**Chapter 63
Ethical challenges**

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**Introduction**

Emergency medical services providers make ethical decisions on a daily basis [1]. They frequently deal with issues of patient refusal, confidentiality, the treatment of minors, and other challenging ethical dilemmas. The fast-paced prehospital work environment compounds the complexity because difficult decisions often need to be made without having all the necessary information and without sufficient time for extended consideration and debate. An understanding of the principles of medical ethics, however, can help guide EMS providers on the front lines when faced with ethical questions.

Emergency medical services medical directors, physicians, and personnel should be familiar with the prevailing statutes of their respective state and local governments because ethical debate may be moot if the law renders a ready decision. However, because individual cases vary widely, the law leaves many ethical questions unanswered. There are important differences between ethics and the law. The law attempts to ensure order by establishing rules that are derived from social values. The law, however, does not attempt to enforce every moral value. Following legal rules alone, therefore, may be ethically insufficient. For example, EMS providers not infrequently encounter patients who refuse care. Although the minimal legal standard requires a signature of release by the informed patient, the signature alone may be ethically insufficient. From an ethical and professional standpoint, it is important to explore the patient’s understanding, concerns, and perhaps alternative options for treatment in order to ensure that the patient is appropriately cared for. It is important to remember that the law establishes rules and regulations based on societal values but it does not mandate the full display of the highest ethical behaviors.

This chapter will introduce core medical ethics principles and demonstrate how they can be applied to common ethical dilemmas encountered in the prehospital setting.

**Refusal of treatment and transport**

*Case #1: EMS responds to a 45-year-old unhelmeted man who was struck by a car while riding his bicycle with his two young sons. The patient is found thrashing about on the ground, with signs of head trauma. When EMS providers attempt to transport the patient to the ambulance, the patient repeatedly refuses care, instead only asking about the whereabouts of his children, who are unharmed and remain at his side. The patient is clearly disoriented and unable to engage the paramedics in any sustained manner. One of the EMS providers asks if the patient can be treated and transferred against his will.*

*Case#2: EMS is dispatched to the home of a 90-year-old woman with known end-stage lung cancer who is complaining of shortness of breath. Upon their arrival, EMS intervention is refused by a cachectic but lucid patient who is very aware of her medical condition. She explains that she has been recently discharged from the hospital after extensive discussions with her oncologist regarding her preference to spend her remaining days at home. She understands that her progressive shortness of breath is a result of her end-stage lung cancer and that she will likely die from the disease in the near future. The patient’s sons and daughters admit that they had initiated the 9-1-1 call because they felt their mother appeared extremely uncomfortable. The patient adamantly refuses any transfer to the hospital, while her family demands that EMS providers “do something” to help her.*

Autonomy is a core principle of medical ethics [2]. Individuals are assumed to have the right to self-determination, even if their decisions result in harm to themselves. Patient refusal of care may apply to a specific course of treatment (e.g. insertion of a peripheral IV) or plan for further care (e.g. patient refusing transportation to the closest hospital in favor of a different facility). For EMS providers, patients have capacity to make their own medical decisions when the following criteria are fulfilled [3,4].

1. The patient must have sufficient information about his or her medical condition.
2. The patient must understand the risks and benefits of available options, including the option not to act.
3. The patient must have the ability to use the above information to make a decision in keeping with his or her personal values.
4. The patient must be able to communicate his or her choices.
5. The patient must have the freedom to act without undue influence from other parties, including family and friends.

If any of the above criteria are not met, EMS providers should balance their respect for the patient’s limited decision-making capacity with their obligation to act in the patient’s best interest. A great challenge for EMS providers is to expertly assess decision-making capacity in order to understand when a refusal is informed and when it is an impulsive gesture of a person who lacks capacity due to severe psychiatric disease, intoxication, or overwhelming medical illness [5]. For example, medical conditions such as hypoglycemia, head trauma, and sepsis can make patients impulsive, restless, angry, and antagonistic such that there may be confusion regarding their ability to reason. If EMS providers believe a patient lacks decision-making capacity (as opposed to competence, which is a legal determination), actions should be taken to ensure the patient’s safety and best interest. In this regard, EMS personnel must operate under the rubric of beneficence, another core principle of medical ethics [2].

In situations of refusal of care, providing unwanted treatment over the objection of a patient with sufficient decision-making capacity may render the EMS provider guilty of battery [6]. Conversely, an impulsive or incompletely informed refusal leading to lack of treatment and transport leaves the provider liable for negligence. It is therefore strongly recommended that whenever EMS providers defer transport or treatment due to a patient’s refusal of care, the patient’s decision-making capacity should be explicitly documented in the medical record, with special attention to the information that was specifically communicated and understood by the patient. Similarly, when EMS providers act in the patient’s best interest and treat or transport a patient who refuses care but who is deemed to have insufficient decision-making capacity, the conditions leading to this determination should be carefully documented. EMS providers must remember that it is not the responsibility of patients to prove they have decisional capacity; it is the responsibility of the provider to identify any impairment of such capacity.

The patient in case #1 clearly did not exhibit signs of decision-making capacity, likely secondary to the head trauma he sustained. EMS providers would be acting ethically to deny his refusal of care and instead act in his best interest by treating and transporting him to a hospital for definitive care.

The patient in case #2, though critically ill, still possessed full decision-making capacity when questioned by EMS personnel. She demonstrated that she sufficiently understood her medical condition, the risks and benefits of refusing further medical care, and how these decisions were in keeping with her personal values of wishing to die at home surrounded by her family and friends. For this patient, her decision to refuse further care is compatible with the EMS provider’s ethical obligation to respect a patient’s autonomy. Although the patient’s family may disagree with the patient’s decision, EMS responders would be acting ethically by respecting her wishes not to be transported to a hospital.

**Triage decisions**

*Case #3: EMS providers are en route to a patient who called 9-1-1 after falling down on the wet floor of a supermarket when they witness a motor vehicle collision at an intersection they had just crossed. It is clear to the paramedics that the occupants of the vehicles suffered injuries, although the severity of the injuries was still undetermined. Calls are just coming in regarding the current accident. One of the EMS providers in the ambulance asks if they should stop to assist at the accident because the 9-1-1 call they are responding to did not appear too serious.*

Emergency medical services systems are designed to encourage the best use of scarce and valuable resources in a given environment. They are operated by individuals with an organized and overarching view of the entire needs of a community at any given time. Paramedics dispatched to calls do not have the luxury of this knowledge and as such should not make triage and rationing decisions on an *ad hoc* basis. EMS providers should, however, report any unexpected events that they encounter and ask for appropriate instruction.

In case #3, the individual at the supermarket may have been much more seriously injured than the paramedics were led to believe. The ethically appropriate action would be for EMS personnel to ask if they should be reassigned to the motor vehicle accident, given their proximity to the incident, and await further instruction from dispatchers and supervisors, who likely have better information regarding other available resources. Of course, if EMS providers encounter a clear and immediate life threat outside their original assignment, it would be reasonable to render assistance. But other than in these extreme and rare circumstances, individual EMS personnel should refrain from varying from designated triage and response assignments.

Emergency medical services providers should also refrain from dissuading patients from seeking transport to a hospital for definitive care. Paramedics may encounter patients who they feel are not ill enough to warrant care in an emergency department. EMS personnel, however, should be strongly cautioned against such action, because they are not trained to render formal medical diagnoses and decide if someone needs a formal medical evaluation [7,8]. Comments to patients such as “he probably will be fine and can avoid waiting for hours in the emergency room” are unwise and outside the EMS scope of practice. EMS physicians, on the other hand, are in a better position to determine if no further care is needed than what is being provided at the scene. Depending on the nature of the EMS physician’s role in the system, it may be reasonable for the physician to encourage non-transport in certain circumstances. This may be an expected role for the EMS physician in the case of a mass casualty event that involves fairly large numbers of uninjured or minimally injured patients. The physician may be able to assess and “clear” these patients at the scene, avoiding unnecessary transports that will burden both the EMS system and the receiving facilities.

**Confidentiality**

*Case #4: Paramedics respond to a call from the home of a prominent local politician after he was found passed out in the bathroom by his wife. At the scene it becomes clear to the EMS providers that the individual is severely intoxicated. After transfer to a local hospital, EMS providers are asked to comment on the circumstances of the politician’s hospital visit by reporters from the local media.*

Health care providers, through the nature of their work, have unique access to the private lives of patients. In order to maintain an honest working patient–caregiver relationship, patient trust in his or her health care providers must not be breached. Although there may be exceptions to this rule (e.g. criminal investigations, patients who admit to suicidal or homicidal ideation, suspected child or elder abuse, and patients who pose a public health threat), health care providers should exercise caution in revealing information to those who do not share a therapeutic relationship with the patient.

When EMS providers are asked to comment on the medical care delivered to any patient, they should exercise caution in what they reveal to media sources. EMS providers may do well to defer all questions to a specially designated media spokesperson, such as the agency’s public information officer, who is well versed in sophisticated media relations. Had the EMS providers in case #4 stated that the patient “will be fine in a few hours,” speculation would arise as to the nature of the hospital visit. Even seemingly benign comments about a patient’s medical condition can be misconstrued. Likewise, health care providers should exercise restraint when asked by curious family members, friends, or colleagues about a prominent figure’s medical condition. Not only would revealing such information represent a breach of patient confidentiality and trust, but strict and enforceable rules exist to discourage curious onlookers without a direct therapeutic relationship from accessing private patient information.

**Truth telling and error disclosure**

*Case #5: EMS providers are called to a restaurant where a 55-year-old man with multiple food allergies complains of hives and itching. Intending to administer diphenhydramine, the EMS provider mistakenly administers 1 mg of 1:1,000 epinephrine IV, resulting in the patient’s hospital admission for monitoring of multiple non-sustained runs of ventricular tachycardia. The patient is ultimately discharged without incident. The EMS provider asks the medical director if the error should be disclosed to the patient.*

Truth telling is important under all circumstances, but more so when upsetting news and information regarding medical errors are disclosed. Many professional societies, patient safety experts, and standard practice guidelines recommend disclosure [9]. There are many reasons favoring the disclosure of harmful errors to patients. Disclosure supports truth telling, patient autonomy, and informed decision making, and is consistent with patients’ preferences [10]. Patients want to know about errors even when the harm is minor, and expect a full explanation and an apology [10]. Patients also seek acknowledgment of the pain and suffering that was caused by the error, along with reassurance that recurrences will be prevented. In addition, disclosing errors promotes patient safety, as it enables the critical appraisal of the conditions leading to errors and the development of interventions to prevent recurrences.

When errors are disclosed, the patient and family must sense honesty in the communication. Patients can often tolerate mistakes, but they will not tolerate providers who do not care. Information regarding errors must be explained to the patient in the proper context, even though the provider’s natural instinct may be to cover up mistakes. This is a precarious maneuver both professionally and legally, especially if the patient or family later discovers the error. Many patients who file medical malpractice claims do so because they believe that disclosure was absent or inadequate and see legal action as their only option for finding out what happened [11].

Historically, providers were advised not to disclose errors to patients out of fear that offering an apology or an admission of fault would precipitate malpractice suits. Recent research suggests this assumption may be unfounded [12]. Health care organizations that have adopted robust disclosure programs are reporting favorable outcomes in the number of claims filed, litigation costs, and time to resolution [12]. In addition, 35 states and the District of Columbia have adopted laws making medical apology inadmissible as a statement of fault, with some states even requiring the disclosure of serious unanticipated outcomes to patients [13]. These developments have led many risk managers and malpractice insurers to strongly advocate for disclosure.

When disclosing a harmful medical error to a patient and his or her family, the provider should focus the conversation around the needs of the patient [9,10]. The provider needs to present information in a fashion that the patient and family can comprehend. Patients should be told the facts surrounding the event, what steps have been taken to address any medical repercussions, and plans to prevent recurrences. Finally, the provider should apologize and express regret for the error. It takes expertise to know how to disclose errors and communicate them properly, and in case #5, EMS providers should work closely with their EMS system leadership in handling these sensitive issues.

**Personal risk**

*Case #6: EMS responds to a call from a local bar where a man was reportedly assaulted during a brawl. On arrival, paramedics observe multiple intoxicated bystanders shouting angrily at each other, some of whom are wielding empty glass bottles. One such bystander calls to EMS providers to help the injured patient inside the bar. Police have not yet arrived on scene.*

Emergency medical services providers frequently encounter situations where the risk of physical harm is present. Although it is impossible to eliminate all potential dangers in the daily work of EMS personnel, reasonable caution can and should be exercised such that risks are minimized. Although the paramedics in case #6 may feel the need to attend to the injured individual, there is no moral requirement for health care providers to submit themselves to significant self-endangerment. The EMS responder should exercise proper judgment in determining what is reasonable and what is foolhardy. When possible, law enforcement officers should become involved to ensure a safe and secure scene. EMS providers have an ethical obligation to not place either themselves or others at undue additional harm.

**Training and research**

*Case #7: EMS providers respond to a call from a nursing home and find a 75-year-old man who has been asystolic for an unknown period of time. EMS providers pronounce death at the scene after the patient begins showing early signs of rigor mortis and dependent lividity. En route to the hospital morgue, one of the paramedics asks if he can intubate the deceased patient using new equipment as part of a study on prehospital intubations conducted by a local academic medical center.*

Continued education for health care providers is essential for quality patient care. Standards of training should be followed to ensure proper use of time and resources. In the case of practicing procedures on the recently deceased, out of respect for patient autonomy and dignity even when the individual is no longer living, consent from appropriate family members or a designated proxy should be obtained [14,15]. EMS providers operate with a significant level of trust from the public and all efforts should be undertaken to not compromise that confidence.

Similarly, caution should be exercised when performing research on patients who cannot give informed consent. In the prehospital and emergency setting, it is difficult, if not impossible, to obtain prospective informed consent from patients in order to enroll them in research trials [16,17]. In recognition of the need for this type of research to take place while concurrently preserving patient autonomy, the Food and Drug Administration (FDA) in conjunction with the Department of Health and Human Services (DHHS) have established clear rules for how such research should be conducted [18]. Among the many requirements for an exception from informed consent for research, the most prominent stipulation mandates that study investigators consult with the community in which the research will be conducted and that there will be close oversight of the clinical investigation by a data monitoring committee as well as an institutional review board [19]. Moreover, study investigators should obtain informed consent from the patient or his or her next of kin whenever and as early as possible. These FDA/DHHS regulations are particularly stringent because when research can only be conducted without the informed consent of subjects, every effort must be made to ensure patient autonomy is protected (see Volume 2, [Chapter 45](https://jigsaw.vitalsource.com/books/9781118990827/epub/OPS/Vol2/c45.xhtml) for additional details).

In case #7, without having obtained prior consent from the patient’s next of kin, it would be ethically inappropriate for the paramedic to practice intubating the deceased patient using the experimental equipment. In addition, had the patient even qualified for the research study, EMS personnel should ensure all procedures and protocols are closely followed in order to protect the patient’s best interests.

**Treatment of minors**

*Case #8: EMS providers are asked to respond to a call from a 15-year-old girl complaining of painful vaginal bleeding. Upon arrival to the house, the patient reports that her parents are both still at work and that they do not know about her approximately 3-month pregnancy. The paramedics discover a large amount of what appears to be active bleeding and the tearful patient is notably pale and diaphoretic. One of the EMS providers asks if they can treat and transport the patient to a hospital without first informing her parents.*

Minors, defined as persons under the age of 18, are legally incapable of giving consent. Instead, they rely on a parent or guardian for informed consent. The few exceptions to this rule apply to a special population of emancipated minors, which is a state-specific definition that usually includes those who are married or by legal decree separated from their parents; those who are pregnant or have had a child; and those who have served in the armed forces [20]. Depending on state laws, EMS personnel can also treat non-emancipated minors without parental consent in special circumstances, such as when a minor seeks care for mental illness, substance abuse, pregnancy, or sexually transmitted diseases [21]. In these potentially stigma-laden situations, the risks in overriding parental consent are outweighed by concerns of individual privacy and benefits to public health. Each state operates under different policies and EMS personnel should be familiar with their local jurisdiction’s conditions in which non-emancipated minors can seek care without parental consent.

In contrast to the emancipated minor, a special category of minor who may be able to offer limited consent for his or her own care is the mature minor. The mature minor (usually 14 years and older) is emotionally and intellectually sophisticated enough to be able to appreciate the nature of the illness along with the risks and benefits of the proposed treatment [20]. A mature minor’s preferences should be taken into account when making treatment decisions [21]. In some cases, a minor originally and incorrectly determined to be emancipated may meet standards for mature minor status. Because the mature minor may not be able to provide complete consent, including both the parents and mature minor in medical decisions is optimal.

Many times EMS providers may be asked to care for minors who injure themselves either without the physical presence of a parent or when the guardian for one reason or another is incapable of consenting for the child. In these cases, an “emergency exception” is invoked such that health care providers are able to treat minors in a timely manner to prevent morbidity and mortality under the rubric of implied consent [21]. Because definitions of conditions that deserve an emergency exception vary from case to case, when in doubt, it is usually preferable for EMS providers to treat and transfer the minor to a hospital when no parent is present. When possible, it is preferable to postpone major medical interventions until the minor’s parents can be involved.

In case #8, EMS providers can ethically treat and transport the patient without prior parental consent. Not only is the patient critically ill and therefore appropriate for treatment under the emergency exception, but by virtue of her pregnancy the patient can be evaluated as an emancipated minor and seek care without parental consent.

When the parent is present and disagrees with the medical decisions of EMS providers, the providers should remember to act first under the principle of the patient’s best interest. If paramedics believe the minor is placed in significant and immediate risk by the parent's medical decisions, they can treat and transport the patient under a temporary protective custody. Protective custody of a minor should be taken only as a last resort and always in close consultation with the direct medical oversight physician and law enforcement personnel. If temporary protective custody of the patient is truly necessary, EMS personnel should remember that the parents do not subsequently lose all decision-making rights on behalf of their child. Paramedics should still involve and seek the consent of the parents in the remainder of the care of the patient as much as possible.

When EMS providers and parents are in agreement over the medical care of the minor, providers should still inform the patient of the medical decision process as much as possible. Even young children can understand the basics of medical care and all efforts should be made to involve them on an age-appropriate level.

**Conclusion**

The cases provided in this chapter illustrate the wide variety of ethical issues that EMS providers encounter on a regular basis. EMS providers should become proficient with the basic principles of medical ethics. In addition, the exercise of ethical judgment should always be performed in conjunction with knowledge of local laws and professional guidelines. Finally, EMS providers must remember to practice excellent communication skills when dealing with potentially complicated issues of patient care.

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