

ETHICS GUIDELINES AND ETHICS EDUCATION FOR EMERGENCY MEDICAL  
TECHNICIANS: A CRITICAL ANALYSIS

BY

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## LIST OF ABBREVIATIONS

American Medical Association	AMA
Department of Transportation	DOT
Emergency Department	ED
Emergency Medical Technician	EMT
Emergency Medical Services	EMS
Federal Emergency Management Agency	FEMA
Motor Vehicle Collision	MVC
National Association of Emergency Medical Technicians	NAEMT
National Highway Traffic Safety Administration	NHTSA
National Institute of Health	NIH
National Registry of Emergency Medical Technicians	NREMT

## ABSTRACT

In this thesis, I address an inadequacy in the chain of emergency medical care. Emergency physicians, nurses, and other staff have updated their ethical guidelines to address important new issues and technologies such as the confidentiality rules implemented under the Health Insurance Portability and Accountability Act (American College of Emergency Physicians, 2011; United States Department of Health and Human Services, 1996). The National Association of Emergency Medical Technicians (NAEMT) Code of Ethics, first adopted in 1978, however, has never been revised (National Association of Emergency Medical Technicians, 1978). All health care providers, from physicians to nurses' aides, bear responsibility for the ethical treatment of their patients. Emphasis on proper ethics in the Emergency Department (ED) is important, but ethical treatment of the patient in the prehospital setting it is just as significant. This thesis reviews the history of Emergency Medical Technicians (EMTs), describes the uniqueness of the professional practice of EMTs, evaluates the current NAEMT Code of Ethics, recommends revisions to those guidelines, and proposes improvements for the ethics education of EMTs during their certification programs.

## INTRODUCTION

The four chapters of this thesis will address the current ethical guidelines and ethics education for EMTs. Chapter One of the thesis will detail the history of Emergency Medical Services (EMS). Until the 1970s, it was common for ambulances to be staffed by undertakers, as they had the only vehicles large enough to accommodate patients. This practice changed in 1971 when the National Highway Traffic Safety Administration (NHTSA) published a study entitled “Accidental Death and Disability: the Neglected Disease of Modern Society.” This study led to increased EMS regulation and efforts to improve the standard of care in pre-hospital emergency care. While standard of care guidelines have been updated regularly since the 1970s, the NAEMT Code of Ethics has not. This difference in the attention given to standards of practice as opposed to professional ethics principles is discussed and likely attributable to the complex development of EMS and the fact that EMS is just one of many branches of the Department of Transportation (DOT).

Chapter Two of the thesis addresses what makes EMS a distinctive health care profession, with a particular focus on what makes EMT practice morally distinctive. This chapter describes the brief training period of EMTs, the highly variable and sometimes dangerous work environment of the EMT, and the challenges of individual decision-making in a protocol-driven health care system. The EMT is usually the first health care provider to meet a patient at a time when he or she is most vulnerable, and this interaction can be crucial for the patient’s well being.

Chapter Three of the thesis provides a moral analysis of the NAEMT Code of Ethics and proposes revisions. This chapter argues that the current principles are inadequate in several ways. The principles found in the NAEMT Code of Ethics are dated, often unclear, and serve to promote EMS as a profession, as opposed to striving for the ethical treatment of patients. In this chapter, I suggest revisions to the Code of Ethics to improve its content as well as to make it more easily understood.

Just as important as revising the NAEMT's Code of Ethics is including more substantial ethics education in the EMS certification curriculum. Chapter Four of the thesis addresses this task. Chapter Four details what is involved in a typical EMT certification curriculum, discusses the inherent inadequacies in the current system, and suggests changes that could be implemented to improve ethics education.

This thesis argues that updating the NAEMT's Code of Ethics should be an essential first step in changing how ethics is viewed in EMS. The fact that the NAEMT hasn't updated its Code of Ethics since 1978 suggests the relative neglect of ethics in EMT training and practice. If the guidelines were updated and emphasized in the EMT curriculum, they would carry with them a new significance. Ethical treatment of the patient is a key component of any health care profession. This thesis argues that updating the NAEMT's ethical guidelines and enhancing ethics education in the EMT curriculum would prove beneficial for both EMTs and their patients.

This thesis uses the National Emergency Medical Services Management Association's definition of EMS that was adopted in 2012:

Emergency Medical Services (EMS) are the integrated system of medical response established and designed to respond, assess, treat, and disposition victims of acute injury or illness and those in need of medically safe transportation. The EMS System includes the full spectrum of response from the recognition of the emergency to access of the health care system, dispatch of an appropriate response, pre-arrival instructions, direct patient care by trained personnel, and appropriate transport or disposition. Any provider participating in any component of this response system is practicing EMS. EMS also includes medical response provided in hazardous environments, rescue situations, disaster and mass casualties, mass gathering events, as well as interfacility transfer of patients and participation in community health activities. (National Emergency Medical Services Management Association, 2012)

## CHAPTER ONE

### THE EVOLUTION OF EMERGENCY MEDICAL SERVICES

Modern day emergency medical services are a recent development in the history of medicine. Though EMS in its current form is a recent development, the precursors of the field can trace their roots and tradition of innovation back to the Crusades. The advances in technology and policy that have led to modern day EMS are numerous, but the turning point for these innovations that resulted in modern day EMS was the publication of the National Highway Traffic Safety Administration's 1966 study entitled *Accidental Death and Disability: The Neglected Disease of Modern Society*. This study led to increased EMS regulation and efforts to improve the standard of care in the pre-hospital emergency setting. While EMS standard of care guidelines have been updated regularly since the 1970s, the National Association of Emergency Medical Technicians Code of Ethics has not. These numerous updates in standard of care guidelines alone would suggest the need for corresponding updates in EMS ethical guidelines. The difference in the attention given to standards of practice as opposed to professional ethics principles is likely attributable to the complex development of EMS. In order to explain this difference, this chapter will review the history of EMS.



## Precursors of Emergency Medical Services

The origin of hospitals dates back over two thousand years to a time when religion and medicine went hand in hand. Appropriately, the history of emergency medical services can also be traced back to religious involvement. From the end of the eleventh century to the late thirteenth century, Christian Europeans participated in the Crusades, religious wars with the purpose of recovering the Holy Land and halting the spread of Islam. The Crusades were violent military campaigns, and it was during these that the first emergency medical care providers emerged, The Knights Hospitallers of the Order of Saint John of Jerusalem. The Knights Hospitallers learned rudimentary first aid from Greek and Arab physicians and set up tents near battlefields to treat wounded soldiers. Battlefield wound treatment at the time would have included washing wounds with vinegar to prevent infection, removing arrows or lances from the body, bandaging wounds, cauterizing wounds with iron tools, and the application of compresses made from herbs (Mitchell, 2004). The Knights Hospitallers are also credited with one of the earliest versions of emergency medical transport, the litter, which was a canvas stretcher that was hung between two poles. The Knights Hospitallers brought their knowledge and innovations back to Europe with them where they developed the horse litter and used their newfound medical knowledge to serve the public (Rosenhek, 2006).

The origin of the word “ambulance” can be accredited to King Ferdinand and Queen Isabella of Spain in 1487. *Ambulancias* were the field hospitals that were set up near the battles of the Spanish Inquisition. In order to save wounded soldiers a

long and potentially life-threatening trip back to a major city, these *ambulancias* were staffed with physicians and stocked with supplies. While this innovation was important, it was not without its flaws. The wounded were not treated until after the battles had ceased, which led to many deaths that could have prevented with more emergent care. This was not addressed until the late 18<sup>th</sup> century when the French military introduced their own innovations to the field of emergency medicine (Lateef, 2005).

Dominique Jean Larrey was chief surgeon of the Grand Army of Napoleon Bonaparte, and in addition to being one of the founders of the concept of triage, he was also one of the first to employ a form of ambulance as a rapid response to an emergency situation. Larrey's version of triage varied from what is employed today in that he advocated for treating those who were in the most dire need of care first, regardless of expected outcome. In the late eighteenth century, Larrey recognized that waiting until after a battle to treat the wounded could have dire consequences for soldiers and as a result developed *ambulances volantes*, or flying ambulances (Ortiz, 1998). These ambulances were two or four wheeled horse-drawn wagons that were deployed on the battlefield to pick up wounded soldiers; Napoleon's Army of the Rhine first used them in 1793. Once evacuated from the field of battle, the treatment these soldiers retrieved was still relatively basic. Amputations were routinely performed without anesthetic, large wounds would be allowed to bleed to remove any possible debris, and many soldiers would end up succumbing to infection, as medical hygiene as it is known today was not employed (Schreier, 2005). Despite the limited medical knowledge of the period, the flying ambulances

resulted in more expedient treatment for soldiers and improved outcomes (Skandalakis, 2006).

It was not long after Larrey's innovations that civilian ambulance services became available, starting in Europe and then spreading to the United States. Major advances were first made in London in 1832 when ambulances, then dubbed cholera carriages, were used to transport patients suffering from the disease. *The Times*, a British daily national newsletter, described these civilian ambulances as follows: "The curative process commences the instant the patient is put in to the carriage; time is saved which can be given to the care of the patient; the patient may be driven to the hospital so speedily that the hospitals may be less numerous and located at greater distances from each other" (Barkley, 1990). This quotation is significant because it mentions what would become key innovations in emergency medicine. The patient would receive immediate care, time would be saved, and hospitals did not have to be nearby in order for patients to receive effective care.

The late 1800s were a time for many EMS innovations. Hospital-based ambulance services came about in the late 1860s, with the first being operated out of Commercial Hospital in Cincinnati, Ohio (Barkley, 1990). In 1869, Bellevue Hospital in New York created an ambulance service that carried modern medical equipment, in addition to medical staff, and in 1887, the St. John Ambulance Brigade began to provide first aid and ambulance services at public events in London (Bell, 2009). 1899 also saw the delivery of the first automobile ambulance at Michael Reese Hospital in Chicago (Barkley, 1990).

World War I (1914-1918) brought more change and innovation to the field of EMS. Notably, traction splints were developed and radically improved the outcomes in patients suffering from femur fractures (Sinclair, 1927). Motorized transportation was a key development in procuring more expedient treatment for soldiers who were no longer suffering injuries from swords, lances, and slingshots, but from gunshot wounds, poison gas inhalation, and tissue damage from shell fragments (Manring, 2009). Two-way radio was also further developed and would eventually allow for quicker and better-organized EMS dispatches.

More advances in EMS planning arose with the advent of World War II. By this time, many of the larger cities in the United States had ambulance services that were run by hospitals. There was a severe shortage of manpower during World War II, and hospitals encountered difficulties with staffing their ambulance operations. In order to continue to provide emergency care, many local governments began to rely on the police and fire departments to staff the ambulances. Police and firefighters provided an emergency services workforce that was able to maintain the ambulance operations, but these public safety officers had no formal medical training. During this period, it was perfectly acceptable for someone who only knew minimal first aid to staff an ambulance (United States Department of Transportation National Highway Traffic Safety Administration, 2007). This is in stark contrast to EMS operation today.

Further advances in medicine took place in the 1950s and 1960s, and these developments altered what could be expected from ambulance services.

Cardiopulmonary resuscitation and portable defibrillators were both demonstrated

to be successful in reviving a patient whose heart had recently stopped, and these developments were quickly integrated into EMS (Kouwenhoven, 1957; Kouwenhoven, 1960). New pharmaceuticals that could be used in the field for acute care were also developed during this time. With the advent of these new technologies, more was expected from medicine and from ambulance services.

Despite these advancements and technologies, regulation of the field was almost nonexistent. Prior to the 1970s, many ambulances that were not operated by hospitals were hearses rather than true emergency medical services vehicles. Undertakers or morticians staffed these makeshift ambulances, not trained or certified emergency care providers (Committee on Trauma and Committee on Shock, Division of Medical Sciences, National Academy of Sciences, National Research Council, 1966). The lack of required certification and lack of care provided while transporting patients came under scrutiny in 1966 when the National Academy of Sciences published its report, *Accidental Death and Disability: The Neglected Disease of Modern Society*.

### The Advent of Modern Emergency Medical Services

*Accidental Death and Disability: The Neglected Disease of Modern Society* is commonly referred to as the “White Paper,” and it served as the catalyst that transformed medicine’s approach to emergency care. As its title suggests, the report demanded that accidental death and disability receive proper attention. The report opened with compelling statistical data, “In 1965, 52 million accidental injuries

killed 107,000, temporarily disabled over 10 million and permanently impaired 400,000 American citizens at a cost of approximately \$18 billion. This neglected epidemic of modern society is the nation's most important environmental health problem." (Committee on Trauma and Committee on Shock, Division of Medical Sciences, National Academy of Sciences, National Research Council, 1966) .The report then states that 49,000 people were killed by injuries sustained in motor vehicle accidents in 1965 and that the "public apathy" about these and other accidental deaths must be altered. At the time the report was published, accidents were the leading cause of death among people aged 1 to 37, and accidents were the fourth leading cause of death overall (Committee on Trauma and Committee on Shock, Division of Medical Sciences, National Academy of Sciences, National Research Council, 1966). The most common cause of accidental death was motor vehicle accidents, and seventy percent of motor vehicle deaths occurred in rural areas, presumably not near hospitals. In only one year, vehicle accidents killed more Americans than were lost in the Korean War (Committee on Trauma and Committee on Shock, Division of Medical Sciences, National Academy of Sciences, National Research Council, 1966). The report sought to shift the focus of emergency medicine from the aforementioned battlefield injuries to those that might be sustained in daily life.

In its very first pages, the "White Paper" called on the public and political authorities to address the inadequacies in emergency medical services, which could presumably combat the loss of life from injuries sustained in motor vehicle accidents and other causes of accidental death. "Few are adequately trained in the

advanced techniques of cardiopulmonary resuscitation, childbirth, or other lifesaving measures, yet every ambulance and rescue squad attendant...should be trained. Local political authorities have neglected their responsibility to provide optimal emergency medical services.” (Committee on Trauma and Committee on Shock, Division of Medical Sciences, National Academy of Sciences, National Research Council, 1966). To combat this, the report called for national conferences on emergency medical services, research on trauma and shock, the establishment of a National Trauma Association, National Council on Accident Prevention, a National Institute of Trauma, and the organization of community councils on emergency medical service for the purpose of coordinating teaching basic and advanced first aid. The report asserted that trauma and the associated musculoskeletal injuries killed thousands of people who would have otherwise gone on to live long and productive lives. The report argued that accidental death should receive as much attention as afflictions that primarily affect the elderly, such as stroke or heart disease.

In a section devoted to emergency first aid and medical care, the “White Paper” highlighted the fact that physicians are rarely able to treat victims on the scene and that many victims must wait until they arrive at the emergency department of the hospital before they receive care. The report used wartime data and pointed out that the time from injury to when care is received is one of the most important elements in preventing death or disability. The development of field medics and the transition from automobile to air transport between World War I and the Vietnam War played a significant role in reducing the time it took for the

patient to be treated (Manring, 2009). “Excellence of initial first aid, efficiency of transportation, and energetic treatment of military casualties have proved to be major factors in the progressive decrease in death rates of battle casualties reaching medical facilities, from 8 percent in World War I, to 4.5 percent in World War II, to 2.5 percent in Korea, to less than 2 percent in Vietnam.” (Committee on Trauma and Committee on Shock, Division of Medical Sciences, National Academy of Sciences, National Research Council, 1966).

Poor general knowledge of first aid was also something that the “White Paper” set out to correct. The report states that every American who has completed the fifth grade should be trained in basic first aid and that the first aid course should be a prerequisite for all emergency services personnel. The report calls for uniformity in certification courses and cites a manual published by the Committee on Trauma of the American College of Surgeons as an example of how this could be done.

Ambulance services were also specifically addressed in the report and described as almost universally inadequate. Any standards that were adhered to were described as low and much of the equipment that was used was expensive, ill designed, and inadequate. The report notes that under the National Traffic and Motor Safety Act of 1966 (P.L. 89-563) national standards could now be set for ambulance design and construction. At the time the report was published, radio communication was virtually nonexistent with no central dispatch or means by which the ambulance operators could contact emergency departments. Ambulance attendants themselves were also found to lack adequate standards. Even if the



attendants did carry with them some form of certification, there was no universal standard by which certification courses were taught (Committee on Trauma and Committee on Shock, Division of Medical Sciences, National Academy of Sciences, National Research Council, 1966).

The “White Paper” did not just call attention to needs without practical solutions; it proposed recommendations that could resolve many of problems that it addressed. The recommendations from the report that relate to EMS are as follows:

- Extension of basic and advanced first aid training to greater numbers of the lay public
- Preparation of nationally acceptable texts, training aids, and courses of instruction for rescue squad personnel, policemen, firemen, and ambulance attendants
- Implementation of recent traffic safety legislation to ensure completely adequate standards for ambulance design and construction, for ambulance equipment and supplies, and for the qualifications and supervision of ambulance personnel
- Adoption at the state level of general policies and regulations pertaining to ambulance services
- Adoption at district, county, and municipal levels of ways and means of providing ambulance services applicable to the conditions of the locality, control and surveillance of ambulance services, and coordination of

ambulance services with health departments, hospitals, traffic authorities, and communication services

- Pilot programs to determine the efficacy of providing physician-staffed ambulances for care at the site of injury and during transportation
- Initiation of pilot programs to evaluate automotive and helicopter ambulance services in sparsely populated areas and in regions where many communities lack hospital facilities adequate to care for seriously injured persons
- Delineation of radio frequency channels and of equipment suitable to provide voice communication between ambulances, emergency department, and other health-related agencies at the community, regional, and national levels
- Pilot studies across the nation for evaluation of models of radio and telephone installations to ensure effectiveness of communication facilities
- Day-to-day use of voice communication facilities by the agencies serving emergency medical needs
- Active exploration of the feasibility of designating a single nationwide telephone number to summon an ambulance (Committee on Trauma and Committee on Shock, Division of Medical Sciences, National Academy of Sciences, National Research Council, 1966)

The Highway Safety Act of 1966 was passed in the same year the “White Paper” was published and resulted in the creation of the Department of Transportation. The DOT was charged with developing policy and infrastructure as

it related to transportation, establishing a national curriculum for emergency medical services personnel, and implementing many of the recommendations found in the “White Paper.” These newly implemented changes and newly standardized curriculum resulted in the development of the first emergency medical technicians and the beginning of modern emergency medical services, as they are known today.

### The Evolution of Modern Emergency Medical Services

*After Accidental Death and Disability: The Neglected Disease of Modern Society* was published, funds started to funnel into EMS development. As EMS was being standardized, the National Registry of Emergency Medical Technicians (NREMT) was created in 1970 with the mission to, “provide a valid, uniform process to assess the knowledge and skills required for competent practice required by professionals throughout their careers and by maintaining a registry of certification status.” (National Registry of Emergency Medical Technicians). In the early seventies, The Department of Health, Education, and Welfare and the Robert Wood Johnson foundation allotted funds towards developing EMS systems. Shortly thereafter, the Emergency Medical Services Systems Act of 1973 (P.L. 93-154) was enacted by Congress as Title XII of the Public Health Services Act and served to layout more EMS guidelines and provide over 300 million dollars in funds for EMS development (National Highway Traffic Safety Administration, 1996). This influx of funds led to real advances in the field, but it was not without consequences. These new funds were made available with caveat that individual states would be required to focus

on the competence and training of the emergency medical service providers (National Highway Traffic Safety Administration, 1996). While this more individualized focus may appear to be a favorable development, it also presented the opportunity for states to define competence differently from one another. The lack of uniformity in state EMS certifications and standards of practice that still exists today can be traced back to the Emergency Medical Systems Act of 1973.

Soon after the Emergency Medical Systems Act of 1973, the American Medical Association (AMA) recognized the EMT-Paramedic as an allied health occupation in 1975, and the American Board of Medical Specialties officially recognized emergency medicine as a specialty in 1979. In 1977 the first national standard curriculum for EMT-Paramedics was published by the NHTSA and the National Council of EMS Educators was formed. The AMA and the Joint Review Committee on Education Programs developed the Essentials for Paramedic Program Accreditation for the EMT-Paramedic in 1978, and this document was adopted as the standard for accreditation (United States Department of Transportation National Highway Traffic Safety Administration, 2009).

It was while these new regulations and certifications were being developed that the National Association of EMTs was founded. While the NREMT had been created several years before, it served merely as an organization that was used to verify certification status. Prior to the inception of the NAEMT there still was not an organization that was run by and for EMTs. There were many statewide organizations, but before the NAEMT, there was very little coordination among them. The organization served to loosely unify this collection of state-run EMS

agencies before it evolved into the separate entity that it is today (National Association of Emergency Medical Technicians, 2005).

In 1981 EMS funding through the EMS Systems Act halted when the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) was passed. The Omnibus Budget Reconciliation Act put EMS funding in the category of state preventive health and health service grants. This change had a significant impact on the field because it resulted in the individual states determining where EMS funding was applied. This state-run control of EMS persists and has helped contribute to a variety of different EMS protocols throughout the United States.

In 1985 the EMT-Paramedic designation was broken up into divisions that resemble the EMS hierarchy of the present day. First responders, EMT-Ambulances, EMT-Intermediates, and EMT-Paramedics were now recognized with their own certification criteria. First responders are now designated emergency medical responders to reflect the unique focus of their occupation. EMT-Ambulances later became classified as EMT-Basics and are now known simply as EMTs. EMT-Intermediates are now referred to as Advanced EMTs and EMT-Paramedics are now known as paramedics (National Association of Emergency Medical Technicians, 2005).

In 1985, the National Research Council's "Injury in America: A Continuing Public Health Problem" called attention to inadequacies in the development of emergency medicine as a field that was developed to combat accidental death and disability. The goal of the report was to identify inadequacies in the field by implementing a statewide assessment program for EMS that would assess EMS

systems based on 10 components: regulation and policy, resource management, human resources and training, transportation facilities, communications, public information and education, medical direction, trauma systems, and evaluation (Committee on Trauma Research, Commission on Life Sciences, National Research Council, and the Institute of Medicine, 1985). Systemic inadequacies were identified and led to further changes in the field in the following decades.

Like the decades before it, the 1990s were also a period of innovation for the field of EMS. Documents such as the “EMS Agenda for the Future” and the “EMS Agenda for the Future Implementation Guide” were published. These documents were statements about how the field hoped to develop and how it could better be integrated into the health care system (National Highway Traffic Safety Administration, 1996). In addition to these mission statements, the National Standard Curricula for every level of EMS was also revised between 1994 and 1999 with the hope of improving the functionality of EMS (National Association of Emergency Medical Technicians, 2005).

The 2000s have continued to build on the progress that was made in the 1990s and have seen the NHTSA publish “EMS Education Agenda for the Future: A Systems Approach,” the “Trauma Systems Agenda for the Future,” and “The National EMS Research Agenda.” It is important to note the frequency of these documents, the broadness of their scope, and that all of these proposed changes to the field have come from government-run agencies, not the NAEMT.

While the formation of the DOT and involvement of the NHTSA may be viewed as an overall positive for the field of EMS, it has been less than ideal for the

field in the long run. It was the initial curriculum developed by the DOT that married EMS to the DOT and the NHTSA, but EMS has since outgrown these organizations. Outside of EMS, the DOT and the NHTSA are not generally concerned with medical or ethical guidelines. Interestingly, EMS is not even mentioned under the “A Brief History of the DOT” at the U.S. Department of Transportation Office of the Historian’s website (United States Department of Transportation Office of the Historian, 2009). This separation between the NAEMT, which is run by EMTs, and the DOT and NHTSA, which are run by the government, have greatly contributed to the disconnect between the DOT updates in standards of care and NAEMT ethical guidelines.

EMS has greatly changed in the last forty years and is still in a state of flux to this day. The nomenclature and guidelines for the delineation of emergency medical service providers have been updated as recently as 2009, and these guidelines stand to change again in the near future as new advances are made (Cason, 2009). The fact that EMS has developed out of the DOT and NHTSA as opposed to its own agency has led to a series of growing pains and changes that have lacked foresight. In spite of this, EMS has gone from emergency roadside care and cardiac treatment, to the first chain in the link of medical care for any and all accidents and injuries in the country. EMS has transformed from an unregulated field to a highly regimented system that can easily be reached anywhere at any time by dialing 9-1-1.

Unfortunately the NAEMT and the DOT rarely seem to coordinate and this has led to changes in standards of care, but not in the NAEMT Code of Ethics. These frequent and drastic changes have resulted in radically different roles for the EMT,

but the NAEMT's Code of Ethics has remained unchanged since 1978. The Code of Ethics of the organization that is supposed to unite and represent EMTs across the country needs to be updated to reflect the multiple changes in the field over the past 35 years.



## CHAPTER TWO

### EMS IS DESERVING OF ITS OWN CODE OF ETHICS

To the layperson, emergency medical services may seem to be an extension of the specialty of emergency medicine. This common view is a misconception, however. In fact, EMS is its own unique field with its own challenges and ethical dilemmas. The current NAEMT Code of Ethics does not adequately acknowledge this reality. The NAEMT Oath and Code of Ethics in their current form draw strongly from two documents that have preceded them, the Hippocratic Oath and the American Medical Association's Principles of Medical Ethics. Acknowledging these two respected documents may be a good starting point for developing a new code of ethics for physicians, but this is neither acceptable nor applicable because of the different professional responsibilities found in the field of EMS.

The United States Department of Transportation technically defines ethics for the EMT, and the DOT defines ethics as personal standards that should govern how a person lives his or her life, which is a drastic deviation from how ethics is traditionally viewed in the health care setting (United States Department of Transportation, 1998). The concept of ethics proposed by the DOT is more about general social standards of behavior than specific professional standards, and this is not an appropriate fit for EMS. The EMT may be the first health care provider whom the patient encounters and he or she will most likely encounter the patient in a setting that is unfamiliar to the EMT. The EMT must work in the field, often in

patients' homes, and has a very different role from an emergency physician. The ultimate goal of the physician is to treat his or her patient to the best of his or her ability, with the hope of resolving the patient's complaint. This is not the case in EMS. The EMT has a much more narrowly focused goal, namely to stabilize, assess, and transport the patient to the nearest hospital. The role of the EMT is unique in health care, and for this reason, EMS needs its own ethics.

### EMT Training

The educational requirements for EMTs are different and much shorter in length than those of emergency physicians and other providers of emergency medical treatment. This is a function of necessity, the numbers of EMTs that are required, and other factors. The EMT level certification course is less than two hundred hours long, and the only prerequisite is a high school diploma, GED, or the successful completion of an exam that assesses reading comprehension skills of at least a tenth-grade level. Physicians, in contrast, must excel in an undergraduate education and complete medical school and residency. These differences in rigor of coursework and education reflect the different functions and decision-making responsibilities of physicians and EMTs. The brief certification curriculum, and the highly time-sensitive environment in which the EMT works create a unique context of practice for the EMT.

The EMS certification curriculum is brief when compared to the training periods of other health care professions. The course is made up of roughly 180

hours that must cover a variety of topics in the depth that is necessary for the EMT to pass both written certification and technical scope of practice exams. In these 180 hours, the EMT must become proficient in everything from airway management, to labor and delivery, to trauma skills and CPR. Often, medical ethics is condensed into one class period, or even half of a class period. In the North Carolina Office of Emergency Medical Services EMT Educational Program Structure, “Medical/Legal and Ethical Issues” are only allotted one of the 180 hours (North Carolina Office of EMS, 2005). Ethics is forced to take a back seat to some of the more hands-on skills that are taught during the certification curriculum. This does not appear to be an issue with the students, as those who enroll in EMT certification programs are generally motivated by the hands-on skills that they are taught. Learning to intubate a patient or how to properly perform CPR properly is much more tangible than learning how to interact with a patient respectfully, but from a moral standpoint, it is not much more important.

Patient care is thought of and taught in the form of an algorithm in EMS. If every patient is supposed to be evaluated using the same general algorithm, the importance of the human component of patient care is lessened and the patient is dehumanized. There is room in the algorithm for patient responses to questions concerning their medical history, but these responses are typically limited to a few basic items captured by an acronym, such as SAMPLE. SAMPLE stands for signs and symptoms, allergies, medications, past pertinent medical history, last oral intake, and events leading up to the chief complaint. This cookie-cutter approach may be

necessary given some of the constraints of EMS, but it cannot be used as an excuse not to treat patients with respect.

Emergency medical scenarios are used as a teaching tool throughout EMT certification courses. These scenarios could raise ethical issues and require responses. A problem here is that the “patient” in these scenarios is often one of the students from the class or one of the instructors, and many students do not take these role-play scenarios or their subject matter as seriously as they would actual patient encounters. The focus of these scenarios is generally on the patient assessment algorithm and the skills that make up the students’ technical scope of practice. Nowhere is there a practical skills lab, evaluation, or checkbox for proper ethical treatment of the patient. Most of the EMT’s ethical education takes place in the field, where he or she learns hands-on patient care from colleagues.

## Ethical Issues

In an article entitled “Why EMS Needs Its Own Ethics”, Craig Klugman outlines potential ethical issues that may arise in the field for an EMT. The scenarios he describes identify some of the issues that need to be addressed this chapter.

### The Work Environment, Safety, and Truth Telling

You arrive at the site of a single-vehicle MVA. A man in his 80s was driving, his wife in the passenger seat. You assess the man as emergent and requiring transport. The man seems unconcerned about

himself but keeps asking about his wife, who is dead. What do you tell him? (Klugman, 2007)

The above scenario highlights several key ethical issues in EMS. The scenario directly engages the reader about the ethical issue of truth telling, but the location of the patient care in this scenario is also significant. The work environment of the EMT is one of the essential reasons why the field of EMS is in need of its own ethics. EMTs almost exclusively work in the field or in an ambulance, as opposed to the in-hospital setting. The field is inherently unfamiliar, variable, and constantly changing. One of the first things that an EMT student is taught is the algorithm for patient assessment, and at the very top of that algorithm is scene safety. EMTs must ensure that the space that they are working in is safe, or at least as safe as it can be, before they treat their patients.

The component of scene safety is not a common occurrence in the hospital setting, and it can present ethical dilemmas. For example, if an EMT is called to the scene of an injury that may have been the result of violence or crime, the police must secure the scene before the EMT is allowed to treat the patient. This is a necessary precaution, but it also delays patient care. Another common example arises when an EMT is called to a motor vehicle collision (MVC). Patient care at the roadside is never going to present an entirely risk-free work environment. There are often multiple patients who must be treated near moving traffic and recently damaged vehicles. Broken glass, fire, airbags that have not deployed, and damage to the vehicle or surrounding area may make extrication of a patient from a vehicle very difficult and hazardous. All of these issues can result in difficult and delayed patient

care, and they require EMTs to make moral judgments about how much personal risk to assume in order to care for their patients. Ethical issues do not arise solely in environments that are clearly hazardous, though. Many ethical dilemmas occur in the home of either the patient or the person who called EMS.

Many EMS calls are dispatched to the home of the patient, and this location brings with it additional ethical considerations. In the field, EMTs have the added challenge of not just being mindful of their patients, but also respectful of their patients' property and of other family members. EMTs traditionally work in pairs, and one of the EMTs may be tasked with politely managing inquisitive family members while his partner assesses and treats the patient. While this is occurring, the EMT must remember that he or she is a guest in someone else's home during a stressful time. An additional consideration is that a spouse or relative may have called EMS against the wishes of the patient. This can lead to potentially hostile environments that the EMT must learn to recognize and handle. Additional complications when treating a patient in his or her home can include aggressive pets, difficulty accessing a patient with the stretcher because of narrow doorways or stairs, and patient dignity and privacy. Cynicism

The use of an ambulance also brings with it additional concerns, as it does not always present the easiest or safest work environment. Patients are likely to need additional care on the way to the hospital, and this often results in one EMT being unsecured in the back of the ambulance while his partner drives quickly, but not always safely, back to the hospital. Starting an intravenous access line in the hospital is one thing, but doing it in the back of a moving ambulance is something

else entirely. This can lead to frustration, additional pain caused to the patient, higher risk of the EMT suffering a needle stick, and less than ideal treatment. It is important that the EMT remains safe and respectful, and delivers adequate care in this high-intensity environment.

The single EMT in the back of the ambulance is another important variable to consider. There is no one else in the cabin with the EMT and the patient, and the responsibility of providing care and being respectful of the patient falls on that individual EMT. EMS calls are inherently stressful, and when a patient is distraught or the EMT is overtired, this pressure can result in frustration and poor treatment of the patient. Additionally, a patient may not feel comfortable confiding in or being treated by a provider who is of a different gender. EMS is one of the very few health care fields where the providers cannot choose whom they treat and patients cannot choose their providers.

The unique role of the EMT in health care is also illustrated in this scenario. The primary goals of the EMT are to stabilize, assess, and transport the patient in an efficient manner. As a result of this different goal, truth telling is something that is viewed differently by physicians and EMTs. Physicians are trained to place a very high priority on truthful communication with patients about their medical condition. The EMT is taught that “bending the truth” may be acceptable under certain circumstances, especially if it will lead to a more cooperative patient. During their training, EMTs are cautioned not to lie, but are told to be reassuring whenever possible. In this scenario, the patient has survived and has a positive prognosis, but his passenger has not been so fortunate. Instead of informing the driver of the

vehicle that the passenger is critically injured or dead, the EMT may say that he must focus on the driver and that the passenger is getting the best care possible from another EMT. While this is not necessarily a lie, it is certainly not the whole truth. This omission of additional information may delay the patient's grief response and result in more rapid extrication and treatment of the patient.

### Privacy and Confidentiality

An elderly man collapses in front of a local coffee house. While he is being assessed for a probable myocardial infarction, a woman runs up and says she's the man's caregiver, though she's not a family member. She has no documentation proving her claim. She demands to know the patient's condition. (Klugman, 2007)

The scenario of the man at the coffee house is not an uncommon one in EMS, and it highlights how patient privacy and confidentiality can be difficult to maintain in the field. EMTs are called to various locations, from the home of a patient to a crowded shopping mall, and bystanders inquiring about the patient are common. Patients may be unable or unwilling to share necessary personal or medical information with the EMT, especially if others are present. There are times when this cannot be avoided, but the EMT should at least attempt to protect the privacy of the patient. This can be done by requesting family members to leave the room, or by removing the patient from the scene and loading him or her into the ambulance. EMTs must also be wary about discussing patient information among themselves at the station or elsewhere, unless such communication contributes to the patient's care.



## Time and Protocol Driven Health Care

A 67-year-old male patient's home healthcare provider calls in alarm because her patient has fallen unconscious. He was just discharged from the hospital last week. The home provider has the patient's advance directive and a copy of a DNR order from his hospitalization. However, there is no prehospital advance directive (out-of-hospital DNR). (Klugman, 2007)

This scenario highlights the protocol-driven nature of EMS and the narrow window of time with which the EMT must operate. The objective of the EMT is to assess a critical patient as rapidly as possible before preparing him or her for transport and then to transport the patient. This time constraint does not allow for moral deliberation about whether to treat the patient that might have occurred in the hospital. As a result of this time constraint, EMS protocols have been constructed in such a way that they attempt to eliminate many decisions that may be difficult for the individual EMT.

In this particular scenario, an EMT would be expected to treat the patient because an original copy of a “portable” or out-of-hospital do not resuscitate order could not be produced. This may clearly be against the patient’s wishes given the previous history of an in-hospital DNR order, but the EMT must stick to protocol, especially when it comes to end-of-life issues like those presented in this scenario. The EMT is taught to function by following standing orders that have been established by the medical director, who is individually liable for the EMT’s actions.

The medical director is a physician who oversees a particular EMS system and is responsible for the treatment of EMS patients within that system. Due to the

fact that medical directors cannot be present for all EMS calls, they develop protocols and standing orders that authorize EMTs to perform procedures and practice under the physician's medical license. An EMT does not have sole authority over his or her patient under any circumstance. If the EMT is unsure about a treatment plan or course of action, he or she must phone medical direction. When an EMT follows his standing orders, he is following off-line medical direction, as opposed to on-line medical direction when the EMT contacts the medical director or attending physician for instructions on how to proceed. The EMT practices under the medical license of his or her medical director, and liability falls on the medical director, making this consultation essential. This lack of independent decision-making authority may lead to additional harm coming to the patient if treatment is delayed or if the EMT acts incorrectly without consulting medical direction. The physician's protocols should govern how the EMT operates, and EMS workers must remain aware of this.

The EMT also has the unique challenge of being the first health care provider to assess the patient. EMTs are responsible for both how a patient will be transported and for where the patient will be transported. The EMT must choose quickly and correctly whether a patient needs transport, which kind of transport the patient may need, and which hospital can provide the best treatment outcomes for this patient. These judgments are all made shortly after an EMT arrives on the scene, and they require a precise knowledge of available hospital resources and transport times to get to those hospitals, a challenge specific to EMS.

During this initial contact with the patient, the EMT must demonstrate both willingness and capability in order to provide the quality care and effective reassurance to the patient. This initial interaction can set the tone for the patient's health care experience, and the EMT should not take it lightly. An incompetent or unsympathetic EMT can result in a patient who is not trusting of the health care that is being provided and who refuses recommended treatment. In addition to being disrespectful, poor treatment of the patient can lead to additional stress for the EMT and worse outcomes for the patient in the long run.

### Consent and Research

A 58-year-old female is having difficulty breathing. After a lifetime of smoking, she figures her time is up and she probably has lung cancer. She indicates she does not want chemotherapy or other cancer treatments, but instead is ready to die. The immediate problem is difficulty getting a good oxygen sat. (Klugman, 2007)

A patient is bleeding out after a motor vehicle accident. Like most ambulances, the responding EMS providers do not stock human blood. The standard protocol is to give patients saline to increase fluid volume and to transport immediately. However, this community is participating in a research trial for a new artificial blood substitute. The patient has lost consciousness, and no one is around who can give consent for his participation (Klugman, 2007)

Patient capacity is also a very significant issue in EMS and it is highlighted by both of the above scenarios. In the hospital setting, if a patient is unable to make his or her own decisions, there is likely time to obtain consent to treatment from a third party authorized to make treatment decisions on the patient's behalf. The EMT often operates under implied or assumed consent, which is to say that the EMT assumes

that the patient would want treatment if he or she were able to make a decision. Informed consent can be difficult to obtain in the hospital setting, and it is even more challenging in the field. Often the patient is not competent, and decisions need to be made without much time for deliberation. This particular scenario can lead to the EMT making health care decisions for the patient that a “reasonable person” would make. Of course, this “reasonable person” concept is a legal fiction that does not provide clear guidance in many situations. Applying this reasonable person standard, or following their assigned protocols, may be the best options available to the EMT, but operating in this manner can lead to treatment that might violate a patient’s beliefs.

If the patient has any form of altered mental status as the result of a head injury, shock, intoxication, or in the case of the first scenario above, a potentially low oxygen saturation, the EMT is taught to assume that the patient is not capable of making his or her own health care decisions. This could present numerous issues if the EMT is not culturally competent. What if the patient in the second scenario was a Christian Scientist who was refusing any assistance from the EMTs? How should the EMTs handle this problem? Should they respect the patient’s wishes and allow him to bleed out, or should they treat him under an assumption of implied consent and risk violating the patient’s beliefs? While an ethical infringement may at times be a necessary shortcoming in the field of EMS, the EMT can still attempt to ascertain the patient’s wishes. An EMT can talk with a patient even if the patient is not alert and oriented to all of person, place, time, and event. The option also exists to speak with friends or family members who may be on the scene.

In regard to informed consent in the second scenario, an EMT also has to deal with problems concerning research ethics. In most ethical research settings, participants have a right to be informed about many of the aspects of the study in which they are participating. The subjects should be free of coercion or undue influence, but this environment cannot exist in EMS. The last example of a potential ethical issue details a patient who is bleeding out. The standard EMS protocol in this situation is to give saline to increase the fluid volume and get the patient to the hospital as quickly as possible. In this scenario, the responding ambulance contains an artificial blood substitute that is currently undergoing research trials. The patient is unconscious, and no one else who could consent for the patient is available. The EMT could treat the patient by way of the emergency exception to informed consent for research, but should this opportunity even exist in the field? The time or additional patient information that would be available in the ED would be absent and the EMTs would have to do what they deem to be correct here, or call medical direction. Thus, EMTs may encounter important issues of research ethics.

As these scenarios illustrate, EMS is a unique field that is deserving of its own ethics guidelines. An EMT becomes certified after a relatively short training period in which he or she will have limited, if any, interaction with patients. The certification curriculum will also train the EMT student to treat the patient as a step in an algorithm if he or she is not careful. Once an EMT makes it into the field, he or she must work in an environment that is time-sensitive and can be both stressful and dangerous. EMS patients are often suffering from an acute health injury or from some form of altered mental status and an EMT must remain calm and reassuring to

his or her patient. With all of these stressors in place, an EMT must maintain professional decorum in order to respect patient dignity, privacy, and confidentiality.

### Personal Experiences

I would like to emphasize that the ethical issues brought up in these scenarios are not hypothetical. During my brief time working in the field, I observed significant lapses in the ethical treatment of patients. My first ride-along, which is a twelve-hour shift that EMT students take, immediately brought ethical concerns to the forefront. Our first call was for a nursing home patient with a urinary tract infection and dementia who needed transport to a nearby hospital. This is a fairly typical EMS call, but I couldn't help but be surprised by what transpired. The EMTs with whom I was working spoke disparagingly about the nursing home staff, which may have been merited, as the patient's bed smelled of old urine, and they were less than cordial to the patient herself. She had dementia, so she could not know how she was being treated, right? As we "packaged" her for transport, I was elected to sit in the back with her while she flailed her limbs and shrieked that she was being hurt. I did my best to pad her body with towels against the backboard and comfort her, but she continued to scream. I was instructed to hold her wrists so that she could not harm herself any further. This caused her yelling to intensify. My partners for the day did not want to restrain her, as that would result in additional documentation,

and seemed to think that watching me struggle with my task of holding her wrists was funny.

The unseemly behavior continued on our next call, which was for a patient with chest pain. We arrived on the scene, which turned out to be a car dealership, and found our patient sitting in a chair breathing rapidly. We hooked her up to a 12-lead electrocardiogram and did not notice anything abnormal. We administered four baby aspirin and stayed with the patient so we could reassess vitals. At this point the patient refused transport and assured us that she was feeling better. It became clear to us that the woman was having a panic attack. My partners gossiped about our patient and mocked her on the way back to the station. They joked about how she clearly couldn't handle the pressure of shopping for a new car and should have just said no to the salesman instead of "faking" a heart attack. I would love to attribute these experiences to the aberrant behavior of the two EMTs with whom I was working that day, but I have found that similar behavior permeates the field of EMS.

A more intense experience with ethical issues came, not during a ride along, but when I was working an Orange County shift two years later. While working a night shift, the dispatcher called us to respond to a general sick call. She quickly upgraded the dispatch to a cardiac arrest as we loaded our gear into the ambulance. As we turned on the lights and sirens, I prepared myself to run a code, but I wasn't prepared to run one with the patient's entire family in the room with us. The patient's children and grandchildren watched as we performed CPR and tried our best to revive their family member, but we couldn't get a pulse back. All of our

training kicked in during the code, but I was not prepared for what happened after the resuscitation attempt. Terrible things happen to the body during CPR. The process of intubation and rescue breathing leads to disturbing sounding respirations when the patient is ventilated; ribs are often broken during chest compression, especially on the elderly; and the patient often voids their bowels when they receive a shock from the automated external defibrillator. The whole process is less than dignified, and even as someone who has had experience in health care, I can't image watching a family member go through it.

To this day, I remember each of the family members' reactions. They were all different and there was no training for that experience. The patient's spouse seemed to accept the news calmly, but his children screamed and wept. One asked us why we couldn't do more. Why couldn't we keep trying? Why we had stopped? The patient's other child asked us for narcotics to deal with the pain of the loss, and the patient's grandson just hung his head and sat quietly. I hadn't lost a patient before that day, and the family's reactions affected me deeply and made me truly consider what it meant to be involved in patient care. I couldn't help but see a family member where the patient was and I couldn't imagine EMTs treating them the way I had seen other patients treated. These experiences, among others, soon convinced me of the moral significance of the situations EMTs must confront and of the importance of ethics training for EMTs.

The EMT has to face a variety of ethical challenges that are unique to the field of the EMS. Some of these challenges have emerged in more recent years, but others have existed and will continue to exist as long as the field does. In Chapter 3, I will



argue that the NAEMT's Code of Ethics is in need of revision to address the specific ethical needs of the field of EMS and to provide more compassionate care for EMS patients.

## CHAPTER THREE

### THE CODE OF ETHICS

#### Origin and Text of the NAEMT Code of Ethics

Emergency physicians and nurses provide care to patients in a setting that may be one of the most stressful in medicine. These professional groups have updated their ethical guidelines to address important new issues and technologies such as the confidentiality rules implemented under the Health Insurance Portability and Accountability Act (American College of Emergency Physicians, 2011; United States Department of Health and Human Services, 1996). There is a glaring ethical omission in the chain of emergency medical services, however. EMTs, who are a vital link in prehospital care, have not had their ethical guidelines updated since 1978. This means that the first group of health care professionals that many patients will see in traumatic situations has not revisited its ethical guidelines in over thirty years. This chapter will analyze the National Association of Emergency Medical Technicians Code of Ethics and propose changes that will both update it and make it more accessible, with the goal of producing more morally responsible EMTs.

The National Association of Emergency Medical Technicians was established as emergency medical services was beginning to gain credibility as a field as a result of the 1966 report *Accidental Death and Disability: The Neglected Disease of Modern Society*. In 1978, two short years after the NAEMT was created, it adopted its Code of Ethics. Dr. Charles Gillespie, who chaired the Emergency Health Services Advisory Council that determined EMS regulations for the state of Georgia, authored the Code

of Ethics that was adopted by the NAEMT. Dr. Gillespie's influences are very clear, as his Oath, which was adopted at the same time as the Code of Ethics, is a paraphrase of part of the Hippocratic Oath.

This chapter will not propose an updated version of Dr. Gillespie's EMT Oath. The Hippocratic Oath has its ceremonial place in medical school graduations, but there is no such environment in EMS. EMT students must pass their written exams and their technical scopes of practice before taking the state or national certification exam. Due to the stepwise certification process, there is not currently an environment for recently certified EMTs to take an oath. I would advocate for retiring Dr. Gillespie's EMT Oath. This EMT Oath is gender-specific and overly religious, two things that are exclusionary and should not be endorsed by the NAEMT.

Dr. Charles Gillespie is well respected in the field of emergency medical services and his contributions should not be discounted. Nevertheless, a field as rapidly changing as EMS should not retain the same code of ethics over a span of more than thirty years. The American College of Emergency Physicians has made an organizational decision that all policy statements will be reviewed after they have been in existence for seven years; maybe this policy of automatic sunseting would prove beneficial for the NAEMT as well (American College of Emergency Physicians, 2013).

The EMT Code of Ethics can both be found in its original form on the NAEMT website. Here is the complete text of the Code, with numbers added to aid in analysis:

Professional status as an Emergency Medical Technician and Emergency Medical Technician-Paramedic is maintained and enriched by the willingness of the individual practitioner to accept and fulfill obligations to society, other medical professionals, and the profession of Emergency Medical Technician. As an Emergency Medical Technician-Paramedic, I solemnly pledge myself to the following code of professional ethics:

1. A fundamental responsibility of the Emergency Medical Technician is to conserve life, to alleviate suffering, to promote health, to do no harm, and to encourage the quality and equal availability of emergency medical care.
2. The Emergency Medical Technician provides services based on human need, with respect for human dignity, unrestricted by consideration of nationality, race creed, color, or status.
3. The Emergency Medical Technician does not use professional knowledge and skills in any enterprise detrimental to the public well being.
4. The Emergency Medical Technician respects and holds in confidence all information of a confidential nature obtained in the course of professional work unless required by law to divulge such information.
5. The Emergency Medical Technician, as a citizen, understands and upholds the law and performs the duties of citizenship; as a professional, the Emergency Medical Technician has the never-ending responsibility to work with concerned citizens and other health care professionals in promoting a high standard of emergency medical care to all people.
6. The Emergency Medical Technician shall maintain professional competence and demonstrate concern for the competence of other members of the Emergency Medical Services health care team.
7. An Emergency Medical Technician assumes responsibility in defining and upholding standards of professional practice and education.
8. The Emergency Medical Technician assumes responsibility for individual professional actions and judgment, both in dependent and independent emergency functions, and knows and upholds the laws which affect the practice of the Emergency Medical Technician.
9. An Emergency Medical Technician has the responsibility to be aware of and participate in matters of legislation affecting the Emergency Medical Service System.
10. The Emergency Medical Technician, or groups of Emergency Medical

Technicians, who advertise professional service, do so in conformity with the dignity of the profession.

11. The Emergency Medical Technician has an obligation to protect the public by not delegating to a person less qualified, any service which requires the professional competence of an Emergency Medical Technician

12. The Emergency Medical Technician will work harmoniously with and sustain confidence in Emergency Medical Technician associates, the nurses, the physicians, and other members of the Emergency Medical Services health care team.

13. The Emergency Medical Technician refuses to participate in unethical procedures, and assumes the responsibility to expose incompetence or unethical conduct of others to the appropriate authority in a proper and professional manner. (National Association of Emergency Medical Technicians, 1978)

### Section-by-Section Analysis of the Code

I proceed now to a section-by-section analysis of the content of the NAEMT Code of Ethics.

#### Introductory Paragraph

Professional status as an Emergency Medical Technician and Emergency Medical Technician-Paramedic is maintained and enriched by the willingness of the individual practitioner to accept and fulfill obligations to society, other medical professionals, and the profession of Emergency Medical Technician. As an Emergency Medical Technician-Paramedic, I solemnly pledge myself to the following code of professional ethics: (National Association of Emergency Medical Technicians, 1978)

This first paragraph of the code begins with classifications that are no longer in use in EMS. Emergency Medical Technician-Paramedics are now simply known as paramedics. This initial paragraph does not mention emergency medical responders and advanced EMTs, two essential classifications within the field of EMS in 2013.

The lead-in to the code is in need of revision as it refers to, “obligations to society, other medical professionals, and the profession of the Emergency Medical Technician,” but omits mention of any obligation to patients. The last sentence reads, “As an Emergency Medical Technician-Paramedic, I solemnly pledge myself to the following code of professional ethics” (National Association of Emergency Medical Technicians, 1978). The language used here is exclusionary. The wording is such that the code appears to only apply to paramedics, not the entire field of EMS. Referring to the NAEMT Code of Ethics as a “solemn pledge” is also interesting because the code is read, not taken with a hand over the heart of the EMT. The reference to a “solemn pledge” conflates Gillespie’s EMT Oath with his Code of Ethics. Physicians do traditionally take an updated version of the Hippocratic Oath upon graduation, but they do not take a pledge to their particular specialty’s code of ethics.

### Principle 1

A fundamental responsibility of the Emergency Medical Technician is to conserve life, to alleviate suffering, to promote health, to do no harm, and to encourage the quality and equal availability of emergency medical care. (National Association of Emergency Medical Technicians, 1978)

The first principle of the code lists several fundamental responsibilities of an EMT and refers to them as a single responsibility. Too much may be packed into a single principle here, and this is the first of several instances where the need for proofreading signals the lack of attention that the NAEMT Code of Ethics has received. The responsibilities covered in this principle may cover the majority of the

fundamental responsibilities of an EMT at their most basic level, but omissions remain. There is no mention of rapid and safe transport, which is certainly a fundamental responsibility of an EMT. These responsibilities could be made more specific and remain up-to-date by including a reference to the core competencies on which EMTs are assessed for their certification and scope of practice. Criteria such as demonstrating splinting and basic airway management are what are focused on in the teaching curriculum, so using the words “fundamental responsibility” here without specifically alluding to the core competencies of EMS certification was an interesting choice. Additionally, it is uncertain whether or not it is the EMT’s job to encourage equal availability of emergency medical care. Yes, the EMT should provide the same standard of care to all of his or her patients, but it is unclear whether this is what the principle is asserting. The first sentence of the body of the code, along with some of those that follow, is reminiscent of the Hippocratic Oath, which was never intended to apply to EMS and is dated in any field of health care. “Do no harm” has become a medical cliché as it is nearly impossible for an EMT to do his or her job without causing some degree of harm to their patient. Spinal immobilization is not comfortable, intravenous medication requires at least one needle puncture, and cardiopulmonary resuscitation is certainly not performed without harming the patient. Yes, as in all fields of health care, the benefits will often outweigh the harms, but specifically mentioning not doing harm in the Code of Ethics, without any further interpretation or clarification, is both outdated and misguided.

## Principle 2

The Emergency Medical Technician provides services based on human need, with respect for human dignity, unrestricted by consideration of nationality, race, creed, color, or status. (National Association of Emergency Medical Technicians, 1978)

In the second principle of the code, the EMT is enjoined to provide services based on human need, with the respect for human dignity and without discrimination. The intent here is to convey that the need for care should determine who should receive the services of the EMT, not other characteristics of the patient. This is an important responsibility that deserves a clearer statement. 'Human need' is an awkward term because the needs for treatment of illness or injury that EMTs tend to are not specific to humans as a species. What is meant by the term 'status' is also unclear here. Keeping prejudices out of health care is an admirable characteristic, but something more than that is necessary. EMTs should be not only free from prejudice, but also culturally humble and compassionate. There are times when cultural differences will present obstacles in the field; EMTs should not ignore these differences and treat their patients as they normally would. When these issues arise, it is the responsibility of the EMT to listen to his or her patient and be respectful of the patient's wishes when possible. Of note, the form of the Code of Ethics that is published on the NAEMT's website does not have a comma between race and creed; failure to correct this typographical error suggests that more attention should be given to the Code of Ethics.



### Principle 3

The Emergency Medical Technician does not use professional knowledge and skills in any enterprise detrimental to the public well being. (National Association of Emergency Medical Technicians, 1978)

The Code's third principle is an interesting one. It may seem redundant after "do no harm" was mentioned, but it suggests a different recipient of the harm. The focus here is on the public well being, as opposed to the well being of the patient. This is an incredibly broad area of concern and could benefit from some elucidation by the NAEMT or Dr. Gillespie. Is the concern here for incorrectly operating an ambulance by speeding or misusing the siren? Is the concern that narcotics could be misused? I maintain that this sentence is too broad and needs to be more specific to convey its point effectively.

### Principle 4

The Emergency Medical Technician respects and holds in confidence all information of a confidential nature obtained in the course of professional work unless required by law to divulge such information. (National Association of Emergency Medical Technicians, 1978)

The fourth principle of the code addresses the topic of patient confidentiality. The wording does not make it clear exactly what information the EMT must respect or classify as confidential or under what circumstances the EMT may be required by law to divulge information. An example of an ethical dilemma here could concern the duty to warn, when an EMT may have to divulge confidential information in order to prevent harm coming to others. This line could both be clarified and

grounded in the present day with a reference to privacy and confidentiality laws. This general allusion to current privacy and confidentiality laws would allow the Code to avoid revision if specific legislature was amended or repealed. A revised version of this principle might allow an EMT to override confidentiality in certain circumstances and might refer to specific privacy and confidentiality regulations.

### Principle 5

The Emergency Medical Technician, as a citizen, understands and upholds the law and performs the duties of citizenship; as a professional, the Emergency Medical Technician has the never-ending responsibility to work with concerned citizens and other health care professionals in promoting a high standard of emergency medical care to all people. (National Association of Emergency Medical Technicians, 1978)

The intent of this fifth principle is puzzling. It suggests a dual identity for EMTs as both citizens and professionals, but the responsibilities entailed by the two roles and the distinction between the two remain unclear. Dr. Gillespie's attempt at dignified word choice here risks obscuring his point. This principle appears to affirm an EMT's obligation to obey and work towards improving the law, while reiterating the point that is made in the second principle that emergency medical care should be available to everyone. The second part of the principle seems to suggest a call to all EMTs to help improve the status of the profession in society, but whether or not this belongs in a code of ethics is questionable.

### Principle 6

The Emergency Medical Technician shall maintain professional competence and demonstrate concern for the competence of other members of the

Emergency Medical Services health care team. (National Association of Emergency Medical Technicians, 1978)

The sixth principle's exhortation to maintain professional competency and ensure that fellow EMTs' skills are up to date is an important affirmation.

Continuing education is essential to the maintenance of professional competence, and many EMS squads already require it. If an active EMT does not attend a certain number of hours of continuing education, he or she is required to retake the certification class and exam, ensuring that he or she maintains an appropriate level of competence. It would be beneficial if the Code of Ethics made some reference to how an EMT would go about maintaining professional competence. The principle also states that an EMT has an obligation to demonstrate concern for the competence of other members of their health care team but does not specify how the EMT should go about this. Should the EMT report other members of the health care team, or should they speak with other members and attempt to aid in areas where they may be lacking?

### Principle 7

An Emergency Medical Technician assumes responsibility in defining and upholding standards of professional practice and education. (National Association of Emergency Medical Technicians, 1978)

Although the seventh principle offers an admirable goal to strive towards, most EMTs will not play a significant role in defining standards of practice or education. Standards of practice generally fall under the purview of a medical director, and education standards are regulated at either the state or the national

level, depending on the EMT's certification. Like principle 5 before it, principle 7 appears to be calling on EMTs to take control of their own profession and elevate its status, an agenda that does not necessarily belong in a modern code of ethics. Of note, Principle 7 and Principle 9 are the only two principles that begin with "An Emergency Medical Technician" as opposed to "The Emergency Medical Technician," a puzzling break in the format of the code.

### Principle 8

The Emergency Medical Technician assumes responsibility for individual professional actions and judgment, both in dependent and independent emergency functions, and knows and upholds the laws which affect the practice of the Emergency Medical Technician. (National Association of Emergency Medical Technicians, 1978)

The eighth principle is another that appears repetitive, but it does reference the judgment of the EMT for the first time. This is significant because it is the first time that the decision-making capacity of the EMT is acknowledged. EMTs are trained to follow algorithms for patient assessment and standing orders for patient treatment, but the judgment of the EMT also plays a significant role in patient care. The EMT must quickly assess his or her patients, decide how best to care for them, and where to transport them. Like Principle 7, this principle may be alluding to something for the field of EMS to strive towards, namely more decision-making authority for individual EMTs. This section could be absorbed by another and have the unclear wording of "in dependent and independent" altered.

## Principle 9

An Emergency Medical Technician has the responsibility to be aware of and participate in matters of legislation affecting the Emergency Medical Service System. (National Association of Emergency Medical Technicians, 1978)

The ninth principle is another interesting addition to the code. Does every EMT really have the responsibility to be aware of *and* participate in matters of legislation that affect EMS? Legislation may take place at a level that is far above the head of an individual EMT, making participation difficult, if not impossible. Again, like many of the principles before it, Principle 9 may be calling for EMTs to become more active participants in the legislation that will directly affect their chosen profession. If this is Principle 9's intention, it could be reworded and emphasize the importance of the EMT being involved in decisions, legislative or otherwise, that affect their profession.

## Principle 10

The Emergency Medical Technician, or groups of Emergency Medical Technicians, who advertise professional service, do so in conformity with the dignity of the profession. (National Association of Emergency Medical Technicians, 1978)

The tenth principle of the code states that EMTs who advertise professional service should conform to the dignity of the profession, without really defining what the dignity of the profession is. This line could be reworded to be more about professional competence and respect for the dignity of patients. The AMA previously included a somewhat different principle in its Code of Medical Ethics that restricted

advertisement, but it was dropped in the 1980s when the Supreme Court upheld an order from the Federal Trade Commission that stated that the AMA must allow physicians to advertise their services (Pertschuk, 1983). It appears that this principle was based on the one that was found in the AMA Code of Medical Ethics and that it is just a holdover from years past that is no longer relevant to individual EMTs. Today's EMTs are usually part of larger organizations that handle the advertisement of professional services.

#### Principle 11

The Emergency Medical Technician has an obligation to protect the public by not delegating to a person less qualified, any service which requires the professional competence of an Emergency Medical Technician. (National Association of Emergency Medical Technicians, 1978)

The eleventh principle addresses the important legal and moral issue of abandonment, as well as the fact that the author of the Code of Ethics believes that only trained EMTs should be able to provide these services. If an EMT transfers care to a person who is incapable of treating or caring for his or her patient, then this constitutes abandonment and the EMT can be held liable for damages suffered by the patient. Abandonment is both legally and ethically wrong, and this is a welcome inclusion in the Code of Ethics. Dr. Gillespie's attempt to choose words that sound dignified again obscures the probable intent of this principle. Is the EMT actually protecting the public by not abandoning his or her patient? Perhaps something about having an obligation to the well being of patients would be a better way to phrase this particular line.

## Principle 12

The Emergency Medical Technician will work harmoniously with and sustain confidence in Emergency Medical Technician associates, the nurses, the physicians, and other members of the Emergency Medical Services health care team. (National Association of Emergency Medical Technicians, 1978)

The twelfth principle of the code addresses the issue of working with other health care providers. EMTs communicate with other emergency medical responders on scene and with physicians and nurses in hospital Emergency Departments. Respectful interaction between health care workers is essential for optimal patient care. It is impossible, however, for the EMT to work harmoniously with and sustain confidence in all of the health care providers that he or she will encounter in his or her career. The content of this principle is valuable, but absolute adherence to it would violate of Principles 6's assertion that the EMT is responsible for ensuring the competency of fellow emergency service providers. This principle should be clarified and state that the EMT has the right and obligation to act if he or she is unable to work harmoniously or sustain confidence in his or her colleagues.

## Principle 13

The Emergency Medical Technician refuses to participate in unethical procedures, and assumes the responsibility to expose incompetence or unethical conduct of others to the appropriate authority in a proper and professional manner. (National Association of Emergency Medical Technicians, 1978)

The thirteenth and final principle of the code of ethics is another necessary inclusion, but it could be further clarified. Principle 13 refers to the right of the EMT

to expose incompetence or unethical conduct, but it is unclear whether or not there is room in this principle for the EMT to conscientiously object if a patient or a fellow health care provider is requesting an unethical procedure. If the EMT were able to conscientiously object, this would be more of a professional privilege than an obligation, which would require rewording of the introductory paragraph of the Code of Ethics. This principle states that the EMT refuses to participate in unethical procedures, but never defines what an unethical procedure might entail. As a result, the first half of final principle of the code of ethics essentially says, “Don’t be unethical.” The reference to exposing incompetence is also something that may be more appropriately included in Principle 6, which already addresses issues of incompetence. This final principle is also notable because it is the first time that a form of the term ‘ethics’ (“unethical”) is actually mentioned in Dr. Gillespie’s code, apart from the title.

### General Observations on the Code

There is some overlap in the current NAEMT Code of Ethics, but this is not necessarily a bad thing. If the principles are clearly explained and qualified in relation to one another, the conflict between principles should be minimal. EMTs should be made aware of the principles and basic responsibilities that are identified in this Code, but this alone is not sufficient. EMTs also need to be given instruction about how to interpret and apply these principles in practice in order to balance the inevitable tension or conflict among these principles.



Dr. Gillespie's Code appears to serve a dual purpose, something that was common in codes of ethics that appeared around the time that his was drafted. The NAEMT Code of Ethics groups together a collection of ethical principles to follow, but many of these principles seem as concerned with building up the profession as they are with ethical behavior. In the present day, I believe that many of these statements would be better suited in an EMS mission statement than in a code of ethics.

Finally, Dr. Gillespie's Code does not appear to be written for the correct audience. The Code has many instances of awkward wording and of principles that are unclear. The Code of Ethics scores a 22.9 on the Flesch-Kincaid Grade Level, a 23.5 on the Automated Readability Index, and a 20 on the SMOG Index. According to these readability scales, these three scores that indicate that a graduate level education is required in order for the Code of Ethics to be understood on the first read through (Readability-Score.com). This is particularly troublesome because EMTs only require a tenth grade reading level and a high school diploma or GED to enroll in certification courses (North Carolina Office of Emergency Medical Services, 2005).

### A Proposed New Code of Ethics

The NAEMT Code of Ethics is not without its flaws, but it should at the very least identify fundamental professional principles an EMT might rely on in the field.

The Code of Ethics does not mention conscientious objection, respect for patient treatment refusals, maintenance of equipment, or being physically competent, all of which are essential components to being a competent EMT. To remedy the deficiencies of the current EMT Code of Ethics, I propose the following:

### A New Code of Ethics for Emergency Medical Technicians

Emergency Medical Technicians (EMTs) demonstrate professionalism by showing respect for patients, fellow medical professionals, and the profession. The EMT should strive to fulfill the following basic moral obligations:

1. The emergency medical technician has an obligation to his or her patients to treat patient welfare as his or her primary goal. In order to ensure this, emergency medical technicians must have the requisite knowledge, skills, and attitudes to treat their patients in accordance with their scope of practice.
2. The emergency medical technician is to treat his or her patients with respect, regardless of beliefs, values, or background, and should make an effort to be aware of and accommodate specific needs that may arise as a result of his or her patient's particular beliefs.
3. The emergency medical technician shall not leave his or her patient, unless required to do so as the result of a mass casualty or triage incident, until the patient has been informed of the potential risks of his or her condition and has signed a treatment refusal form.
4. The emergency medical technician shall remain aware and respectful of the scene at which they are working.
5. The emergency medical technician shall strive to be reassuring without fostering any false hope when conveying medical information to his or her patient.
6. The emergency medical technician shall not transfer care of his or her patient to anyone who is not qualified to care for the patient.
7. The emergency medical technician shall use equipment and medical knowledge in such a way that will not put fellow health care providers, patients, or third parties at risk or jeopardize their well-being.

8. The emergency medical technician shall not participate in unethical procedures and reserves the right to conscientiously object to unethical procedures that may be requested by the patient or by fellow health care providers.

9. The emergency medical technician shall be well versed in privacy and confidentiality and will treat confidential patient information as such, unless required by moral obligation or law to divulge patient information.

10. The emergency medical technician shall cooperate and be honest with emergency medical responders, police officers, firefighters and other emergency personnel, respecting their professional roles and relationships with emergency medical services.

11. The emergency medical technician is responsible for maintaining his or her own competence, as well as the competence of coworkers, in accordance with having the utmost respect for the well-being of his or her patients.

12. The emergency medical technician has an obligation to communicate to his or her supervisor any concerns that he or she has about the competence of fellow emergency medical technicians.

This proposed code of ethics is intended to serve as an update of the 1978 Code that captures many of the issues that arise in EMS, without being too restrictive. However, a different code of ethics is of little use if no one can understand it. This proposed code of ethics scores roughly 5 points lower on all of the previously mentioned readability metrics, which means that on average 5 fewer years of education are needed to understand it on the first read through (Readability-Score.com). This code of ethics would be of equally little use if no one were made aware of it. There are states, such as Georgia, that make the NAEMT Code of Ethics a part of their curriculum, but many EMTs are unaware that a code of ethics even exists.

EMS currently teaches their EMTs that they are the most important person on the scene. The next level of priority is their partner and then comes the patient.

This makes sense from a logistical standpoint because an EMT cannot treat or transport himself if he is injured, but this doesn't make sense from an ethical standpoint. The job of an EMT is patient care, but an EMT is taught to hope for a quiet shift, and patients are often treated as inconveniences or interruptions, rather than ends in themselves. Too often, this attitude is taught by certification instructors and reinforced by fellow EMTs during the training period of a recruit. Thinking of patients as inconveniences leads to behavior that is both selfish and unethical; such behavior has no legitimate place in EMS or health care. Imagine that a person who is likely going through one of most traumatic experiences of his or her life might be viewed an inconvenience by some health care providers. I believe that a revised and better-implemented code of ethics can play a part in correcting this ethical deficiency that is currently so prominent in the field. To counter this self-focused attitude, the Code that I have proposed places a heavy emphasis on the professional responsibilities of EMTs towards their patients. Despite this emphasis, I did not feel comfortable proposing a Code of Ethics that did not include the basic professional prerogative of conscientious objection.

The current NAEMT Code of Ethics, along with EMT certification courses, does not do enough to prepare EMTs to deal with dilemmas that will arise when they begin to work in the field. EMS education in its current form simply does not prepare EMTs for the first time they transport a nursing home patient, or enter the home of a patient with dementia, or lose a patient with family members present. What is the most ethical course of action to take when an EMT errs during on-the-job training and the patient suffers as a result? How should EMTs comfort a grieving

family member? Should they remain silent? Should they apologize? There is no single right answer, but a renewed focus on ethics can result in EMTs who are aware of their moral responsibilities and who can care for their patients more appropriately during their times of need.

## CHAPTER FOUR

### ETHICS IN EMS EDUCATION

The revisions to the NAEMT's Code of Ethics are both necessary and important, but their influence will be negligible if the EMT certification curriculum does not include more substantial ethics education. EMS education is different than that of other health care providers--the curriculum is very brief, and so time is a very limited resource. The EMT certification courses are usually taught over the course of a semester or a year, as opposed to several years. This time constraint makes it incredibly challenging to include more time for any one subject, but it can be done.

A typical EMT certification course includes roughly 180 hours of instruction, with the North Carolina certification course recommending only 169 hours (North Carolina Office of EMS, 2005). These hours include classroom time, hands-on skills development, case-based drill scenarios, written and hands-on skill testing, and a 12-hour ride-along shift. In the EMT educational program structure that is recommended in North Carolina, ethics is part of the first module, entitled "preparatory." That first module is made up of seven components, with the recommended hours for each component in parenthesis:

- Introduction to EMS Systems (1)
- The Well Being of the EMT (1)
- Medical/Legal and Ethical Issues (1)
- The Human Body (4)
- Baseline Vital Signs and SAMPLE History (4)
- Lifting and Moving Patients (3)
- Evaluation: Preparatory (1) (North Carolina Office of EMS, 2005)

These recommended totals add up to fourteen hours of coursework with one hour of evaluation for the material covered. Only one hour is devoted to the ethics component of the module and that hour is shared with medical/legal issues. Time may be a limited resource in an EMT certification class, but devoting a fraction of an hour to ethical issues is not enough. If the entire hour were devoted to ethical issues alone, it would only make up a fraction of one percent of the certification course. In comparison, The North Carolina Office of EMS recommends that a paramedic level certification include 596 hours of in-class instruction, but ethics only accounts for two of the 82 hours found in the introductory paramedic module (North Carolina Office of EMS, 2005).

The great disparity in classroom hours in these two courses is due to the fact that the courses teach different skills and have very different criteria for certification. As an EMT, skills will not be tested in the field as part of the certification curriculum, but as a paramedic a certain number of skills must be performed during clinical rotations. Because these skills must be practiced, paramedics are given more hands-on time with patients during their certification course. These increased amounts of time with patients during certification and the additional hour that is spent on ethics are not because a paramedic will spend any more time with a patient in the field. Yes, paramedics will be asked to run advanced life support calls, but some ambulances are staffed only by basic EMTs with paramedics on standby.

Why is this discrepancy so prominent? If patient care is clearly the goal of EMS or any health care profession, why is such little time devoted to it? Caring for the patient's chief complaint by following standing orders and procedures is one thing, but treating the patient well and being there for them in a time of need is something different entirely. EMT students must have the opportunity to focus more time on ethics. Patients may have to be traction splinted or have their bleeding controlled in a textbook manner, but they are not going to believe that they received high quality care if they are not treated well and with respect.

To paraphrase the discussion in chapter 2, emergency care is a unique branch of health care, and EMS has a very different role than other providers within this branch. The patients that EMTs care for are often experiencing some form of acute health problem and are anxious, in pain, or display altered mental status of some kind. Working with acutely ill or injured patients in an uncontrolled and highly charged work environment, EMTs must often make very difficult moral decisions. The current educational model for dealing with the stresses of ethical decision-making in the field is inadequate.

Currently, EMT instructors teach the existing ethical guidelines in a slide presentation that often does not focus solely on ethics. This presentation describes ethical issues, steps that should be taken in making ethical decisions, and how to apply certain tests to determine a rapid approach to ethical problems. For example, the following slides are drawn from Kenneth J. Sternig's "Ethics in Emergency Medicine" presentation:





Figure 1: Steps in Ethical Decision Making

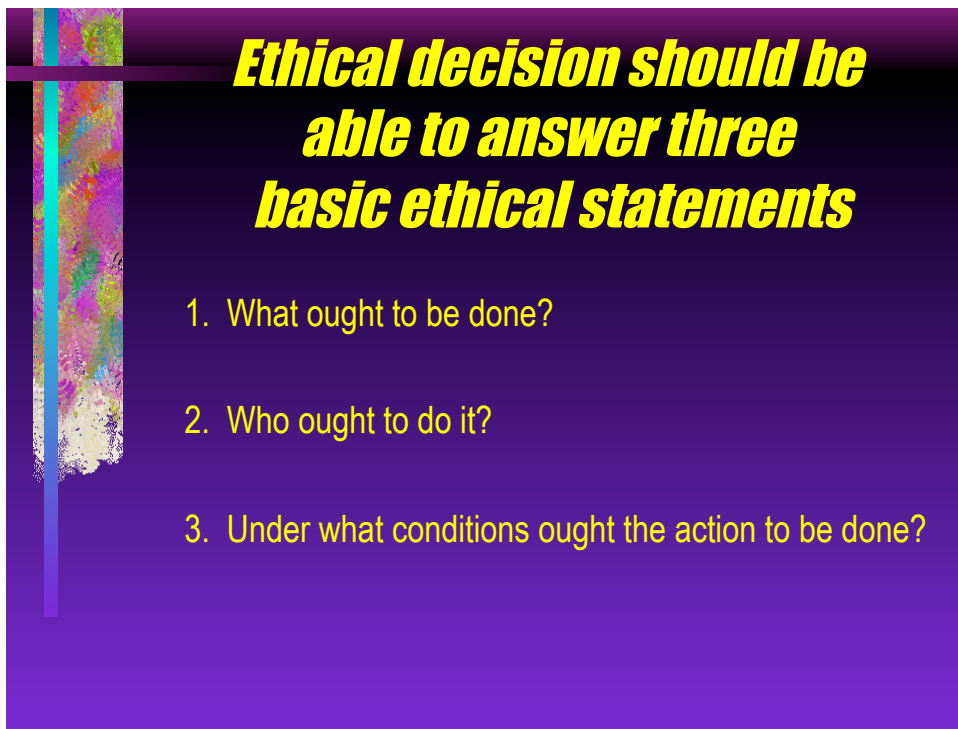


Figure 2: Ethical Decisions and Three Basic Ethical Statements

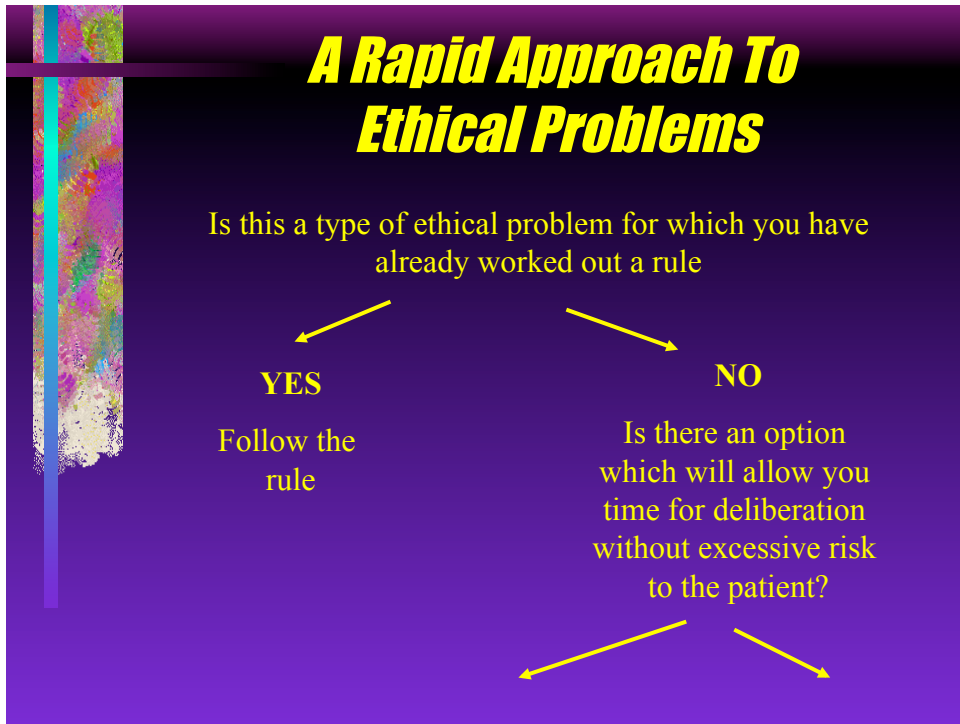


Figure 3: A Rapid Approach to Ethical Problems 1

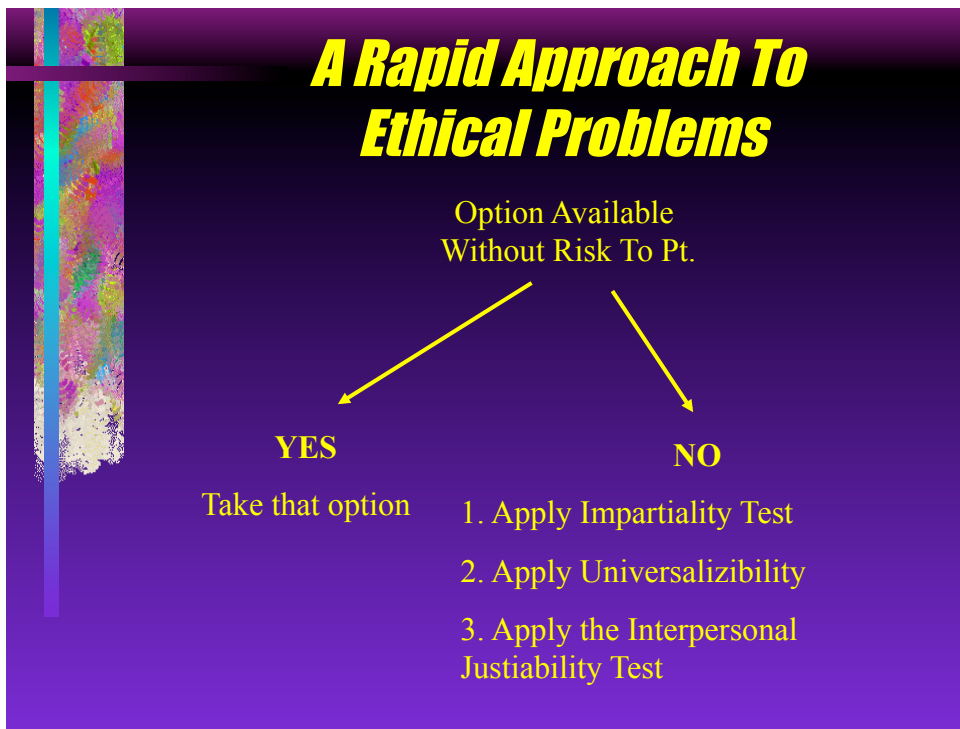


Figure 4: A Rapid Approach to Ethical Problems 2

Mr. Sternig's slides do provide a framework for ethical decision-making, but EMS students cannot be expected to understand and weigh the listed ethical values in under an hour, let alone become familiar with the impartiality, universalizability, or justifiability tests. Considering alternatives when ethical questions are presented and applying the aforementioned tests is extremely challenging in the work environment of the EMT. Brief presentation of the "Rapid Approach to Ethical Problems" in these slides is unlikely to result in sound ethical judgments by EMTs. Both competency and expediency in weighing ethical values and making decisions that are morally defensible only come with continued discussion and practice.

Certification instructors frequently share their teaching materials with one another to ensure that all of the material is being covered in the best way possible. A problem with sharing these presentations, however, is that the original presenter's main points or intentions may not be entirely clear or completely understood by other instructors. Many ethics presentations include case scenarios. Follow-up slides raise questions, but very rarely provide answers. Here is one example:

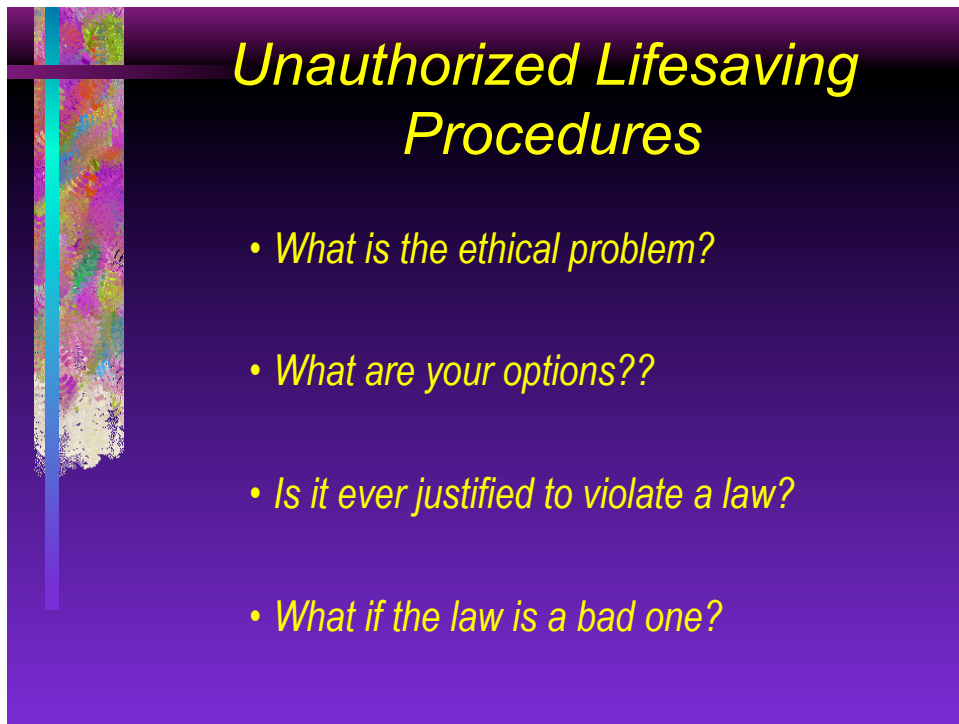


Figure 5: Unauthorized Lifesaving Procedures

Slide 5 does raise important and necessary questions, but what if Mr. Sternig was using the questions on this slide as a lead-in for more specific discussion of the ethical issues? EMS instructors might use this slide to facilitate an ethics discussion, but this is very different in format and content from the material that they are used to presenting. It would be beneficial for both the instructor and his or her students if the instructor could become familiar with a model for ethics consultation and have key discussion points listed on a subsequent slide. The instructor could then present how the model is used and implement it in class to encourage debate, bring up different viewpoints, and increase class participation.

With regard to the goal of increasing discussion and class participation, the fact that the ethics module is discussed early in the certification course is significant.

In my teaching experience, the dynamic of an EMT certification course changes from the beginning to the end. As students and instructors become more comfortable with one another, discussions and questions are more in-depth, and hands-on skills testing is taken more seriously. Unfortunately though, after initial exposure to ethics in the first module of the current EMT certification course, students have very little reason to revisit it. EMT students are often curious about the “worst” event that their instructors have experienced in the field. These conversations usually take place off to the side or during a break, often turn into valuable teaching moments, and present a great opportunity for a discussion of ethics. Ethics is not always an easy topic to discuss, but this more conversational approach would serve the purpose better, especially if it could be given more attention later in the course. At this point students would be more familiar with their role as an EMT and more comfortable with having a discussion, as opposed to attempting to absorb material that is presented in the format of a lecture.

The time that is spent on ethics generally focuses on issues or scenarios with simple solutions or answers; for example, if a family member is being difficult during patient treatment, a student would verbalize that he or she would like the family member to step aside or leave the room. However, problems are not resolved so easily in the field. My experience has shown me that ethical treatment of patients is a key component of field work in EMS, but it is generally not viewed as one of the core competencies of an EMT certification class. Because ethics is not viewed as a core competency for EMTs, the ethics module of the course is not given sufficient

classroom time. The current list of key topics of the “Medical/Legal and Ethics” component of the certification classes is as follows:

US DOT NHTSA National EMS Education Standards:  
Medical/Legal and Ethics

EMT

- All covered at fundamental depth, foundational breadth
- Consent/refusal of care
- Confidentiality
- Advanced directives
- Tort and criminal actions
- Evidence preservation
- Statutory responsibilities
- Mandatory Reporting
- Ethics principles/moral obligations
- End-of-life issues at simple depth and simple breadth

Paramedic

All covered at complex depth and comprehensive breadth

- Consent/refusal of care
- Confidentiality
- Advanced directives
- Tort and criminal actions
- Evidence preservation
- Statutory responsibilities
- Mandatory Reporting
- Ethics principles/moral obligations
- Health care regulation
- Patient rights/advocacy
- Ethical tests and decision making

(NHTSA, 2011)

The United States DOT National EMS Education Standards are broad in scope, but they are still far from complete. Even the paramedic-level education standards fail to address many of the morally distinctive features of EMT practice that were outlined in chapter two. The volatility of working in the field is a unique feature of EMS ethics, but there is no mention of working in an uncontrolled, highly charged,

and potentially dangerous environment. These education standards do not even mention the balance between individual decision-making, following protocols, and getting direct advice from a supervising physician or the time-sensitive nature of the patient's condition that may complicate this balance. Including an updated Code of Ethics in the teaching curriculum, or reviewing what makes EMS deserving of its own ethics guidelines and including these topics in the "medical/legal and ethics" education standards could address these shortcomings.

Despite the fact that some ambulance services only employ EMTs, the teaching guidelines dictate that more topics should be covered in greater depth only by the paramedic-level certification program. These additional topics, and the greater depth and breadth of coverage of all of the topics, can be assumed to fit in the one additional hour that has been allocated to ethics in paramedic certification courses. In a typical EMT certification class, ethical guidelines are mentioned, briefly tested, and seldom revisited. I have argued that the current content and format of this teaching does not adequately prepare EMT students to treat their future patients correctly, for the following reasons: too many complex topics are covered with too little time allotted, many of the morally distinctive features of EMT practices are not mentioned, the information is presented in the wrong format for teaching ethical content, the instructors are not trained to facilitate an ethical discussion, and the NAEMT's Code of Ethics is also outdated. Unprepared EMTs and paramedics may treat patients improperly without even realizing it and this may lead to a reduced standard of care.

More hours of class time should be devoted to ethics education. Adding just several hours of ethics to class time would substantially increase the percentage of time that students spend with the material. Even if ethics must still be covered in a truncated manner because of time or resource constraints, adding only an additional hour to the curriculum that consists solely of ethics, in addition to the recommendations to follow, would represent a significant improvement.

Even if more hours of class time cannot be allocated to the ethical treatment of patients, ethics could be integrated into the skills components of the curriculum. Tens of hours of class time are spent practicing skills and running through potential treatment scenarios. Time could easily be made for ethics if the moral dimensions of interaction with the patients were addressed during these exercises. For example, training for extrication from a motor vehicle could include, in addition to stabilizing the spine and removing the patient from a car, attention to how to respond to questions asked by the patient if the passenger in the car appears critically injured. Cardiac arrest scenarios would not have to end with the patient not being revived, but with how the EMT should cope with the aftermath.

These scenarios are useful teaching tools, but they are not without their faults. When similar scenarios are run with familiar patients whose roles are played by students and instructors, the emphasis is on the patient assessment algorithm and not on the patients themselves. This familiarity with the algorithm is necessary because it is following this algorithm and scope of practice that allows students to excel on their technical scope of practice and written examinations, but the



repetitions can also have the unintended effect of dehumanizing the patient. There are ways to combat this potential problem, though.

In the certification course that I was a part of, we would run scenarios with actors, who were volunteers or EMTs themselves, serving as patients during two or three of our longer class sessions. We would apply mock injuries to the patients and assign them scenarios. The “patients” would scream, cry, become unresponsive, and otherwise do their best to accurately simulate real patient interaction in the field. The students were placed in groups of four or more, depending on class size, and were tasked with delegating responsibility and properly caring for and “packaging” their patients. The students were given three different scenarios throughout the day and the transformation from the first to the last was frequently significant. The students went from not knowing how to deal with a “real” patient, to quickly and accurately managing scenarios. Our students always felt these days to be some of the most instructive, because they provided an opportunity to apply their skills while dealing with a simulation of the very real stresses of fieldwork. The use of these actors resulted in more realistic scenarios that helped to demonstrate how patient care is provided in the field. These more realistic scenarios could be used to help demonstrate the importance of ethical issues, similar to the way they are used to simulate patient care.

EMT certification courses are currently taught and evaluated in such a way that learning ethical treatment of the patient is not essential for completion of the class. The course concludes with a written exam and a technical scope of practice review that tests students’ hands-on skills and patient assessment. Upon successful

completion of both of these tests, the student may take the state or national certification exam, which is a written, multiple-choice test. All of these tests focus more on medical knowledge, patient assessment, and implementation of hands-on skills, than on proper ethical treatment of the patient.

The easiest option for increased focus on the ethical treatment of the patient would be for more ethics questions to be included in the question banks for the certification exams. Ethical problems could easily be condensed and put in the form of multiple-choice questions for certification exams if necessary. Testing ethics in this way is less than ideal, but making the material testable is a necessary step for getting both students and instructors to take it more seriously.

Another alternative for enhancing the ethical education of EMTs does exist. When EMTs are first hired after they have become certified, they work as third riders, an additional EMT on an ambulance that is traditionally staffed by two people. This allows the EMT-in-training to gather knowledge and practice procedures while under the supervision of two established EMTs. During this period the EMT will have to become familiar with driving the ambulance, learn the routes to the local schools and hospitals, and demonstrate a certain level of competence before he or she is allowed to be “cut loose” and operate on a two person crew. While the trainee is going through this process, he or she must also take online certification courses through the Federal Emergency Management Agency (FEMA).

FEMA provides information about disaster and mass-casualty incident management online and then immediately administers a certification test for the EMT to ensure that he or she understands the relevant material. The National

Institute of Health (NIH) offers something similar to FEMA, with online tests and ethics training for professionals engaged in human subjects research. If online ethics training became readily available, it could be included as a requirement for EMTs, and ethics could be assessed outside of the certification curriculum, but before EMTs are “cut loose” in the field.

None of these suggested changes is likely going to be made unless EMS is given a reason to sharpen its focus on ethics. Calling attention to the frequency of ethical issues in EMS and the fact that the NAEMT has not updated its code of ethics since 1978 might be able to serve as a catalyst to drive this change. A revised code of ethics could both call attention to ethical issues in EMS and give certification instructors something more appropriate to use as a teaching tool.

Certification instructors are not used to lecturing about ethical theories, and EMT students are not used to absorbing information that is more theory-based. If EMT educators presented their students with a revised code of ethics and reviewed the list of principles with them, it could prove to be useful. As it stands today, students have to seek out the NAEMT’s Code of Ethics on their own, as it is not part of the curriculum. Instructors should present the Code of Ethics in class and work through each principle, discussing what it means and how it could pertain to certain scenarios. Practical application of the Code would serve to increase student interest and enhance the learning experience. Going through the Code like this would root ethical theories in EMS practice and give the students something to strive towards.

An overlooked issue with regard to ethics is burnout. Burnout is a very real problem in the field of EMS, and is a contributing factor to the average EMS career

only lasting between seven and ten years (Patton, 2012). Proper education in ethics may serve to help combat this. If EMTs are more aware of their role in health care and what to expect in the field, there will be an increased likelihood that they will better deal with traumatic or difficult ethical situations. EMS is a highly protocol-driven field, but given a better education in ethics, the EMT would be less likely to second-guess or blame himself or herself for a negative outcome. EMTs might be better able to understand the protocols and standing orders that they must follow and to cope with the stresses of the field. If time and scheduling could allow for it in the curriculum, bringing in other EMTs to discuss ethical issues would also help. Hearing difficult stories, from those who are willing to share them, can let an EMT know what to expect in the field and combat the feelings that arise after negative patient outcomes. Ethical issues will arise in the field, and the students should not be left blindsided, only seeking out peers after something negative occurs.

Ethics education is clearly something that needs to be addressed in EMS, and I believe that the above recommendations could be a starting point to address inadequacies in the EMT certification curriculum. If only an hour could be added to the curriculum for ethics education, it could be used to review and apply the Code of Ethics to relevant scenarios. The current United States DOT NHTSA National EMS Education Standards do not address all of the morally distinctive components of EMT practice, and spending more time with the Code of Ethics can help with this issue. EMT certification instructors also need to be better educated when it comes to facilitating ethics discussions. Discussions on ethics should take place later in the certification curriculum when students are more familiar with their role as future

EMTs and have become more comfortable voicing their concerns with their instructors and classmates. Scenarios are frequently practiced in the EMT certification curriculum, and they should be better utilized to practice morally justifiable decision-making. The patient assessment algorithm can still be a focal point, but scenarios can easily be altered to include ethics issues without adding additional time to the course. In order for students to treat ethics as a more serious part of the curriculum, it must become a larger part of the testable material. Adding ethics questions to the question banks for the certification testing, or including ethics issues in a student's technical scope of practice would require more attention to be devoted to the topic. Finally, if the EMT certification curriculum cannot be adequately improved, EMS agencies could require some form of online ethics testing to be completed before new EMTs can be "cut loose" to practice without supervision.

### Conclusion and Summary

Having experienced what I have in the field and having spent the next two years teaching the EMT curriculum, I know that the changes I have recommended can and should be made. A crucial first step in ethics being given more attention is updating the NAEMT Code of Ethics. The first chapter of this thesis outlined the history of EMS came how the field ended up without any updates to its Code of Ethics for over 30 years. I believe that knowledge of the history of EMS suggests

reasons for the neglect of the NAEMT Code of Ethics and the need for a revised code to prevent future negligence.

The second chapter of the thesis addressed why EMS is morally distinctive and deserving of its own ethics guidelines. Chapter Two focused on the brief training period for EMTs, the highly charged, dangerous, and time-sensitive nature of their work environment, and the stress involved with treating patients who are suffering from an acute illness or injury. The challenge of striking a balance among following protocols, independent decision-making, and following direct orders from a supervising physician was also highlighted in this chapter. These features of EMT practice establish its uniqueness and show how inadequate the ethical guidelines set forth by the NAEMT's Code of Ethics and the National EMS Education Standards are.

In the third chapter, I analyzed the principles of the NAEMT Code of Ethics and gave my critiques for each of them. I found that the NAEMT Code of Ethics was dated, used unclear language, and included principles that appeared to belong in an EMT mission statement, as opposed to a Code of Ethics. I proposed an updated code that addressed my concerns in an attempt to update ethics in EMS. If the NAEMT Code of Ethics was updated and emphasized in the EMS curriculum, along with the other changes proposed in Chapter Four, ethics would carry a new weight.

Ethical treatment of patients is one of the cornerstones of health care. If the suggestions made in this thesis are implemented, I believe that a great inadequacy in the field of EMS can be addressed. EMTs who are better suited to deal with potential ethical issues in patient care will be the result, and patients will receive a

higher quality of care. EMS is an incredibly important part of our health care system, and the impact of EMS personnel should not be understated. EMTs are on the frontlines of medicine, where many ethical issues arise that must be dealt with quickly and compassionately. The NAEMT and the national standard EMT curriculum owe it to these EMTs and their patients to focus more attention on the field of ethics.

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## CURRICULUM VITAE

**BLAKE WINSTON**

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### **SCHOOL ADDRESS**

2700 Reynolda Rd  
Apt 1216  
Winston Salem, NC 27106  
704-904-4974

### **HOME ADDRESS**

1017 Laurel Park Lane  
Charlotte, North Carolina 28270

### **EDUCATION**

#### **Wake Forest University**

M.A., Bioethics, expected graduation August 2013

#### **The University of North Carolina at Chapel Hill**

B.S., Biology, May 2011

#### **Charlotte Country Day School**

High School Diploma, May 2007

### **RESEARCH**

Ann Matthyse Microbiology Lab

Chapel Hill, NC

### **EXPERIENCE**

#### **Agrobacterium Tumefaciens Research**

8/11-12/11

- Prepared plasmid in *E. coli*
- Introduced the plasmid into *A. tumefaciens* to obtain transposon mutants
- Screened for mutants by way of differential media
- Isolated an *A. tumefaciens* mutant that was incapable of growth on galactose
- Tested for and observed virulence of the mutant on *Bryophyllum*

### **LAB SKILLS / EQUIPMENT KNOWLEDGE**

Growing and Maintaining Bacterial Cultures  
Characterizing Bacterial Mutants  
Preparation of Nutrient Media  
Autoclave Operation  
Dissection  
Sterile Technique  
Viable Cell Count  
Transposon Mutagenesis  
Slide Preparation  
Brightfield Microscopy  
Virulence Assay

Spectrophotometry  
Gel Electrophoresis  
Gram Staining  
Contrast Staining  
Isolation of Bacterial DNA from Environmental Samples  
Protein Purification  
Crystallization and Purification of Products  
Melting Point Analysis  
Vaccuum Filtration  
Analyzation of Compounds using NMR  
Cloning and Transformation

**OTHER  
SKILLS**

Microsoft Office  
MATLAB  
Intro to Blackboard and Blackboard Instructor Courses  
Completed

- Creating a course on Blackboard
- Posting to an existing course on Blackboard

Airway Management

- King Airway
- Combitube
- Oral Pharyngeal Airway
- Nasal Pharyngeal Airway
- Bag Valve Mask
- Non-Rebreather Mask
- Nasal Cannula
- CPAP

Trauma Management

- Joint and Extremity Splinting
- Backboarding
- Shock Management and Bleeding Control

Field Labor and Delivery  
CPR  
Public Speaking, Organizational, and Communication Skills

**LICENSURE**

EMT-Basic Certification  
American Heart Association Health Care Provider CPR  
Certification  
Certified Emergency Vehicle Operator

**VOLUNTEER  
EXPERIENCE**

South Orange Rescue Squad Carrboro, NC  
**Volunteer EMT-Basic** 5/11-2/12

- Function as a volunteer EMT-Basic in Orange County, North Carolina
- Provide Emergency Care including trauma management, airway management, CPR, splinting, extrication, and field labor and delivery
- Staff UNC and local high school events in Orange County, North Carolina
- Serve as a third rider on Orange County EMS shifts

Jackson Park Ministries Charlotte, NC  
**Volunteer** 12/11

- Organized and distributed toys to families for Christmas

Durham Tech Community College Durham, NC  
**Volunteer EMT-Basic Skills Instructor** 8/10-1/11

- Demonstrate skills necessary to pass the EMT-Basic Certification Exam
- Skills demonstrated include CPR, vitals, trauma management, airway management, splinting, extrication, field labor and delivery, and knowledge of medical terminology

Presbyterian Hospital Charlotte, NC  
**Junior Volunteer** 8/05-5/07

- Aided nurses, physicians, and physicians assistants in cardiology, orthopedics, and pediatric oncology
- Faxed and filed patient information as necessary
- Ensured that all patient rooms were stocked with supplies
- Patient care
- Over 250 hours of volunteer service

Habitat for Humanity Guangzhou, China  
**Volunteer** 4/07

- Traveled to Guangzhou, China
- Helped dig trenches for a new water main
- Helped build houses

- Practiced Chinese

**WORK  
EXPERIENCE**

The University of North Carolina at Chapel Hill Chapel Hill, N  
**Biological Chemistry Teaching Assistant** 8/11-12/11

- Developed lesson plans for and held supplemental instruction sessions for Biological Chemistry
- Explained concepts of Biological Chemistry including thermodynamics, amino acids, protein architecture and structure, protein purification, enzymes, cellular metabolism, DNA replication, and protein biosynthesis
- Held review sessions prior to exams
- Encouraged individual and class learning

Durham Tech Community College Durham, NC  
**EMT-Basic Certification Instructor** 1/11-1/13

- Lecture and demonstrate skills necessary to pass the EMT-Basic Certification Exam
- Skills include CPR, vitals, trauma management, airway management, splinting, extrication, field labor and delivery, and knowledge of medical terminology

Pasta & Provisions Charlotte, NC  
**Cashier, Stocker** 8/05-2/06

- Responsible for cashing out customers
- Managed credit card transactions
- Packaged and distributed product
- Performed general stocking duties including organizing displays and freezers

**HONORS**

Recipient of the Bioethics Scholarship

The University of North Carolina at Chapel Hill Dean's list  
Spring 2011

**ACTIVITIES**

**American Society for Bioethics and Humanities (ASBH)  
Wake Forest University Student Representative  
10/18/12-10/21/12**

- Traveled to Washington, DC to participate in the annual ASBH conference
- Promoted Wake Forest University's Bioethics Program



**Director of Operations for the Association for Carolina  
Emergency Response and Injury Prevention (ACERIP)  
8/10-5/12**

- Officer position in ACERIP, UNC's EMS organization
- Provided education to the community on how to plan for and deal with emergency situations
- Promoted EMT-Basic certification class through Durham Tech
- Coordinated EMS events
- Involved in planning for on-campus EMS station

Wake Forest University Bioethics Department Event  
Committee Member August 2012-August 2012

The University of North Carolina at Chapel Hill Chinese  
Conversation Club Member 2007-2011

Member of the Tarhealers, UNC health professions cycling  
team May 2011-May 2012

Alliance of AIDS Services - Carolina, AIDS Walk and Ride.  
100 mile bike ride and fundraising with the Tarhealers. June  
2011

**COURSES**

**The University of North Carolina at Chapel Hill**

BIOL 101 - Principles of Biology  
BIOL 101L - Introductory Biology Lab  
BIOL 201 - Ecology and Evolution  
BIOL 202 - Molecular Biology and Genetics  
BIOL 205 - Cell and Developmental Biology  
BIOL 252 - Fundamental Human Anatomy and Physiology  
BIOL 276 - Evolution of Vertebrate Life  
BIOL 276L - Vertebrate Structure and Evolution Lab  
BIOL 321 - Introduction to Immunology  
BIOL 421L - Microbiology Lab Research  
BIOL 422 - Microbiology  
BIOL 426 - Biology of Blood Diseases  
BIOL 430 - Introductory Biological Chemistry  
BIOL 450 - Introduction to Neurobiology  
BIOL 455 - Behavior Neuroscience  
BIOL 461 - Fundamentals of Ecology  
BIOL 555 - Paleobotany  
CHEM 101 - General Description Chemistry I  
CHEM 101L - Quantitative Chemistry Lab

CHEM 102 - General Description Chemistry II  
CHEM 102L - Quantitative Chemistry Lab II  
CHEM 241 - Analytical Chemistry  
CHEM 241L - Analytical Chemistry Lab  
CHEM 261 - Introductory Organic Chemistry I  
CHEM 262 - Introductory Organic Chemistry II  
CHEM 262L - Organic Chemistry Lab  
CHIN 101 - Elementary Chinese  
CHIN 102 - Elementary Chinese II  
CHIN 203 - Intermediate Chinese  
CHIN 204 - Intermediate Chinese II  
CHIN 252 - Chinese Culture  
CHIN 305 - Advanced Chinese  
CHIN 306 - Business Chinese  
COMP 116 - Introductory Scientific Programming  
ENGL 101 - English Composition and Rhetoric I  
ENGL 102 - English Composition and Rhetoric II  
GEOG 120 - World Regional Geography  
GEOL 105 - Violent Earth  
HIST 128 - American History since 1865  
INTS 393 - Great Decisions  
MATH 231 - One Variable Function Calculus  
MUSC 103 - Individual String Lessons (Guitar)  
MUSC 121 - Fundamentals of Music 1  
PHIL 101 - Introduction to Philosophy  
PHYA 107 - Life Fitness  
PHYS 104 - General Physics I  
PHYS 105 - General Physics II  
PSYC 101 - General Psychology  
SOCI 122 - Race and Ethnic relations  
SOCI 130 - Family and Society  
STOR 155 - Introductory Statistics

### **Wake Forest University**

BIE 703 - Bioethics Theory  
BIE 704 - Public Policy, Medicine, & Justice  
BIE 705 - Clinical Ethics  
BIE 706 - Bioethics Seminar  
BIE 709 - Ethics of Health Communication  
BIE 711 - Current Topics in Clinical and Biomedical  
Research Ethics  
BIE 727 - Performable Case Studies in Bioethics  
BIE 739 - Neuroethics  
BIE 792 - Thesis Research