuse care despite a serious illness. In this circumstance, if the patient was declared by law to be temporarily incompetent to make such decisions, care could be instituted. However, such decisions require a judicial determination. Only the rare EMS system can obtain rapid judicial determinations of competence.

Most emergency medical services are challenged to determine which patient refusals are acceptable. At a minimum, a patient must demonstrate an understanding of his or her illness, recognition of the risks of refusing care, be able to manipulate the information rationally, and freely and voluntarily refuse intervention. Further intervention should be carried out on any patient who cannot meet these criteria. In daily operations, the provider is confronted with the reluctant patient, the agitated patient, the impulsive, the incoherent patient, or the intoxicated patient who refuses transport to an emergency department. Since judicial determinations of incompetence usually are not available quickly, how should the provider respond to the refusal? When should the provider transport a potentially ill but reluctant patient? When must the provider demand that a patient be transported against his or her will? Do emergency medical services systems need to develop policies to obtain judicial determinations of patient competence rapidly? Such questions need to be discussed within each emergency medical services system. Communication with medical control must be encouraged. Prehospital care providers must have the ability to assess a

patient's decision-making ability. The greater the potential harm which could result from refusing care, the greater the decision-making ability that must be demonstrated by the patient. Ideally, rapid judicial determinations of competence should be available.

### *Duty to Provide Care*

The prehospital arena is unique among medical environments. Must the prehospital providers enter a building where they feel threatened? How should they interact with a dangerous patient? Each system must work out such issues regarding the duty of the prehospital provider. Clear policy can minimize conflict. As one policy is developed, some fundamental ethical principles must be recognized. Prehospital care providers have no duty to place themselves at risk in order to care for a patient. There is no responsibility to risk one's own health or safety for the benefit of another. However, dangerous circumstances can be anticipated; when they occur, the support of peace officers should be enlisted.

Other duties of the prehospital personnel and the emergency medical service include the obligation to ensure that prehospital personnel are trained to a standard that is consistent and has been accepted by the community. The system must be sure that its units are capable of expeditious and safe response and are equipped appropriately. There is no duty to provide every technology available or the highest-level training for every crew. There is a duty to provide a medically acceptable standard of care and ensure continuing education and quality assurance. The system has a duty to meet the commitments which it undertakes.

### *Confidentially*

When should the provider speak with the press? Should they speak with police regarding intoxicated patients? Should they ever be concerned about broadcasting names over radio frequencies that can be monitored by the public? Are prehospital care providers appropriately sensitive regarding the confidentiality of patient's medical diagnoses? Numerous threats to patient confidentiality exist in the routine of prehospital care. In a very short time, prehospital care providers become privileged to sensitive information. Indiscriminate discussion or inappropriate release of the information could present both ethical and legal threats. All information which is encountered by prehospital personnel must be considered privileged and treated as confidential. Information should be communicated only to those who are assuming direct care of the patient and who have similar obligations of confidentiality. The only information which should be discussed over the radio is that which is necessary to provide for optimal care of the patient.

Casual conversations should be avoided with parties uninvolved in the care of patients. Discussion of cases which do not identify the patient and are used for educational purposes present no ethical conflict. Clear policy and appropriate education are important to promote the highest standards of prehospital care.

## **Summary and Conclusions**

Patient autonomy, beneficence, and justice are the fundamental ethical principles of an emergency medical service. Ethical conflicts are present in the daily practice of prehospital care. These conflicts surround issues of resuscitation, futile therapy, consent, and refusal of care, duty, and confidentiality. Emergency medical services must remain fair and equitable, equally available to those it is designed to serve, regardless of the patient's social or economic status. Establishing priorities for patient care is dictated by medical and operational concerns.

Education and information regarding ethical issues are important for the providers of prehospital medical care as well as the medical director. Policies and protocols must continue to be developed to address requests to limit resuscitation, such as refusal of care and patient confidentiality. Policies should be developed in conjunction with experienced legal advice.

Current training does not equip even the most advanced prehospital care provider to deal easily with every potential situation. Many learn by experience, some are guided by clear policy. Ideally, medical control personnel will be educated, interested, and available to address dilemmas which arise. Where possible, policies and procedures should be developed to address ethical issues which are likely to be faced by EMS personnel.

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