

ABSTRACT

BRAITHWAITE, SUSAN SMITH. Ethics in Paramedic Practice: A Qualitative Case Study of Paramedic Perceptions of Ethical Decision-Making in Practice. (Under the direction of Dr. Susan J. Barcinas).

The purpose of this qualitative study is to understand how practicing paramedics perceive ethics in patient care, specifically the process of navigating ethical decision-making in emergent situations. The Iserson Model for ethical decision making in emergency medicine was used as the conceptual framework. This exploratory case study utilized semi-structured interviews of thirteen North Carolina certified and educated paramedics, nine men and four women, as the primary method of data collection. Open-coding and theoretical framework coding were the two methods used. Paramedics ethical values, accountability, professional identity, and decision stress were the themes determined during the initial coding process. Reliance on previous experience in decision-making, consult, emergent ethical decision-making and the Iserson Model, “Rapid Approach to Ethical Problems” were themes determined during the theoretical framework coding process. Findings suggest that participants do not routinely use a process driven application as they make emergent decisions. They do, however, frequently consider feelings of empathy (a step in the Iserson Model) as they navigate such decisions. Findings further suggest the participants both learn ethical decision-making from peers and mentors in a community of practice through experiential learning, and then critically reflect on ethical dilemmas within the same community. This study illuminates the understanding of ethics in the unique profession of practicing paramedics and contributes to the literature in adult education for the health care professions.

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Ethics in Paramedic Practice: A Qualitative Case Study of Paramedic
Perceptions of Ethical Decision-Making in Practice

by
Susan Smith Braithwaite

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APPROVED BY:

Dr. Susan J. Barcinas
Committee Chair

Dr. Kevin Brady

Dr. Brad Mehlenbacher

Dr. Chad Hoggan

DEDICATION

I am dedicating this research to my mother, Margaret Ann Smith. She believed in me while I was trying to get a G.E.D., convinced me that education was the path to a life of security and opportunity, and then inspired and supported me as I kept moving until I had reached the top, my Ed. D. Mom is a great teacher that taught me so much about life and learning.

BIOGRAPHY

Born in Pennsylvania and having lived in Florida, Susan Smith Braithwaite moved to North Carolina in 1999. In 2000 she transitioned from full-time paramedic and part-time EMS instructor to a full-time program director at a community college. She has since remained in adult education, and is now a professor at Western Carolina University. This represented a long time career goal and a return to teach at her alma mater, a graduate of the Emergency Medical Care program in 1988.

Susan began graduate study in 2003 when North Carolina State University offered a cohort program at Johnston Community College. With the encouragement of her mother, Susan began her graduate journey in a course entitled the Adult Learner, taught by Dr. Colleen Weissner. Dr. Weissner passed away while Susan was still on her graduate journey, but remains an inspiration of what it is to be an adult learner and to teach the adult learner.

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CHAPTER 1: INTRODUCTION

Emergency Medical Services has become a common expectation of today's American life. A call for help through an easily accessed telecommunication system, 9-1-1, typically results in the dispatch of highly trained medical professionals that are able to care for the traumatized or critically ill patient from the time of arrival on scene through treatment and transport to the hospital, including, if necessary, further transfer to trauma centers or invasive heart centers. The highest certification level within the Emergency Medical Services (EMS) system is the paramedic. Paramedics are responsible for life and death decisions, with a radically increased level of autonomy in recent years. The rapid growth of EMS systems nation-wide, in combination with advancing medical science, has proven challenging for educators who strive to prepare competently trained professionals who can meet the growing demand. Currently, there is a lack of EMS literature to inform training as well as disparities among states in governing the provision of training programs. Ethical practice, as an example, is scarcely represented in EMS education publications. A popular version of an initial paramedic textbook, Mosby's Paramedic Textbook (2012), offers an eight page overview of the topic in a 1,565 page text. Further, navigation of ethical practice and related decision-making receives little attention. While the impetus for greater understanding of ethics in paramedic practice is apparent, the resources or processes for teaching or guiding ethics in practice are not. Of similar note, there is no theoretical explanation for how paramedics learn ethical practice, specifically ethical decision-making.

This study addresses this research gap with the goal of informing the EMS and EMS education community about how paramedics perceive the navigation of ethics in practice,

specifically ethical decision-making. It also serves as a first step towards contributing empirical information to guide future development of improved ethics training in paramedic instruction. The required didactic component for paramedic ethics trainings is negligible. There is no requirement for a scenario based practice, nor a component in clinical internship training for ethical decision-making. Of similar note, no evaluation method to verify competence in ethical decision-making exists in the national curriculum standard (National Highway Traffic and Safety Administration, (NHTSA) 1998).

The paramedic profession has undergone exponential growth since its inception in the late 1960's. The new degree of autonomy and increased reliance on the understanding and ability of competent paramedics further suggests an increased demand for ethical practice. While overall training and internship requirements have changed dramatically, ethics, as a didactic requirement in initial paramedic training programs, has not changed to reflect this critical need for the paramedic's ability to make ethical decisions.

Purpose of the Study/Research Question

This exploratory qualitative case study investigated the following research question: What are paramedic perceptions of ethical decision-making in practice? Given the lack of ethics training in EMS education, it is assumed that learning ethical practice in patient care occurs through on-the-job experience. Ultimately, the study findings will contribute to several gaps in the literature to varying degrees, including EMS studies on ethical professional practice and the potential development of a training curriculum for EMS ethics. The conceptual framework chosen for this research has been adapted from the Iserson Model for ethical decision-making found in the current Paramedic Textbook (2012) by Sanders.

Conceptual Framework

Iserson's Rapid Approach to Ethical Problems in an Emergency has been adapted as the conceptual framework for this study. The Iserson Model is the only method that offers a suggested series of steps in emergent ethical medical situations, and it is published in recent paramedic texts (Sanders, 2012). As an emergency room physician, Dr. Iserson was discouraged when he faced ethical decisions and noted that the only ethics literature that existed to guide practitioners was laborious and suggested courses of action which often took days to accomplish, involving the input of several professionals. The emergency room physician, like the paramedic, makes emergent decisions, often in completely autonomous or time sensitive circumstances.

Iserson's Model is simplistic. Iserson et al. (1995) suggest the "rules of thumb give the emergency medicine practitioner a process to use for emergency ethical decision-making even in cases where there is not time to go through a detailed systematic process of ethical deliberation" (p. 44). In such cases, Iserson et al. (1995) advocate that the first actual step, when immersed in an ethical dilemma, is to reflect and see if a prior ethical decision may have yielded a "rule" applicable to the current situation. Patients are individuals with circumstances that are unique to each emergency situation. Ethical decisions in practice that are of similar nature may or may not occur in such frequency and clarity as to allow the paramedic to consider them as the "rule." Nonetheless, this first reflective step is important for current and future understandings. If the answer is "yes," the practitioner repeats the prior situational response. If the answer is "no," the subsequent response is to consider options that would "buy you time for deliberation without excessive risk to the patient"

(Iserson et al., 1995, p. 45). If no prior experience is helpful to the situation at hand, Iserson et al. (1995) suggest that the best decisions are those with communication to other practitioners or especially the Medical Director. Often, particularly in decisions of patient resuscitation, there is no time for deliberation or communication with other resources. If no options to extend decision time exist, Iserson et al. (1995) suggest three successive questions:

- 1) Impartiality Test, Would you be willing to have this action performed if you were in the patient's place?,
- 2) Universalizability Test, Are you willing to have this action performed in all relevantly similar circumstances?, and
- 3) Interpersonal Justifiability Test, Are you able to provide good reasons to justify your actions to others? (p. 46).

It is the three aforementioned strategies that capture the intensity of the paramedic's need to rapidly process a critical decision as an autonomous agent operating for the wellbeing of the patient. This approach also captures the essential notion of ethics in health care to "do no harm," in that they expressly seek a decision that represents the best care as another would want for themselves. Questions one and two ask the paramedic to put themselves in the place of the patient as they consider actions. The final question, justifiability, suggests that although the situation may be critical, consider the mitigating circumstances and authority of the opinions that are considered. Paramedics answer to the patient and loved ones in a literal and immediate sense. Paramedics further answer to the organizational guidelines, accreditation agency, and the overseeing Medical Director. Easily remembered and practiced, the series of questions proposed by Iserson et al. (1995) lend themselves to the time sensitive nature of emergent decision-making. Further, the Iserson Model is suitable to situations of autonomy often faced by paramedics. Paramedics, functioning independently

and as the highest certified team member responsible for decisions that are often ethical in nature, require an easily adaptable model that considers the uniqueness of such autonomous circumstances and is exclusive of interaction with other professionals. Acknowledging that the Iserson Model appears to be most suitable for situations of autonomy and emergency in patient care, this research study adapted the model as a lens through which to explore understandings of the practice of ethics in EMS settings.

Significance of the Study

No literature exists to explain how paramedics perceive ethical practice in patient care. No literature exists to describe the process of ethical decision-making in the paramedic context. This research will not only contribute to our understandings of ethics in paramedic practice, but will inform the education and research communities insofar as future educational protocols could potentially be based on research, rather than inference. Undeniably the research and education communities are responsible for preparing paramedics that are as competent in ethical decision-making as they are in treatment decisions. The purpose of this qualitative case study is to understand how practicing paramedics perceive ethics in patient care, specifically, ethical decision-making.

Curriculum for health care professions has been developed within the tenets of adult learning theory. The psychomotor, cognitive, and affective domains are the three learning domains first advanced by Benjamin Bloom (1956) and readily identified in learning objectives for paramedic training. Specific topics within the curriculum are planned from instructional design through competency testing with regard to their relationship to each of the three domains. Topics exist with a combination of the domains, some using all three.

For example, paramedics are initially taught to manage patients with chest pain using the cognitive domain. Lectures address the anatomy, physiology, assessment, treatment, and disease processes of cardiac emergencies. Building upon the cognitive foundation, paramedics are then taught the associated psychomotor skills that relate to the assessment and treatment of chest pain patients. Affective domain learning requires the paramedic to demonstrate delivery of the combined knowledge and skills as a team leader able to make rapid decisions that are communicated to the patient care team, and yet calm the patient so as to reduce anxiety that can worsen chest pain.

Paramedic education programs do not require ethics to be taught within the psychomotor domain. However, ethical practice is a learned behavior, much like a skill. The application of ethical decision-making or navigating ethical situations in the specific practice of pre-hospital patient care considers reasoning and judgment inclusive of the laws, organizational guidelines, norms, and values of the medical practice. Receiving minimal classroom exposure through lecture, the field application of ethics is not included in current curriculum, so the “skill” is never practiced. Of similar note, considerations of ethical practice are not addressed as a part of clinical internships. The practice and application of ethics and ethical decision-making should be addressed through the affective domain, linked to classroom and clinical internship settings. Ostensibly, continuing education programs for practicing field paramedics should also incorporate such enhanced teaching strategies.

While the connection of learning to classroom and internship is apparent and expected, findings suggest that paramedics learn ethical practice through experience. These experiences include those of patient care situations and the social interactions that surround

the professional context of EMS. This research study was developed in consideration of the literature that specifically relates to learning that occurs through experiences, as supported by experiential learning theory. Experience through field internships is designed for paramedic training programs to form concrete memories associated with learning that can lead to competency. The study of such perceptions of field practice can be used to inform and to plan future learning experiences. Kolb (1984) suggests that experience gives “a concrete, publicly shared reference point for testing the implications and validity of ideas created during the learning process” (p. 21).

While the intended audience for this research is the EMS education community for use in the development and delivery of paramedic training in ethical practice and decision-making, conceivably, other professional contexts may also consider the findings of this research. Findings of this study are essential to further research that seeks to further connect ethical practice in context with individual experiences and understandings. By connecting ethics to stories of paramedics in practice, understanding takes on a richness whereby the decisions take on the life of the practitioner and inform our views of ethics in situated experiences.

Definition of Terms

Paramedic is a medical professional, usually a member of the emergency medical service, who primarily provides pre-hospital advanced medical and trauma care. A paramedic is charged with providing emergency on-scene treatment, crisis intervention, life-saving stabilization and, when appropriate, transport of ill or injured patients to definitive

emergency medical and surgical treatment facilities, such as trauma centers (Sanders, 2012, p. 3).

Emergency Medical Services (abbreviated to the initials "EMS") are a branch of emergency services dedicated to providing out-of-hospital acute medical care and/or transport to definitive care, to patients with illnesses and injuries which the patient, or the medical practitioner, believes constitutes a medical emergency (Sanders, 2012, p. 3).

Medical Ethics, or Bioethics, is primarily a field of applied ethics, the study of moral values and judgments as they apply to medicine. As a scholarly discipline, medical ethics encompasses its practical application in clinical settings as well as on its history, philosophy, theology, and sociology. Medical ethics tends to be understood narrowly as an applied professional ethics. The two fields often overlap and the distinction is more a matter of style than professional consensus. Medical ethics shares many principles with other branches of healthcare ethics, such as nursing ethics (Sanders, 2012, p. 109).

Ethics is the major branch of philosophy, encompassing proper conduct and good living. It is significantly broader than the common conception of ethics as the analyzing of right and wrong. A central aspect of ethics is "the good life" - the life worth living or that is simply satisfying, which is held by many philosophers to be more important than moral conduct (Sanders, 2012, p. 109).

Morals in the "normative" sense, refers directly to what is right and wrong, regardless of what people think. Morals behavior may be associated with an individual, or a sense of doing the right thing as related to a prescribed behavior norm (Sanders, 2012, p. 109).

While morals and ethics exist in an intertwined existence, ethics is most commonly referred to when describing behavior in professional practice. For this reason, ethics will be the chosen term in this study with reference to decisions in professional paramedic practice.

Research Method

The research question is situated in a social context, specific to a particular aspect of professional practice. Merriam (2009) describes such an endeavor by stating that “qualitative researchers are interested in understanding how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences” (p. 5).

Qualitative research seeks to allow the participants and the context under study to emerge in findings through a rich descriptive explanation, yet requires the selection of a methodology and design that achieves the stated goal and lends credibility to the outcome.

The case study method illuminates the participant, contextual aspects, and the depth of insight necessary to offer an understanding of a phenomenon not represented in literature. An exploratory case study is well suited to framing the “how” intent of determining the research question: What are paramedic perceptions of ethical decision-making in practice? Yin (2009) suggests, “you would use case study method because you wanted to understand a real life phenomenon in depth, but such an understanding encompassed important contextual conditions - because they were highly pertinent to your phenomenon of study” (p. 18). Case study methodology ideally frames this study so that the findings truly relate to the explored phenomenon of ethics and ethical decisions in practice and accomplishes the intent of the research question.

Summary

Modern EMS has evolved rapidly, if not explosively, as a profession and yet still faces challenges that are inherent to its development and inception in the 1960's. Indeed, many of the concerns faced by EMS educators relate to the development of a new profession under the auspices of a governmental oversight that was never designed to keep up with medical advances and the universal need for widespread EMS. EMS education as a community of professionals has lacked for research that is specific to EMS practice. The concern is compounded by a disparity among EMS systems and training programs from state to state in a unique, and relatively young by comparison, branch of medicine.

Ethics, the ability to make sound ethical decisions with autonomy in the most emergent of settings, is an important aspect of paramedic practice, yet it receives little attention in education programs, no consistency among programs of study, with little to no suitable literature to suggest best practices for application. This research addressed the gap in literature specific to how paramedics perceive ethics and ethical decision-making in practice. While insight was gained as to the decision-making process as paramedics navigate ethical decisions, the "heaviness" associated with years of such decisions was also described by participants. Future study and development of best practices for training are the intended outcomes for the understanding gained from this study.

Chapter Two will serve as an extensive review of the literature specific to the intended study. A review of literature relevant to EMS as a profession will be addressed, followed by a review of ethics in literature. Finally, a review of learning theories will be presented, to include experiential learning and situated cognition. Chapter Three will offer

an in depth description of the research methodology, an exploratory case study within the tenets of the qualitative paradigm. Chapter Four presents the research findings through the participants' voice. Chapter Five is a summation of major findings and suggested implications for future practice, theory, and research.

CHAPTER 2: THE LITERATURE REVIEW

Introduction

Three thematic areas of literature are reviewed in this chapter. First, supporting literature on Emergency Medical Services (EMS) professional publications and journal articles will be discussed. EMS as a profession came into focus in the two most recent decades, and limited literature exists to fill emergent needs in the profession that include: critical stressors to the paramedic, job turnover, and issues surrounding recent changes in resuscitation protocol.

The second area of literature, ethics theory, as an expansive and aged theory base, is deliberately introduced in a historical lineage dating from Immanuel Kant in the late 1700's to the current trends in work place ethics, such as bioethics. Specifically, the Iserson Model for ethical decision-making will serve as the theoretical framework for this study. Each of the theoretical perspectives in ethics were chosen, firstly because they directly connect with one another as generations of thought, and secondly for the direct relationship to context of practice based ethics chosen for this study.

The third area of literature, experiential learning and situated cognition, are offered as a theory base to inform our understandings and offer a foundation for the application of the data through development of effective training that addresses the connection between experiential learning, both taught and practiced ethical decision-making. Experiential learning and situated cognition theories best address learning that occurs in the context of lived experiences. For the proposed study, ethical decision-making as a learned "skill" arguably occurs in the context of paramedic practice situations, such as patient care.

Experiential learning theories have long been considered for the development and application of professional education, particularly in the health profession where a clinical aspect of training requires field practice.

Historical Perspective

Central to the understanding of current paramedic training and education in the United States is the acknowledgement of its beginning. Just as EMS exists as a unique branch of medicine, the history and inception of the profession has an interesting place in the current trends of EMS training and education. Specifically, three historical underpinnings have formed the EMS system and training programs in widespread use today: military history, civilian medical research, and federal legislation. Finally, an overview of civilian EMS education programs in the United States is offered to summarize the relationship to the Department of Transportation legislation.

The modern EMS system has a history that in part originates with wartime management and transfer of wounded soldiers. Although the use of helicopters to move wounded soldiers began during the Korean conflict, military trained corpsmen, for the first time in military history, were used to provide urgent care during flight to field hospitals during the Vietnam War. Military practice has not only revolutionized the transport of soldiers to include a medically trained caregiver, but also the general science of treatment in the traumatized patient. “The management of trauma patients has historically been strongly influenced by lessons learned in military conflicts and wars” (Eastman, 2007, p. 193). To date, trauma care remains greatly impacted by wartime research.

Medical research on the civilian front has also greatly impacted EMS system

formation. For example, in 1960 the use of Cardiopulmonary Resuscitation was being shown to be efficacious for patients in cardiac arrest. Seeking to reduce cardiac mortality and morbidity, the “chain of survival” advanced by the American Heart Association, suggested that an organized system should begin with the call for help and include the rapid response, assessment, treatment, and transport of the cardiac patient to the nearest hospital. Still the dominant influence of emergent care, perhaps advancement in care of the critically ill patient has placed the greatest need for decision-making in the emergent pre-hospital setting (Sanders, 2012).

Perhaps the greatest catalyst to organized EMS came with a federal dictate in 1966. The percentage of Americans who owned vehicles to travel on the new interstate highways resulted in a dramatic increase in motor vehicle collision mortality and morbidity. Indeed, in 1965, “49,000 deaths were due to motor-vehicle accidents,” (NRC, 1966, p. 5) more than the combined mortality for eight years of the Vietnam conflict. In 1966, the National Research Council published a paper entitled “Accidental Death and Disability, The neglected Disease of Modern Society” that was affectionately called the “White Paper.” This insight offered by military trained officials led to the first systematic approach to pre-hospital care and the transport of the sick and injured beginning in the same year when Congress passed the Highway Safety Act that led to the creation of the U.S. Department of Transportation and the National Highway Traffic and Safety Administration.

EMS training arose to answer the needs defined by the “White Paper.” While mandated as part of the 1966 legislation, the original national training guidelines were not published until 1969, and provided little more than a required minimum for certification

hours and American Heart Association guideline for cardiac emergencies and CPR, almost to the exclusion of other physical problems. Ill-equipped to oversee EMS training programs, the U.S. Department of Transportation (DOT) offered minimal guidelines and delegated education and certification of providers to the states. The disparities among the fifty states' offerings of EMS education continued to increase through the decades that followed. It wasn't until 1988 that the first standardized national curriculum for paramedics offered learning objectives and clinical competencies for EMS training institutions. Recognized as a need by the National Association of EMS Physicians and the National Association of State EMS Directors, funding was authorized for the development of "The EMS Agenda for the Future," published in 2000. The "agenda" offered a summary of recommendations. Among them, the need for EMS research was addressed such to "include research related objectives in the education processes of EMS providers and managers" (NHTSA, 1996, p. 67). In 2013, the DOT remains the federal oversight agency for EMS in the United States, and EMS educators are still working to correct the disparity in training practices and provide a unified and universal set of standards for practice in accordance with the "agenda."

Training for EMS professionals is most commonly offered through community colleges that adopt the national standard curriculum and then oversee delivery according the state guidelines. While universities, hospitals, and even EMS systems have had a hand in the offering of paramedic training, the community college system has emerged as the primary provider for initial and continuing education training programs. Educator qualifications, required credits/hours for program completion, the combination of didactic, psychomotor, and affective domain teaching, all remain under individual state oversight. The universally

accepted goal for paramedic training includes a cognitive curriculum component coupled with psychomotor skill proficiency and practices through scenarios, followed by clinical internships under the direction of an approved paramedic preceptor (field trainer) to refine the affective domain requirements of paramedic practice.

In a unique branch of medicine, the practicing EMS professional operates with an unusual degree of autonomy while under the direction of a physician medical director. Certified paramedics, having completed a training program and passed a certification exam, follow prescribed protocols for advanced patient care that are set forth by the medical director. Current cardiac care, for example, is delivered in the field with a consistency and effectiveness that matches Emergency Department care. Paramedics assess heart rhythms, give drugs, defibrillate, and ultimately may terminate resuscitation efforts in the pre-hospital environment. This autonomy and reliance on critical decision-making has escalated at a rate well beyond the inclusion of enhanced training programs, which are still struggling for a universal oversight and set of standards. Just as research driven literature is imperative to competent medical practice in pre-hospital medicine, there is a need for research which informs the best education practices for educating EMS professionals. According to the EMS Workforce Agenda (2011),

the ability of an EMS system to deliver high quality pre-hospital emergency care depends upon a qualified and capable workforce. However, in the past 40 years of modern EMS, clinical care issues have dominated the research literature, with little attention paid to the workforce beyond its education and training. As a result, the

understanding of workforce issues and methods that attempt to address these issues vary greatly across both state and local levels (p. 2)

Emergency Medical Services Overview

Misconceptions related to common terms of the profession occur frequently. Perhaps this is due to the overuse of “emergency medical” as it is applied to *both* the service and the professionals that provide that service. The term Emergency Medical Services (EMS) describes the systematic approach to providing medical care, universally, for citizens both urban and rural, both injured and ill. The systematic approach to EMS includes ten essential components that were outlined in 1988 by the National Highway Traffic Safety Administration for the implementation of statewide EMS assessment programs. The components include policy, human resources, training, transportation, communications, medical direction, trauma systems, and evaluation. Essentially, each state is responsible for administratively assuring EMS system access from the point of the 9-1-1 call through the delivery to an appropriate hospital and the means to verify that every aspect of care and transportation between the two was delivered to the highest standard. The relationship between federal government and state oversight of EMS is historically rooted to a document prepared by the National Research Council (1966) entitled “Accidental Death and Disability: The Neglected Disease of Modern Society.” Affectionately called the “white paper,” this research concluded that the leading cause of death in America was injury, and that “ambulances were inappropriately designed, ill-equipped, and staffed inadequately trained personnel; and that at least 50 % of the nation’s ambulance services were provided by 12,000 morticians” (NHTSA, 1996, EMS Agenda for the Future). That same year, the National

Highway Traffic Safety Act established the Department of Transportation (DOT) to fund and oversee the implementation of training and the development of statewide EMS systems (NHTSA, 1996). While the DOT remains the federal oversight for EMS, each state remains tasked with the provision of both educational requirements for EMS professionals and EMS system delivery.

The term paramedic refers to the highest certification of EMS professional. The term Emergency Medical Technician (EMT) is often found in combination with a certification level. For example, EMT-Basic would suggest certification at the entry level for EMS services, while EMT- Paramedic, would suggest the highest level of pre-hospital certification. The National Registry of EMT's has advanced job titles and descriptions in combination with a national standard for examining and certifying EMS professionals, such as the paramedic. While inconsistencies still exist among the states, the definition provided by the National Registry of EMT's is the accepted standard, "paramedics provide the most advanced care of all EMS professionals" (<https://www.nremt.org>). Able to offer care consistent with the hospital emergency room for cardiac patients, the paramedic functions as the team leader and directs care on scene. Skills include advanced airway management, a wide variety of drugs, and cardiac procedures from infield pacing to defibrillation. Paramedics specialize in rapid assessment using diagnostic techniques made mobile for transport, such as twelve lead electrocardiographic monitoring.

The setting for paramedic practice has diversified in the last decade. As the demand for health care access increases, paramedics have moved from the traditional role of "9-1-1" Emergency Medical Services response, to working alongside physicians and nurses in

Emergency Departments of hospitals, doctor's offices, and cardiac catheterization labs in hospitals. Paramedics practice in the air through fixed wing transport services that move ill or injured patients internationally, and helicopter response to move patient emergently. Paramedics respond by ground to move patients from smaller (tertiary) hospitals to larger trauma, cardiac, neonate, or burn specialty hospitals. Moving beyond the initial paramedic certification program, many paramedics add critical care certifications to work for inter-facility transport services. Of similar note, paramedic certification is often combined with police, and firefighting certification in an approach referred to as "public safety." Still other paramedics work for the federal government on military bases or in prisons.

Just as the variety of practice settings varies, the variety of shifts and organizational structure varies. Some paramedics work 24 hour shifts two to three times per week with as little as 24 hours off between. Some work twelve hour shifts. Paramedics are employed privately, through hospitals, or through state, federal, county, and city municipalities. Pay remains an issue addressed in crisis by managers as they struggle with high turnover and vacancies. As the paramedic profession evolved from state to state, the certification process suffered a lack of continuity and professional education that ultimately affected the pay in comparison with other allied health professions of similar education requirements.

Universal to all paramedics is the concept of medical direction. Considered an extension of the physician Medical Director, the paramedic in any setting shares this requirement for medical practice over-sight. While each state is tasked with the legislative provision for EMS, the practicing EMS provider is considered to be an extension of the physician. The nurse is trained to care for a patient in response to physician's orders and

operates in close relationship to the physician. In contrast, the EMS provider responds to patient situations without the direct supervision of the physician. In this case the provider must be trained to assess the patient and determine a course of treatment that is consistent with the physician Medical Director's wishes. The accepted terms for this relationship are on-line or standing order medical direction (Sanders, 2012). The paramedic arrives on scene and using a set of treatment protocols encompassing emergent medical and trauma care, assesses the patient, determines the specific treatment appropriate and delivers it, operating as an extension of his or her Medical Director. This relationship affords the paramedic a great deal of practice autonomy and further underscores the uniqueness of the EMS practice.

The first standardized national curriculum, complete with learning objectives and clinical competencies for paramedics, was offered in 1988. Recognized as a need by the National Association of EMS Physicians and the National Association of State EMS Directors, funding was authorized for the development of "The EMS Agenda for the Future," published in 2000. In an effort to assess the climate of Emergency Medical Services across the nation and determine a future course of action, the agenda became well known to managers and educators of EMS. The agenda offered a summary of recommendations that still remains the beacon for state systems today. Among the key recommendations, the need for EMS research was addressed such to "include research related objectives in the education processes of EMS providers and managers" (NHTSA, 1996, p. 67). The lack of EMS specific research had finally been expanded to include the pre-hospital clinical setting of EMS. In addition, EMS Education systems were formally addressed in the agenda, and later expanded into the "EMS Education Agenda for the Future: A Systems Approach."

Prevailing as the universally accepted goal for the future of EMS Education, the agenda vision statement suggests that based on the National EMS Education Standards, revised and adopted in 1998, education should “represent the intersection of the EMS Professional and the formal education system” with programs based on “sound educational principles and broadly recognized as an achievement worthy of formal academic credit” (NHTSA, 1996, p. 1). The education agenda serves as a master plan for unifying the education of paramedics through a national certification process for paramedics and the accreditation of the educational programs from which they graduate.

In 2014, the disparity among paramedic training programs is obvious. Programs are offered as baccalaureate degrees through universities and as certificate programs through hospitals or municipalities. Emergency Medical Technician (EMT) and paramedic programs are being offered as minors in conjunction with programs of study such as Exercise Physiology or Athletic Training. The NHTSA goal for all training to be offered through accredited programs that achieve a national standard curriculum will further allow for research-based best practices in both didactic and field training curricula. The area of paramedic ethics, once adequately researched, could be adopted through the national standard and delivered with a consistency allowing paramedic practice across the nation a level of competency in ethical decision-making.

As noted, the national standard curriculum has provided for a set of universal competencies. Each state has determined the adherence to the national standard, delivery and certification for EMS providers. The National Registry has provided a national standardized exam and job descriptions for each of the defined levels of EMS professionals. State

governments still determine both systems requirements and certification processes for the provision of EMS in their jurisdiction. As a result, the paramedic profession is plagued with a job description that is little understood, a lack of national licensing that would allow recognition among the other allied health professions, a resultant low pay, and inconsistent training practices. The “National EMS Research Agenda (EMS Research Agenda)” identifies “two primary barriers that have inhibited the development of a strong research program in EMS: a paucity of well-trained researchers with an interest in EMS research and a lack of reliable funding sources to support research” (NHTSA, 2011, p. 22). Specific to the intent of this research study, “the quality and scope of EMS education program data needs improvement. A national effort will be needed to lead the development of common data definitions for educational programs and graduates” (NHTSA, 2011, p. 25).

Emergency Medical Services Literature

The “EMS Workforce Agenda for the Future” cites the need for EMS research as critical to the “vision; a well-educated, adequately prepared, and appropriately credentialed EMS workforce who are valued, well-compensated, healthy and safe” (NHTSA, May 2011, p. 6). The study of Emergency Medical Services (EMS) has occurred most notably in the last two decades. EMS literature is considerably limited, perhaps in part due to the relative youth of the field in comparison of other branches of medicine, and also because of a need for graduate-level educated EMS professionals who contribute to the research community. Existing literature reflects the salient trends and issues of the profession and is found almost exclusively in peer reviewed trade journals. Research categorically aligns with two areas of paramedic practice: medical science that directly reflects trends and applications in current

patient care, and the social or behavioral considerations that are germane to paramedic practice. The majority of EMS literature relates to the medical science aspect of the profession. The limited research related to the behavioral aspects has been conducted with a focus on the greatest threats to the workforce in EMS.

Research in EMS literature that has been conducted in the qualitative tradition is nearly non-existent. Most medical research favors the more generalizable and scientifically validated quantitative approach. Binder and Chapman (1995) suggest that “qualitative research methodologies, though often used in other fields and in medical educational investigations, have not been used to study problems in emergency medicine” (p. 1). Binder and Chapman (1995) argue for more qualitative studies in order to expand our understanding of emergency medicine processes stating that “these methodologies address qualitative data and provide a process of describing, interpreting, and explaining the dynamics of a population or phenomenon” (p. 1).

Themes in EMS literature. This literature review was accomplished through a thorough search of publications, scholarly articles, and professional or practice-related journals. Articles were initially sorted between those directed at the scientific aspects of patient care, and those that pertained to the behavioral or situational aspects of paramedic practice. At this time, there is no research which specifically addresses ethics as basis for decision-making in paramedic patient care. The remaining identified literature focused upon professional ethics, stress and job retention issues, patient care decisions, and resuscitation decisions in pre-hospital cardiac arrest.

Professional ethics. Perhaps the qualitative study most closely related to the proposed research study is authored by Sine and Northcutt (2008), entitled “A qualitative analysis of the central values of professional paramedics.” Sine and Northcutt (2008) also note the critical need for ethical decision-making increasing with the level of autonomy and expectation of the modern paramedic. “Changes in the organization and provision of prehospital emergency healthcare in the last decade create new moral challenges for emergency medicine; these changes also accentuate the need for paramedics to make rapid and reasoned ethical judgements” (Sine & Northcutt, 2008, p. 335). Rather than focusing on how paramedics learn such ethical decision skills, this study explores the values related to such decisions. The article “describes how the professional life of the paramedic is one in which competing values must constantly be weighed against each other in ‘real time’ with little opportunity for deliberation and reflection” (Sine & Northcutt, 2008, p. 336). Sine and Northcutt (2008) conducted an interactive qualitative study in which a group of seasoned paramedics were read case studies involving ethics in patient care. As the group discussed the cases, they determined values and the relationship and importance of each value to the application of ethics to patient care. The values determined to be “central” are: patient advocacy, treatment and procedures (competence), bias to be ignored, compassion, survivor care, medical authority (respect), and objectivity. Sine and Northcutt (2008) concluded that “compassion and objectivity compete against each other because they are two elements of the ethical decision existential core” (p. 341). As a part of their findings, Sine and Northcutt (2008) further agree that neither a professional code of ethics, nor classroom teaching

accomplish what is necessary to prepare the paramedic for ethical practice and ethical decision-making.

Stress and job retention. EMS has been plagued with a high turnover often associated with the high stress of managing critical incidents and low pay. Studies specifically addressed concepts such as job stressors and job satisfaction, coping, and psychological distress associated with patient care in EMS. Arguably, decision-making in the practice of patients' care, particularly those associated with critical incidents, is a major job stressor.

The current literature shows that paramedics struggle with stress and balancing empathy and duty when such decisions are made. Two separate studies published in the *Pre-Hospital Disaster Medicine* address the effects of stress. "A significant portion of an EMT's job satisfaction and psychological well-being is associated with the degree to which they are experiencing job-related stress, and, furthermore, this distress level appears to be clinically elevated" (Boudreaux, Mandry, & Brantly, 1997, p. 242). In addition to job-related stress effecting perceptions of well-being and satisfaction, "results suggest that patient care is a critical factor in daily stress among EMT's, both on workdays and post-workdays, providing preliminary evidence for a carryover effect" (Boudreaux, Jones, Mandry, & Brantley, 1996, p. 188). Job satisfaction is of concern to the profession and job turnover relative to stress.

A qualitative study in EMS examined the thoughts and feelings of paramedics as investigated through "eight questions designed to explore entry into emergency medical services, what it is like to be an EMT or paramedic, and the EMT educational process" (Patterson, Probst, Leith, Corwin, & Powell, 2005, p. 153). The study determined common

themes among EMS professionals regarding future career moves, motivation for the career, and beliefs about the EMS profession. Many of the respondents used EMS as a career path to another profession. Patterson et al. (2005) also found that most “respondents believed the job was stressful yet rewarding” (p. 162). Whether leaving the profession in pursuit of another allied health profession, or as a result of the job stress and its negative impact on personal lives, this study identified factors that appear likely to contribute to low employee retention in this occupation. While stressors are not specifically cited in this article, common stressors that are the subject of other articles include: danger associated with the job, stress of life or death decisions, treatment of elderly and pediatric patients, advancements in science, and changes in patient care to include in-field termination of resuscitation decisions. In the sections that follow, specific themes in literature are referenced.

Decision-making. Decision-making as a particular aspect of the EMS profession is the subject of numerous quantitative studies. Concerned for the effectiveness of decisions made in field, studies have addressed key dimensions of paramedic decisions such as: decision-making with limited point of view, mistakes in pre-hospital care decisions, decisions made in high acuity emergency calls, and paramedic judgment regarding pediatric trauma patients. The intent of such studies is to inform the community about the practice of decision-making, for better or worse, in pursuit of best practices. Yet, no decision-making studies address the best methods to instruct and prepare for such practices.

Becker et al. (2013) studied high risk situations encountered by EMS that could result in the need for resolution of conflicts on scene, suggesting that the information would allow for the creation of protocols and policies to benefit that provider (p. 487).

Common situations with ethical underpinnings encountered by EMS personnel and managers include; denying or delaying transport of patients with non-emergency conditions, use of lights and sirens for patient transport, determination of medical futility in the field, termination of resuscitation, restriction of EMS provider duty hours to prevent fatigue, substance abuse by EMS providers, disaster triage and difficulty in switching from individual care to mass-casualty care, and the challenges of child maltreatment recognition and reporting (Becker et al., 2013, p. 487)

The care of patients in non-emergent conditions, resuscitation and child abuse are noted as themes in this study. Also noting the “paucity of literature regarding the ethical dilemmas encountered by EMTs in the out-of-hospital setting” (Heilicser, Stocking, & Seigler, 1996, p. 239) designed a study to “suggest educational and policy approaches for dealing with the full range of ethical problems that confront EMTs” (Heilicser et al., 1996, p. 239). Similar to the findings of this study and the Becker et al. (2013) study, results show “the most described conflicts involving do-not-resuscitate (DNR) situation” followed by “inappropriate calls and difficult patients, problems with other professionals, transport problems and problems with minors... attitude problems and disrespect, and dilemmas in field triaging and trauma” (Heilicser et al., 1996, p. 241).

French and Casali (2008) completed a mixed methods study in Australia that focused on factors such as gender, experience, and age. None of these factors was found to influence ethical decision-making, however the study did determine that “the most significant ethical principle used by ambulance professionals is the rights based reasoning (morality).” This lies in stark contrast to the findings of “professional perceived ethical principles of EMS

organization as utility” (French & Casali, 2008, p. 50). While participants believed they acted in ethical decision-making on behalf of the patients’ best interest, they believed that the organization they worked for acted using a “cost/benefit approach” that French and Casali (2008) describe as dichotomy on the approaches to care that should be addressed (p. 50).

Dr. Kenneth Iserson (2008) co-authored an article entitled “Fight or Flight: The Ethics of Emergency Physician Disaster Response.” This work represents a paradigm shift from the Iserson et al. (1995) text used for the conceptual framework on this research. In this article, Iserson et al. consider the decisions of health care workers as they respond in situations of disaster. Iserson et al. (2008) note that many responders describe a conflict between “a duty to treat during disasters and social crisis, as well as moral reasons that may limit or override such a duty (p. 1). The effects of fear in the decision to participate in care giving situations with noted danger to the care giver were further addressed in the article. While not specifically addressing the need for ethical decision-making training to prepare responders, Iserson et al. (2008) suggest that preparation and policies should be offered to encourage providers in such situations. Dr. Iserson is the author of the model used for the theoretical framework in this study, first published in 1986, the second edition was updated in 1995. Of note, no further publication of this text has been issued since. While the Iserson Model of practice context is that of an emergency room physician, the degree of autonomy and emergency nature of ethical decisions are comparable to that of patient care situations in emergency medical services response.

Resuscitation decisions. Resuscitation decisions have gained a dominant focus in literature due to the recent shift in the management of cardiac arrest. Scientific evidence has

pointed to the efficacy of pre-hospital cardiac arrest resuscitation. Deemed comparable in hospital practices, the complications of moving arrest patients led to the changes in EMS protocol that allow the paramedic to manage and terminate cardiac arrest resuscitations in field. This specific practice of ethical care, as it relates to the decision to begin and end efforts in cardiac arrest, was the subject of a study regarding paramedic perceptions of the new protocol. Grudzen et al. (2009) found that “participants view the ability to forgo or halt resuscitation in the field as empowering and do not believe it presents harm to patients or families under most circumstances” (p. 537).

“The Ethics of Resuscitation: How do Paramedics Experience Ethical Dilemmas When Faced with Cancer Patients with Cardiac Arrest?” (Nordby & Nøhr, 2012, p. 68) is the only qualitative study currently addressing ethics in EMS. This study crosses several of the themes presented in this study: ethics, decision-making, qualitative study, and resuscitation. In a Canadian study, Verbeek, Morrison and Guru (1999) determined that out-of hospital DNR policies would preserve that patient’s right to decide, alleviate stress for both caregiver and paramedic and reduce the resources spent resuscitating patients that did not wish to be, most with terminal illness (p. 1254). Gillon (1991) quotes the work of Dr. Kenneth Iserson (conceptual model for this study) by describing disparities between an American response to cardiac arrest resuscitation without a do-not-resuscitate order and that of Great Britain, are in agreement that more freedom to withhold efforts in futile resuscitation events is the best practice. Iserson (1991) confirms “in most states, EMS personnel are not authorized to pronounce patients dead, they are required to attempt resuscitation with all of the modalities at their disposal except in the most obvious cases of death” (p. 21). Gillon (1991) writes:

The theme that ambulancemen have to obey strict protocols that require them to resuscitate unless there is “the most obvious” case of death or unless the doctor instructs otherwise, merely begs to moral issue and indicates, if the foregoing analysis is correct, that such a strict protocol is mistaken (p. 4).

While current protocols favor EMS honoring DNR’s, this study underscores the ethical challenges in cardiac arrest resuscitation of terminal patients. Gillon (1991) and Iserson (1991) favor further advancement in the paramedic’s decision-making autonomy to withhold attempts to resuscitate without obvious death and DNR, in the case of terminal patients. Naess, Steen and Steen (1996) studied the ethics of decisions made by Oslo Norway paramedics facing out-of-hospital resuscitation. Findings are congruent with participant findings of this study. The discontinuation of CPR in younger patients is difficult even when attempts have failed. Respondents also emphasized the right to die a natural death for an elderly or seriously ill patient. Paramedics were less likely to start CPR in situations of bystander expectations that include family acceptance of the patient’s death or the unwillingness of family to witness the patient’s existence in a negative state.

Ethics Introduction and Definitions

As it is nearly impossible to understand ethics and morals as separate concepts, many philosophers and theorists offer definitions for each, with significant overlap. Veatch (2012) by example, defines moral principles as “general and abstract characteristics of morally right action” (p. 10), yet a part of “normative ethics.” Hakim (2006) defines ethics as “the study of moral conduct” (p. 660). Walker (2007) suggests that morality “consists of a family of practices that show what is valued by making people accountable to each other for it,” (p. 10)

and that “ethics tries to find out whether certain things are really right or good” (p. 13). While the historical perspective of ethics frequently connects to moral understanding or moral development theories, I will seek to clarify terminology and delineate those theories which have most directly impacted ethics as it applies to the practice of health care. Perhaps the more expansive and foundational concept is that of moral philosophy. Hoffman (2000) suggests that “moral principles are grounded in bodies of philosophical and religious thought that are rooted in the histories of many cultures” (p. 222). Origins of moral philosophy reach back to the most ancient of times and yet have added dimension in the last century to include social applications. May (1996) describes his view of moral theory “to be understood as framed by the specific socialization of various societies” (p. 3). Agreeing that children come to “have moral institutions as a result of childhood socialization” (p. 3), May (1996) believes that “adults are motivated to act in specific moral ways because of the socialization patterns they have been exposed to” (p. 4). Other theorists have focused on the tenants of cognitive development, believing that morality emerges as children learn in stages of moral thinking. Progression through developmental stages is considered in a hierarchical fashion that is universal, realizing the “speed and endpoint of development may differ considerably from person to person and from culture to culture” (Kuhmerker, 1991, p. 19). Feminist scholarship suggests that “moral orientation or the standpoint taken in solving moral problems is associated both with gender and with the problem being solved” (Gilligan, Ward, & Taylor, 1988, p. xxxvi). Differentiating that a masculine voice may consider concerns of justice and rights, while feminine “conceptions of self and morality might be inextricably linked” (Gilligan et al., 1988, p. 23) to concern and caring for others. As the perspectives

and applications of moral philosophy shift among the aforementioned theoretical underpinnings, central to all remains the broad definition that “morals refer to social standards or customs, dealing with what is right or wrong in a practical sense” (Sanders, 2012, p. 109).

Ethics, by definition, seems a more focused concept within the broader definition for morals. Like “morals”, ethics considers the application of right and wrong to decisions and judgments, but rather in the context of “honorable actions designed by a group with expected conformity” (Sanders, 2012, p. 109). While the commonality remains the concept of right and wrong, the more explicit is that the individual’s concept of right and wrong now relates to the decisions made through membership to a group, such as a profession. May (1996) suggests that “professional roles are thought to create responsibilities by virtue of the professional’s agreement to take on a certain set of tasks in society” (p. 109). Individuals often assume a separate identity as the member of a profession, regarding themselves in the way the society regards that profession. It can be argued that one can operate as a moral individual and yet make an unethical decision, a decision that is acceptable to societal or even religious identity, yet is unacceptable within the norms of the specific context of application, such as a profession. Still others, such as Noddings (2007) argue that ethics and morality are intertwined such that the “individual thus described as a rational agent, not a real, full-bodied individual with attachments, emotions, and community affiliations” (p. 178), would follow rules and customs associated with a moral life in any circumstance, alone, or in social context. The ethical underpinnings of a profession are accompanied by a set of standards that are specific to that field. The medical profession, as an example, asserts

unique claims to the role of ethics in professional practice. The Hippocratic Oath (see Appendix E) has origins to the ancient Pythagoreans, yet remains the revised and current assumption of ethics by oath for contemporary physicians (Markel, 2004). While recognizing that physicians are indebted members of society by their learned skills and ability, they must apply a test of impartiality for the “good” of the patient. Ethics, then, becomes a choice connected with learned collective practice and not solely the will of the individual. Lammers and Verhey (1987) suggest that “the one swearing this oath adopted more than a set of rules and skills; he or she adopted an identity and the goods and standards of medicine as a practice were owned as one’s own and gave shape to integrity with one’s identity” (p. 77). Beyond the suggestion that a practitioner must be moral to espouse ethical principle, the individual assuming the oath is seemingly offered a higher ethical standard by association. Walker (2009) suggests that we are “situated observers whose observations are shaped not only by moral assumptions, but by much of what we take for granted experientially, socially, institutionally, and culturally” (p. 10). Ethics is a learned precept “in the particular communities of judgment from their typical application within those communities to particular situations” (Walker, 2009, p. 10).

Foundations of Ethics in Literature

While the lineage of moral and ethical philosophy pre-dates Socrates, theoretical foundations presented for this literature review will be discussed using three generations of thought: the modern, the contemporary and current trends. Socrates is considered by Hakim (2006) to be one of three great philosophers during the fourth and fifth centuries, along with Plato and Aristotle. Hakim (2006) states the main feature of Socrates’ thought is “that of

ethical wisdom- the recognition of the fundamental importance of the ethical in the life of man and of doing good as the basic principle of human activity” (p. 32). In his historical overview, Hakim (2006) describes Socrates’ time period as “Ancient Period; The Spirit of Greek philosophy” (p. v). Immanuel Kant (1724-1804) is said to be a Modern Period philosopher. Kohlberg is considered a Contemporary Period philosopher. Kant and Kohlberg have been chosen from numerous theorists for the dominance of their work, their relationship to each other, and to current trends in ethical theory. Finally, the Iserson Model, considered a specific example of a current trend in ethics, will be presented as a specific framework for the study of ethical decision-making in EMS.

Modern period philosophy: Immanuel Kant. Born in Germany in 1724, Immanuel Kant emerges from the history of philosophy as a dominant voice in the study of morality. Kant’s view of the human mind included three faculties: sensibility, understanding, and reason. While sensibility of the surrounding world gave way to understanding of the same, reasoning incorporated soul, God, and world. In Kant’s view, “knowledge is limited to the combined role of sensibility and understanding,” whereas “pure reason in its function with objects of thought that have no connection to sensible realm” (Hakim, 2006, p. 394). “According to Kant, the basis of moral action is duty” (Ruggerio, 2004, p. 146). While moral reasoning includes a sense of duty or obligation, “Kant clearly sees that oughtness entails freedom” (Hakim, 2006, p. 395). The concept of freedom to do as we ought was the essential element that allowed Kant to examine the will. Confines of obligation or law clouded examination of human will. Kant is quoted by Hakim (2006) as stating “perfect accordance of the will with the moral law is holiness, a perfection of which no rational being

of the sensible world is capable of at any moment of his existence” (p. 396). Moral intention, with perfection as an unattainable goal, existed as an endless movement between knowledge and reasoning as influenced by free will, by God, or law. Described as a philosopher from the formalist school, Kant is perhaps most credited with his views on moral judgment, and differentiated by Munsey (1980) as the intersection between “morality as internal principles from external events and expectations” (p. 43). Kant, in summary, was an early ethics philosopher believing that humans are capable of being rational and therefore self-governing of their own actions. Later philosophers, such as Lawrence Kohlberg, would build on this belief.

Contemporary period philosophy: Lawrence Kohlberg. Lawrence Kohlberg, born in 1927, is well known for his theory of moral development. In an epilogue for a book entitled *The Kohlberg Legacy: For the Helping Professions*, Kohlberg describes his own personal search for the meaning of morality. Among conflicting philosophies, Kohlberg found Kant’s principle, “treat every human being as an end in himself, not only as a means” (Kuhmerker, 1991, p. 13), as the fundamental essence of justice. Kohlberg’s graduate study and professional career sought to step back from the understandings of moral judgment and universal justice to the “study of reasoning and its development” (Kuhmerker, 1991, p. 14). The culmination of research across decades, cultures and disciplines resulted in a theory of moral development using three levels: pre-conventional, conventional, and post-conventional, that corresponded with six stages (two in each level). The first level is found in the elementary school ages and is formed by “notions of goodness and badness” and “avoidance of punishment” (Munsey, 1980, p. 91). The second level is found in society with

two stages. The first stage, the desire to seek approval of others as “conformity to stereotypical images” and the second stage, “orientation toward authority, fixed rules, or the maintenance of social order” (Munsey, 1980, p. 92). The third post-conventional level, according to Kohlberg, may not be reached by all adults as it includes a genuine interest in the welfare of others and the demands of individual “conscience in accord with self-chosen ethical principles” (Munsey, 1980, p. 93). For example, Kohlberg suggests that the differences between the second, and the highest level of moral development for the practicing paramedic, may be doing what is right for the patient so that in turn the professional may egocentrically attain accolades and enjoy job security. At the third level, the paramedic practicing compassionate and ethically sound patient care does so strictly for the good of the patient. In this case, the paramedic merely enjoys this behavior as an achievement of “self-chosen ethical principle” (Munsey, 1980, p. 93). Believing the human beings progressed through stages of moral development via interactions with their social environments, Kohlberg also reasoned that these stages could not be “jumped” and that progression, not regression, was a given. Perhaps the most criticized point of Kohlberg’s theory is the assumption that “adequate normative ethical theory is a definition of sound moral judgment” (Munsey, 1980, p. 172). Cognitive moral development according to stages is presumably the quest for sound moral judgment. Kuhmerker (1991) summarizes, “Kohlberg placed moral meaning making and conscious concern for principles of justice at the center of his theory” (p. 36). Hoffman further critiques Kohlberg as a follower of Kant, reasoning the pursuit of justice and caring as an assumption for moral behavior is too limiting, “I prefer to view caring and the different types of justice as ‘ideal types’ that may occur in varying degrees in

all situations” (Hoffman, 2000, p. 20). While caring and justice may run congruently in a given dilemma, they also conflict. Kohlberg, to date a dominant voice in childhood cognitive and developmental psychology, believed that “moral development in children proceeds not by their learning a particular value system and adopting it uncritically, but rather by embracing a critical standpoint from which they can come to appreciate or reject given values” (May, 1996, p. 19). Thus said, Kohlberg, in keeping with the “Kantian image of the self as pure, rational agent” (Gilligan, Ward & Taylor, 1988, p. 22), views the morally developed adult as capable and objective of moral judgment in situations of human choice.

Current Trends in Ethics Literature

The justice tradition of ethics philosophy is inclusive of two core principles, personal liberty, and a social contract. Kittay and Meyers (1987) state that “together, these elements form the basis for the ideal of individual autonomy that distinguishes the justice tradition” (p. 4). Autonomy, for philosophers such as Immanuel Kant, considers the individual to be self-governing, in that “each person is the source of moral and political principles that person obeys” (Kittay & Meyers, 1987, p. 5). As autonomous individuals, they are free to conduct their lives as they see fit “provided they do not violate others” (Kittay & Meyers, 1987, p. 5). It is the notion of autonomy that instigates the key difference between justice tradition and the care perspective on ethics. Autonomy grants the individual entitlement of protection and a pursuit of happiness, yet it does not entitle the individual to aid. “Though it is morally commendable to help the needy, and though justice may require helping the needy, it is disputable whether anyone has the right to such positive benefits as medical care, decent housing, or education” (Kittay & Meyers, 1987, p. 5). Emerging from a feminist

epistemology, the care perspective contradicts the justice ethics on this, and other beliefs. Kittay and Meyers (1987) suggest that “theoretically the distinction between justice and care cuts across the familiar divisions between thinking and feeling, egoism and altruism, theoretical and practical reasoning” (p. 20). This distinction presents a “shift in the focus of attention from concerns about justice to concerns about care and changes the definition of what constitutes a moral problem” (Kittay & Meyers, 1987, p. 20). In the context of health care professions, both ethical principles (justice and caring) may factor in and compete during the process of ethical practice. Hoffman (2000) suggests that in such cases, caring is “logically subordinate to justice obligations in situations where the two conflict” (p. 224). By its very nature and inception, the notion of providing care to the sick and injured incorporates the ethic of a universal right to good care. Can the medical care delivered to a patient be separated from the ethic of caring and empathy? Hoffman (2000) suggests that both caring and justice “share an empathetic motive base- empathy defined as an affective response- more appropriate to another’s situation than one’s own” (p. 4). For some theorists, the vacillation between an ethic of justice and care in patient care resides with gender scholarship. Gilligan, Ward, and Taylor (1988) hypothesized “1) that there are two distinct modes of moral judgment- justice and care- in the thinking of men and women; 2) that these are gender related; and 3) that modes or moral judgment might be related to modes of self-definition” (p. 23). In the sections that follow, the feminist perspectives of Gilligan, Noddings, and Walker, as well as the bioethics perspective, are presented as current literature relevant to understandings of ethics in professional practice.

Feminist perspectives. Carol Gilligan advances a psychology theory that challenges “justice perspective fails to capture the import of the concerns expressed by women, the ethical practice strategies employed by women, and the course of women’s distinctive moral development” (Kittay & Meyers, 1987, p. 7). Gilligan et al. (1988) found that the conflicting voices of moral reasoning that represented justice and caring were “although not gender specific,” they were “gender related, suggesting that the gender differences recurrently observed in moral reasoning signify differences in moral orientation” (p. 8). Can gender related ethics in the notion of “caring” be applied to a care giving profession such as healthcare? To answer this question, Gilligan et al. (1988) conducted a study that imposed emotions associated with masculine voice, as justice, and feminine voice, as care. Perceptions regarding the intimate relationship of physician to patient were examined for feelings of achievement and nurturance that would further translate into associations of vulnerability differences in the genders. This study found that male physicians associated fear in intimate connection with patients as a potential for failure, while women articulated “a perspective which links achievement with attachment” such that Gilligan et al. (1988) suggest that women’s perceptions “may heal the breach in medicine between patient care and scientific success” (p. 262).

Feminist ethics moves beyond the practitioner and patient relationship to include the community surrounding the practice of patient care. Walker (2007) states that “feminist ethics pursues questions about authority, credibility, and representation in moral life and in the practice of moral theorizing itself” (p. 60). Walker (2007) suggests that her theory aligns with the ethic of care proposed by Gilligan et al. (2007), in that “we are obligated to respond

to particular others when circumstance or on-going relationship render them especially, conspicuously, or particularly dependent on us” (p. 113). The practice of ethics and ethical decision-making in a social context is closely related to the individual’s sense of responsibility within that social context and to those for whom the decision affects.

Walker (2007) advances calls for an expressive-collaborative model for understanding responsibility (p. 9) and suggests a study of the “moral knowledge produced and sustained within communities” (p. 66). Considering moral knowledge in relationship to social context, Walker (2007) believes that the study of such moral understandings requires identifying “what kinds of things people need to know to live according to moral understandings that prevail in (any of) their (possibly multiple) communities or societies” (p. 66). This perspective considers moral learning and practice to be negotiated and practiced as members learn responsibility. “Morality consists in interpersonal acknowledgements and constraint, from which people learn that they are responsible for things and to others” (Walker, 2007, p. 5). Consistent with the assumptions that paramedics learn ethical practice through experiences, learning is also a product of the people inhabiting the paramedic’s practice context.

Specifically, Walker (2007) asserts that morality exists in the following ways: 1) “In practice, not in theories” (p. 15) as we “learn” and develop habits of mind and behavior, 2) when we act in ethical situations, our practices are “practices of responsibility that implement commonly shared understandings about who gets to what to whom and who is supposed to do what for whom” (p. 16), 3) it isn’t socially modular in that “is cannot be extricated from other social practices” (p. 17), nor separated from people as they are social beings and relate

to one another, and 4) seen as a consequence of the prior three assumptions, “morality needs to be seen as something existing” (p. 19) and realistic, not an idealistic concept. Paramedic students and those new to the practice are likely to:

Identify what kinds of things people need to know to live according to moral understandings that prevail in (any of) their (possibly multiple) communities or societies and must supply critical strategies and standards for testing whether understandings about how to live that are most credited in a community or society deserve their authority (Walker, 2007, p. 60)

We learn to understand what people do in a social and situational dynamic and work from there to develop standards, strategies, and in deed, our own concepts of ethical practice within a social context. The nature of ethics is holistic and inclusive of the situation and social context in which it is learned.

Agreeing that ethics exists as a dynamic between people, Noddings (2003) articulates a feminist approach to ethics as “the philosophical study of morality” (p. 26) and maintains that “morality as an active virtue requires two feelings” (p. 79), with the first of these feelings being the “sentiment of natural caring” (p. 79). The growth and inspiration of ethical caring requires first, an understanding and experience of caring and being cared for that Noddings (2003) sees as an expected progression. Noddings (2003) states that a “mother’s caretaking efforts on behalf of her child is not usually considered ethical, but natural” (p. 79). The second sentiment exists in relationship to the first, and “occurs in response to remembrance of the first” (p. 79). Memories of being cared for then guides the caring shown for others. “Ethical caring requires an effort that is not needed in natural caring” (p. 80). While ethics

may mature as a result of memories and understanding associated with being cared for, application to the professional context requires the individual to accept the notion of ethical behavior as their “best self.” Noddings (2003) relates that “caring itself and the ethical ideal that strives to maintain and enhance it guide us in moral decisions and conduct” (p. 105). Ethics as an extension of care-giving in the professional context, then, is a product of and in relationship to one’s own experiences with being cared for. Noddings (1996) suggests that this care based ethic should be an “integral part of bioethical theory and health care practice” so that as healthcare professionals face moral questions, they “reflect upon the moral voices employed in moral thought and practice” (p. 106).

Bioethics. Bioethics is defined as ethics applied to the life sciences. Sanders (2010) broadly states that “bioethics is the systematic study of moral dimensions, including moral visions, decisions, conduct, and policies of the life sciences and health care” (p. 110). Bioethics draws upon the common understandings and definitions of ethics, yet narrows its focus to human interest. Lammers and Verhey (1987) offer five characteristics of the bioethics field that include: decision-oriented (should we resuscitate this cardiac arrest patient), individualistic (beginning with the practitioner and patient relationship), ahistorical (assumes that right decisions will be correct in all similar cases), scientific evidence is the normative (science sets criteria for acceptability of evidence, and includes a grounding of norms (theological assumptions such as Christian ethics). Perhaps the greatest challenge is that ethical decisions in the life sciences often regard human health and wellness, not objects or politics, and while decision-oriented, there is the “possibility that every possible action may embody some important values and that what may be at stake is not finding the ‘right’

answer but choosing among competing values” (Lammers & Verhey, 1987, p. 65). When faced with no “right answers”, the health care practitioner encounters an emotional hurdle of fear and consequence. Definitions and philosophies tend to lack clear application when an ethical dilemma presents. Bioethical theorists tend to present case-based accounts for ethical discussion. Veatch (2012), by example, begins his book with a case entitled “The Boy Who Ate the Pickle.” Following the brief case presentation of a child questionably brain dead, Veatch (2012) suggests that health practitioners must work through levels of moral discourse in an attempt to provide that most appropriate action for the young patient described. The first level is the “case” itself. Often ethical decisions occur without being heralded as such, because there was no conflict. Yet, if all cases had clear and distinct answers, ethics would not come into question of “right or wrong.” The first level, or case level, also considers other cases of similarity that can be used in comparison. Using the presented case in point, Veatch (2012) suggests that if the problem is not settled, the second level of discourse is “moral rules and right (Codes of Ethics). Perhaps the case in question is governed, or “grounded in a moral system” (Veatch, 2012, p. 3). Physicians often adopt a version of the Hippocratic Oath, while other professions may have similar prescriptive codes. Complex cases may cross numerous “codes” through the involvement of differing perspectives, interpretations, and disciplines. If unsettled, Veatch (2012) suggests that the third level of discourse is normative ethics. “It is this level that the broad and basic norms of behavior and character are discussed” (p. 5). Normative ethics call to question action theory, including: beneficence (do good), non-maleficence (do no harm), and respect for autonomy and justice. Additionally, normative ethics considers value theory or, what are the consequences?, and finally,

normative ethics calls to question virtue theory, or consideration for the character of the actors deciding. Ruggerio (2004) states that normative ethics “answers specific moral questions, determining what is reasonable and therefore what people should believe” (p. 6). The final level of discourse, metaethics, is said by Ruggerio (2004) to “examine ethical systems to appraise their logical foundations and internal consistency” (p. 6). Metaethics pursues the source of ethics and then further asks how we may know that these ethical answers are right. Veatch (2012) reveals controversy within the bioethics community by stating that some see the progression of levels as a top to bottom movement, while others counter for the converse. In summary Veatch (2012) suggests that with “a full and consistent approach to bioethics, eventually all four of these levels must be brought into equilibrium” (p. 9).

Bioethics is vast, it deals with complex issues that encompass varied professionals in the life sciences, secular and religious considerations, and the constant concept of ‘will it benefit the patient?’ as applied to health sciences. Applications of bioethics include abortion, stem cell research, death and dying, incompetent patients, and transplantation, to name a few. Equally precarious to apply to a professional context, bioethics continues to be described as an often difficult decision with many ethical considerations and no clear answer. Walker (2007) further complicates what she describes as “often uncomfortable but essential reflection concerns the relationship of power and authority present in many kinds of situations that bioethics has reason to address” (Lindemann, Verkerk, & Walker, 2009, p. 10). While bioethics addresses the nature of concerns when humans are entrusted to the care of professionals in the health care context, it fails to offer any clear and applicable set

guidelines for the practitioner making an ethical decision. There are no pocket guides or assurances that all practitioners come to the table with the same training in ethics. Bioethics also assumes the luxury of time to consider the depth and breadth of ethical decisions, consider other cases and points of view, and finally, to have applied rather deep ethical framing to the picture at hand.

Iserson model. As practicing physicians in the emergency department of hospitals, Iserson, Sanders, Mathieu, and Buchanon (1995) recognized the need for an emergent ethical decision-making process. Iserson et al. (1995) writings suggest:

Traditional medical-ethics commentators tend to treat the problems peculiar to emergency situations in one of three ways: 1) they give very few types of cases (triage, for instance, and difficulties in obtaining a patient's informed consent) some attention, 2) they cite cases of exception to a general rule, or 3) they bypass the ethical dilemmas of emergency care all together (p. 3)

Realizing a need created by such dilemmas encountered during times of duress and emergent need, Iserson et al. (1995) developed a simplistic, rapid approach to ethical decision-making. In keeping with bioethical tradition, the text offers cases for discussion with demonstrations using the proposed model. The Iserson Model is a suitable framework aligning with the purpose of this qualitative case study to understand how practicing paramedics perceive ethical decision-making in emergent patient care.

Attributes. Perhaps the greatest strength of the Iserson Model is that it exists in unique contrast to the laborious ethical decision models that have been used in other applications of bioethics. Veatch (2012), for example, advocates for the involvement of

“many different people in the assessment, by using the consensus of a large group of people rather than relying solely on the judgment of an individual” (p. 48). Obviously, such debate takes considerable time and the luxury of opinions and resources. In contrast, the Iserson Model becomes more readily applicable in the emergent situation shared by emergency physicians and paramedics. The linear progressive steps suggested by Iserson et al. (1995) can be taught, memorized, and practiced offering a realistic tool for ethical decision-making in emergent situations where life and death outcomes are reduced to seconds. The Iserson Model suggests a simple series of questions for the paramedic facing an ethical dilemma. Like so many other treatment decisions in emergency medicine, Iserson et al. (1995) suggest first asking “is it necessary to use a more rapid approach to ethical decision-making?” (p. 44). The luxury of time affords the greater debate and predictably the most appropriate decisions; however, in any patient care situation faced by paramedics, patient condition or situational demands exclude the allowance of time for consideration. In such a case, Iserson et al. (1995) advocate that the first actual step is to reflect and see if a prior ethical decision may have yielded a “rule” applicable to current situation. If the answer is “yes”, the practitioner follows the prior rule. If the answer is “no”, the subsequent response is to consider options that would “buy you time for deliberation without excessive risk to the patient” (p. 45). If no options to extend decision time exist, Iserson et al. (1995) suggest three successive questions:

- 1) Impartiality Test, “Would you be willing to have this action performed if you were in the patient’s place?,
- 2) Universalizability Test, “Are you willing to have this action performed in all relevantly similar circumstances?,
- and 3) Interpersonal Justifiability

Test, Are you able to provide good reasons to justify your actions to others? (Iserson et al., 1995, p. 46).

Easily remembered and practiced questions lend themselves to the time sensitive nature of emergent decision-making, but further lend themselves to the situations of autonomy often faced by paramedics. Paramedics, functioning independently and as the highest certified team member, responsible for decisions often ethical in nature, require an easily adaptable model that, when unavoidable, is exclusive of interaction with other professions or opinion, unlike other models. Kant's concept of autonomy is "governed by one's true (impartial) self" (Kittay & Myers, 1987, p. 132). "Autonomy as impartiality is a crucial aspect of the ideal perspective from which moral principles are to be reviewed and defended" (Kittay & Myers, 1987, p. 132). While the Iserson Model is interdisciplinary and applicable to other professional contexts, it clearly embodies the nature of the autonomous, rapid decisions. Finally, the Iserson Model encourages reflection and building of ethical skills by procession, and includes a step to encourage the practitioner to consider other previous ethical decisions of similar regard which following use, are regarded by Iserson et al. (1995) as the "rule." No studies were found to address the application and efficacy of the Iserson Model in paramedic practice. Klugman (1998) suggests:

EMS providers should not be quick to adopt the bedside principles of biomedical ethics, but should recognize their unique role in the healthcare system and develop a tool that acknowledges those differences and provides true assistance in making choices at the gurney side (p. 1)

Attesting to the need for an EMS specific approach to ethical decision-making, Klugman (1998) states “the EMT Code of Ethics was published in 1978 and has not been updated since. The medical ethics landscape, however, has changed a great deal, and new challenges have arisen” (p. 3). Further stating that principles of ethics such as nonmaleficence, beneficence, autonomy (self-governance), and justice have been “considered to be guidelines for moral deliberation. Yet how these principles are operationalized can differ by setting, situation and professional obligation” (Klugman, 1998, p. 5). While the Iserson Model exists as a model for decision-making for unique professional contexts such as paramedic, further study is needed to confirm the efficacy.

The third thematic area of literature in this review is that of experiential learning. Experiential and situated cognition theories are relevant to this study as they lend an understanding of how people learn by experience and learn in relation to the communities that they are members of, in this case the paramedic and broader medical community. The constructivist approach to adult learning suggests that learners make meaning from the world around them. Experiential learning theory specifically addresses learning from lived experiences and in ‘hands on’ ways.

Experiential Learning Theories in Literature

In the late 1960’s, Malcolm Knowles built upon the notion of andragogy defined as “the art and science of helping adults learn,” (Merriam & Brockett, 1997, p. 15) with four assumptions:

Self-concept (being responsible for their own lives and capable of self-direction), the role of experience (greater volume and quality than children), readiness to learn (to

cope with real life situations), and the orientation of learning (that of problem or task centered) (Merriam & Brockett, 1997 p. 135).

Among these assumptions was the rational that “an adult accumulates a growing reservoir of experience, which is a rich resource for learning” (Merriam, Caffarella, & Baumgartner, 2007, p. 84). While Knowles acknowledged that adults have experiences that they bring to learning, experiential learning theory has emerged from a constructivist viewpoint to further suggest that learners actively construct meaning from their experiences, rather than receiving it passively from the educator. Fenwick (2003) describes experiential learning by stating that “the most prevalent understanding of experiential learning is based on reflection on experience,” where the “learner supposedly reflects on concrete experience to form mental structures” (p. 22). While the basic tenant of experiential learning remains the adult’s ability to reflect and make meaning to create new learning, other perspectives have been advanced that explicitly focus on the context of the experience. One such perspective, situated learning, suggests that “knowing and learning are defined as engaging in changing processes of social activity” (Fenwick, 2003, p. 25). Adult learning that occurs through the experiences that relate to a specific community of practice, often informally, are said by Fenwick (2003) to be learning “rooted in the situation in which the person participates, not in the head of that person as intellectual concepts produced by reflection” (p. 12). Ostensibly, the paramedic practices decision-making limited to a community of practice setting. I will position the intended research by postulating that paramedics learn ethical practice through experience (experiential learning theory), but also, specifically through the social context of the situation (situative learning theory) in which they practice. Both theories are rooted to the

constructivist viewpoint. Learning occurs when the adult makes meaning as a result of ongoing interactions within their environment.

Constructivism: the orientation. Considering learning as a process, rather than an end product, considerably opens the field of adult learning to a vast array of theoretical orientations. From generations of theorists, representing many disciplines with interest in how adults learn, Merriam, Cafferella, and Baumgartner (2007) refine traditions of learning theories into five basic orientations: behaviorist, humanist, cognitivist, social cognitive, and constructivist. Defining learning as a “process that brings together cognitive, emotional, and environmental influences and experiences for acquiring, enhancing, or making changes in one’s knowledge, skills, values, and worldviews” (Merriam et al., 2007, p. 277) illuminates the link between the learning process and the adult experience. The basic tenant of the “constructivist stance maintains that learning is a process of constructing meaning; it is how people make sense of their experience” (Merriam et al., 2007, p. 291). The constructivist orientation, as a fundamental assumption, “encompasses a number of related perspectives” (Merriam et al., 2007, p. 291). Merriam et al. (2007) explain that within the constructivist tradition, perspectives include the “nature of reality, the role of experience, what knowledge is of interest, and whether the process of meaning making is primarily individual or social” (p. 291). Some of the theoretical perspectives emerging from the constructivist orientation are Experiential Learning Theory, Transformative Learning, Reflective Practice, Communities of Practice, and Situated Learning. Fenwick’s (2003) “perspectives” will be used as a framework, to organize and demonstrate relationships among perspectives within the experiential learning literature. Fenwick (2003) acknowledges the foundational premise

of the theories within the constructivist framework by stating that "individuals are understood to actively construct their own knowledge, not passively absorb already existing concepts, through interaction with their environments" (p. 23). Consistent with Constructivist views of knowledge creation, experiential learning theories help us to understand the ways in which adults make meaning from their lived experiences in relationship to one another and in the contexts in which they practice.

Fenwick's perspectives: the framework. Fenwick (2003) presents an organized and coherent view of the dominant theories in literature specific to experiential learning. This literature review will use the Fenwick Perspectives as a way to introduce and demonstrate the relationship of experiential learning theories to each other, and to this study. While Fenwick (2003) presents her first perspective as the "dominant constructivist conception of experiential learning, based on a belief that individuals construct personal knowledge by mentally reflecting on concrete experience" (p. 21), she challenges this stance using four alternative perspectives: situative perspective, psychoanalytic perspective, critical cultural perspective, and ecological approach, to explore how people learn in experiential learning situations. Fenwick (2003) suggests that "the most prevalent understanding of experiential learning is based on reflection on experience" (p. 22). In this way, learning occurs as adults live experiences and reflect on them to make stored memories. Fenwick's (2003) framework on experiential learning theory will be used to demonstrate the relationship between constructivist orientation, experiential learning theory, and specifically, the situated perspective. Additionally, to recognize the role of reflection, central to constructivist notions

about knowledge acquisition and within the experiential perspective, a brief discussion of reflective practice theory is included.

Fenwick (2003) presents five dimensions of experiential learning theory: purpose, interpretation, engagement, self, and context. These dimensions offer a way to dissect the concept of learning from experience, and to further our understanding about the nature of “experience” as it relates to each of the five theoretical perspectives. Regarding purpose, a student may engage in learning through an experience. It may be fulfillment with their own purpose, rather than that of the instructor. Similarly, an individual’s interpretation of an experience affects how they recall and construct meaning from the event. This interpretation may vary among individuals experiencing the same event. Engagement considers the level of participation in an experience is proportional to degree of interpretation and meaning. In keeping with other feminist orientation philosophies, such as feminist ethics, the concept of “self” suggests that learning through experience cannot be separated from the self as a member of a social context. The “context” is a dimension of an experience that shapes the learning that will follow. Context is particularly important to the research of learning from experiences that occur in a specific context, such as that of ethics in the context of patient care. Fenwick (2003) states that the context “includes historical location and meaning of an activity, its geographical space and movement, as well as its cultural meanings and socio-political dynamics” (p. 18). In comparison, two adults facing a similar experience may make different meanings as they reflect based on unique cultural norms or political currents influencing each experience. Fenwick (2003) further relates that the dimension of context is a “situation characterized by a specific combination of features at any given time, and it

changes over time” (p. 18). While the multi-dimensional aspect of this theoretical assumption expands our understanding of a simple definition, learning through experience, it offers many ways to approach the “experience” for understanding and utilizing the learning outcome. Fenwick (2003) uses the dimensions of experience to create a simplistic framework of perspectives, each uniquely related to specific aspects of the adult “experience”.

Experiential learning: the theoretical assumption. The importance of experience to adult learning is easily accepted and foundational to adult education. The importance of experiential learning theories has prompted research and initiatives to apply the literature to a wide variety of settings in both higher education and vocational training. The number of adults participating as nontraditional students in higher education continues to escalate forcing educators to consider best practice approaches and prompting the “idea that the experiences of learners should be acknowledged” (Tennant & Pogson, 1995, p. 149). In addition, there is an increased demand to prepare a workforce with “stronger links between education and work, and experiential learning methods help educators to address this demand” (Tennant & Pogson, 1995, p. 149). Merriam and Brockett (1997) suggest that “the key role of experience in the process of learning has its roots in the progressive philosophy of John Dewey (1938)” (p. 152). Dewey’s work is presented as a foundational concept to the experiential learning theory movement, and further introduces the work of David Kolb (1984). Merriam and Brockett (1997) profess Kolb as having made “important theoretical contributions to our understanding of experiential learning” (p. 153). Expanding on the foundational work of Dewey, Kolb’s work added to the literature in subsequent decades with

a model that made the theoretical underpinnings more tacit to the educator. The reflective cyclic process he proposed moved the experiential learning theory from philosophy to a formalized applicable approach for use in a variety of environments and with varied learning styles. Both Dewey and Kolb have advanced ideas regarding adult learning through experience. Experience captures the phenomena in this study. Paramedics learn from the experience of making ethical decisions in emergency patient care.

John Dewey. John Dewey has often been touted as the father of experiential learning in historical accounts of adult education. Roberts (2012) states that it is well documented that Dewey was one of the key figures that “used and reacted against Greek notions of experience in formulating their own philosophies of experience in education” (p. 15). Having examined the pragmatic roots of Western thought on learning through experience, Dewey is credited with the “ability to bring a very robust philosophical stance to the practical problems of education and schooling” (Roberts, 2012, p. 52). Dewey was impassioned about his concept of learning through experience. Merriam et al. (2007) state Dewey “postulated that all genuine education comes through experience” (p. 162). While learning from experience can empower adults, not all experiences result in learning, and “sometimes we learn things from our experience that are actually harmful to our own or others growth or well-being” (Fenwick, 2003, p. 7). Dewey states that “every experience enacted and undergone modifies the one who acts and undergoes, while this modification affects whether we wish it or not, the quality of subsequent experiences” (Tennant & Pogson, 1995, p. 154). Educators may seek to use the adult experience to achieve learning objectives by inviting reflection in the classroom, or through the intentional structure of learning experiences.

Merriam et al. (2007) suggests applications, “educators serve as facilitators of reflection” (p. 169), and also, become the “assessor of learners’ prior experiential learning” (p. 169).

Suitable as a theoretical basis for adults learning as they experience professional roles, Dewey’s work served as a platform for workplace education and the vocational education programs that seek to link learning to practice. Initial paramedic training as an example, exists formally in the classroom and is inclusive of clinical practice in the workplace. Paramedics, as they begin professional practice roles, continue to develop and learn from experiences. Merriam et al. (2007) describes Dewey’s notion of learning through experience as being dependent on the “two major principles of continuity and interaction” (p. 162). Continuity becomes a link between past experiences and current experiences. “Learners must connect what they have learned from current experiences to those in the past as well as see possible future implications” (Merriam et al., 2007, p. 162). Interaction “posits that an experience is always what it is because of a transaction taking place between an individual and what, at the time, constitutes his environment” (Merriam et al., 2007, p. 162). Thus said, the role of the educator is to link these pieces of one’s environment into a new and complete “whole”. Experience is a continuous reservoir from which the educator may draw. For Dewey, “knowledge is the product of interaction between the experiencing subject and the external objective world” (Tennant & Pogson, 1995, p. 165). Roberts (2012) criticizes this over generalization by saying “but then doesn’t all learning involve experience and can we only define experiential education as education that involves experience? If so, we really haven’t articulated anything at all” (p. 3). Dewey’s concentration on experience as the focal point for adult learning served as the impetus for other theorists, such as a David Kolb, who

further deliberated and expended on the complexities of the knowledge construction related to experiential learning theory.

David Kolb. “While Dewey explored how people learn from life experiences, Kolb went one step further” (Merriam et al, 2007, p. 163). Examining the works of Dewey, Kolb and other theorists compiled six general propositions of experiential learning theory. First, learning is best conceived as a process, not in terms of outcomes. Second, learning is relearning. Third, learners must move between opposing modes of reflection and action, feeling and thinking. Fourth, learning is holistic. Fifth, learning involves interactions between learner and the environment. Finally, learning is constructivist in nature (Merriam et al., 2007, p. 163). Kolb specifically set out to understand and define the process through which experiential learning takes place. He explained his theory as a cyclic relationship, never-ending and inter-related, that began with a concrete experience. The Kolb Model followed the tenants of constructive orientation in that following the experience, reflective observation began. It is from this reflection that adults begin to construct new meanings, and by Kolb’s description, abstract conceptualization. The fourth and final step in Kolb’s Model is active experimentation. Like Dewey, Kolb believed that not all experiences resulted in learning. However, when adult reflection results in a new concept or understanding, learning is likely to have occurred and be used in the fourth and final phase, active experimentation. Kolb believed that “learning is a continuous process, grounded in experience” (Merriam et al., 2007, p. 161), not ending with a final product. Active experimentation would lead to new experiences and further begin the cyclic process of reflection and the formation of new

learned concepts. In keeping with constructivism, and central to experiential learning theories, is the contention that:

Learning happens only when there is reflective thought and internal processing of that experience by the learner, in a way that actively makes sense of the experience that links the experience to previous learning, and that transforms the learner's previous understandings in some way (Fenwick, 2003, p. 47).

Tennant & Pogson (1995) suggest that a growing emphasis has been placed on experience in adult education, stating "focusing on the learner's experience as an integral part of the tradition that places the learner at the center of the education process" (p. 149). A basic premise exists that practicing paramedics learn through experiences, considering Kolb's stages, experience alone does not teach. Exposure to a myriad of adult experiences does not ensure learning. The influence of reflection, conceptualization and experimentation must accompany the experience. As educators and theorists have analyzed theories for applications and new understandings, questions arise. Fenwick is quoted by Merriam as stating "a critique of Kolb's model is that learner's context is not taken into consideration" (Merriam et al., 2007, p. 164). While Kolb recognizes his approach as a "holistic integrative perspective on learning combining experience, perception, cognition and behavior," (Kolb, 1984, p. 21) his emphasis is not on the specific behaviors and social context in which they occur. Other critics note the same gap in Kolb's explanation, Michelson is quoted by Miller (2000) arguing "for an epistemology that recognizes knowledge as situated and socially constructed" (p. 82). Kolb, like his predecessor Dewey, laid the groundwork for further

expansion and perspective of learning through experience, such as the contextual or situative perspective.

Situated learning: the perspective. Fenwick suggests that there are four alternative perspectives to constructivism: situative perspectives, psychoanalytic perspectives, critical cultural perspectives, and ecological approaches. “These perspectives are useful for educators in shedding light on complex dimensions of the learning-in-experience question. They also help educators with different responses to the question about the most appropriate role for educators in working with adults’ experience” (Fenwick, 2003, p. 6). The adult learning theory proposed as most applicable to paramedic learning in the context of ethical practice, is experiential learning theory. I suggest that this experiential learning occurs in relationship to the social context of the situation. For this reason, the situative perspective will also be presented, as a perspective of the experiential learning theory and used to “emphasize the connection between individuals and their communities of practice in a collective explanation of experiential learning” (Fenwick, 2003, p. 25).

Fenwick (2003) describes the premise of situated learning perspective on experiential learning theory by stating, “knowledge is not considered a substance to be ingested and then transferred to a new situation, but part of the very process of participation in the immediate situation and community of practice” (p. 25). The situated learning perspective emerges from a socio-cultural consideration that emphasizes the nature of the context in which the experience occurs. Having shifted the emphasis from the individual to the context, Daley (2000) suggests situated cognition can be conceptualized as having four interrelated learning aspects: 1) learning that is situated in the context of authentic practice, 2) transfer limited to

similar situations, 3) learning is a social phenomenon, and 4) learning that relies on use of prior knowledge (p. 36). Appropriate for unique aspects of the social context surrounding practice, situative learning theory considers the effects of social interactions as they add dimension to learned experiences. Paramedics, for example, practice ethical decision-making in the context of patient care with only medical laws and organizational guidelines as a framework. While the understanding and application of legal guidelines is an aspect of ethics, it does not represent the totality of ethical situations or dilemmas in practice.

Certified paramedics share the commonality of national standard training on ethics and the application of law to this process. Situated learning is often connected to communities of practice in the education literature. Lave and Wenger (1991) describe the concept of a community of practice as a “set of relations among persons, activity, and world, over time and in relation to other tangential and overlapping communities of practice” (p. 98). This notion explains learning that may occur through interaction with paramedics as they discuss and consider ethical decisions. To explain the transition of practitioners as they learn socially while entering into a community of practice as novices and emerging as experienced professionals, Lave and Wenger (1991) identified a process of “legitimate peripheral participation to describe the way learners inevitably participate in communities of practitioners and that the mastery of knowledge and skill requires newcomers to move toward full participation in the socio cultural practice of the community” (p. 29). This consideration is inclusive of learning from situational experience from initiation into a community of practice and throughout the process of mastery, common to the experiences of paramedic students as they complete field internships, or newly graduated paramedics.

Fenwick (2003) suggests that through the situated perspective, the process of knowing is essentially embodied, realized through action, and therefore often worked out in the domain beyond consciousness” (p. 26). This aspect of knowledge construction contrasts the experiential ideology that adults reflect of experiences to make new meanings. Critics of situative perspectives theory believe this tendency to become a part of the culture of the community of practice, and therefore embody its teaching, may result in “patterns and procedures that are harmful, unjust, exclusive, or just plain dysfunctional in preventing the community from fulfilling its core purpose” (Fenwick, 2003, p. 27). Further criticisms center on the exclusion of human emotion from the social identity within the community. It can be argued that the interning paramedic student or newly hired graduate endure pressure to achieve, be accepted as a team member and gain the trust of more senior members. Concerns for power flow through a community, fear and conflict may motivate a practicing professional as they learn in the situated context. While emotion plays a part in the emergent nature of ethical patient care in paramedic practice, the focus of situated perspective as a theoretical explanation shifts the dominant learning tenant to the social interaction. Wilson is quoted by Merriam and Brockett (1997) as stating:

In order to understand the central place of context in thinking and learning, we have to recognize that cognition is a social activity that incorporates the mind, the body, the activity, and the ingredients of the setting in a complex interactive and recursive manner (p. 156).

Reflection on experience. While reflection-in-action as a theory is not presented as an area of adult learning theory literature for consideration in the proposed research, a brief

overview is offered for clarification, as many concepts and terms are shared among the literature cited. The Constructivist orientation to adult learning suggests that the connection between experience and knowledge is reflection. Donald Schön (1983) “advocates what he terms reflection in action, the process by which he sees professionals engaging with problems and learning experientially, that is reflecting on the experience in the midst of practice” (Tennant & Pogson, 1995, p. 161). Schön (1983) was particularly interested in knowledge that resulted in reflection specific to professional practice. While Dewey’s notion of reflection was crucial to the knowledge construction, reflection-in-action as a theory is much more specific to reflection as the experience is occurring. Schön (1983) states that “reflection-in-action is central to the art through which practitioners sometimes cope with the troublesome divergent situations of practice” (p. 62) and that the “pace and duration of episodes of reflection-in-action vary with the pace and duration of the situations of practice” (p. 62). Schön (1983) believed that the practitioner could “criticize the tacit understandings that have grown up around the repetitive experiences of a specialized practice; he can make new sense of the situations of uncertainty or uniqueness which he may allow himself to experience” (p. 61). Brookfield (1986) describes the process of reflection-in-action by saying that “when practitioners are faced with new and unfamiliar situations and have to react immediately to them, they call on their intuitive sense of professional correctness and their accumulated experience to introduce some order into their responses” (p. 247). As previously stated, correlation exists with the constructivist notion of reflection, but also with experiential learning theory and the situative perspective. Schön (1983) distinguishes his position by stating that “our conceptions of the art of practice ought to give a central place to

the ways in which practitioners learn to create opportunities for reflection in action” (p. 279). Schön (1983) recognizes reflection as a common event in practice, and relates to criticisms by stating that “nevertheless, because professionalism is still mainly identified with technical expertise, reflection in action is not generally accepted- even by those who do it- as a legitimate form of professional knowing” (p. 69). Reflection is notably important to the meaning paramedics make as they make ethical decisions in practice, and remains central to the constructivist, experiential learning and situative learning literature.

Summary and consideration of learning theories. This chapter presents an overview of two areas of learning theories in explanation for how paramedics may develop a sense of ethical practice and the navigation of ethical decision-making in practice. The first, experiential learning, places the focus on learning as constructing knowledge through doing, or habits of mind in combination with skill that develops over time through trial and error, observation, and active participation in activities. The second, the situated perspective, recognizes the importance of the social context surrounding the community of practice in which the experience occurs. The lineage of both theoretical positions relates to a constructivist orientation, where learning is made in the cognitive process of the adult as they relate to the world around them, not merely transferred from the educator to student.

The Constructivist orientation as an epistemology is chosen in alignment with researcher beliefs that paramedics come to practice ethical decisions as they form their own understandings, not as a result of transferred information in the formal education setting. The experiential theory platform is the ideal selection to illuminate the stories paramedics tell as they describe ethical experiences in practice, and how they came to this knowledge. The

situated perspective allows closer examination of the possibilities that within the specific community of practicing paramedics, the social nature of the experience may contribute to the learning.

Fenwick's "perspectives" on experiential learning theory have been used to frame the close relationship of selected theories. The Constructivist orientation exists as the first generation of large group of epistemological assumptions of knowledge. The second generation is experiential learning. Experiential learning theories have expanded to include a third generation of thought, among them, the situated perspective. Fenwick frames both theory and relationship with her constructivist perspective, and four alternatives within experiential learning. Paramedics undeniably learn from experience. While framework's gather theoretical assumptions and organize them for comparison and contrast as research is considered, the theory literature is used to explain and to form understandings from research that will inform the education community. The selected literature for the proposed research is primarily the experiential learning theory, and the situated learning perspective as it relates to a community of practice.

Summary of Literature Review

EMS literature does not address the education and training of paramedics specific to ethical practice. Existing literature specific to the profession considers education issues in light of competency exams and concerns for accreditation. While the paramedic is a unique branch of medicine with urgency and autonomy germane to the ethical decision-making process, other applied health professions literature was considered for a suitable comparison, and again, no suitable literature addressed the research question. While adult learning theory

literature is considerably extensive, no specific research exists to explain the research question, what are paramedics' perceptions of ethical decision-making in practice? Of similar note, theories surrounding our assumptions about this in practice fail to capture the unique aspects of paramedic ethical care and the decisions surrounding such care such as autonomy and the lack of time for deliberation and reflection due to the critical nature of an ever- evolving field of practice. This literature review has sought to position the proposed study within the tenets of aforementioned themes in research. Having illuminated the gap in research surrounding ethics as a learned behavior in paramedic practice, this study seeks to inform and expand the understanding of how paramedics learn to make ethical decisions in practice. Given this intended contribution to the education community, the understandings gained from the study will provide a foundation for future planning of training objectives and competencies in EMS education certification programs and continuing education opportunities for existing practicing paramedics.

CHAPTER 3: METHODOLOGY

Introduction

This study explores the professional practice of the paramedic through describing and analyzing the perceptions of practitioner's understandings of ethical practice. This chapter will provide an overview of the qualitative paradigm in relationship with the chosen methodology, case study. An overview of the conceptual framework is provided. This chapter further describes the research design and protocol.

Purpose and Research Question

The purpose of this qualitative case study is to understand how practicing paramedics perceive ethics in patient care, specifically, ethical decision-making. Formal training in ethics is limited to a short didactic component for initial certification programs, requiring no classroom or clinical practice to apply ethical concepts or decision-making skills. The research question guided the development of the study: What are paramedic perceptions of ethical decision-making in practice? The Iserson Model for ethical decision-making is found in the ethics chapter of Mosby's Paramedic Textbook (Sanders, 2012, p. 113). This model was adapted and used as a conceptual framework, guiding the research design and data analysis.

Conceptual Framework

Ethical theory relative to professional practice has been presented through historical overview of foundation philosophies and current trends in ethics literature. The use of an ethical framework in the context of EMS practice requires the consideration of unique aspects of the profession. While bioethics as a specialization of ethics theory is unique to

patient care and appropriately considers the duty and responsibility associated with the caregiving profession, it lacks applicability to all healthcare disciplines. In the context of paramedic practice, ethical decision-making occurs in emergent situations, often with a threat of life, and under conditions of autonomy. As Iserson et al. suggests, “the following rules of thumb give the emergency medicine practitioner a process to use for emergency ethical decision-making even in cases where there is not time to go through a detailed systematic process of ethical deliberation,” (Iserson et al., 1995, p. 44). The conceptual framework for this study used an adaptation of Iserson’s Rapid Approach to Ethical Problems in and Emergency. As described in the fourth edition of Mosby’s Paramedic Textbook (2012), Iserson et al. suggest that “rules of thumb” are:

- 1) Ask yourself whether you have experienced a similar ethical problem in the past.
- 2) Buy time for deliberation and consult co-workers or medical direction.
- 3) Is the situation is emergent,
 - TEST 1: Impartiality. Would you accept the action if you were in the patient’s place?
 - TEST 2: Universalizability. Would you feel comfortable having this action applied in similar circumstances?
 - TEST 3: Interpersonal Justifiability. Are you able to find good reasons or justify your actions? (p. 113).

By its nature, the contexts of some emergency calls are bound to be repeated or even to remind the paramedic of prior situations. Iserson et al. (1995) suggest that this prior experience may help to inform the ethical decision being currently faced (p. 44). Given the

emergent nature of EMS, it appears unlikely that paramedics will have the opportunity to “buy” time for deliberation. Even in non-emergent care situations, there is an expectation that the EMS crew will complete the patient care “call” in a timely manner so as to return to an available duty status in the event that another emergency call should be received. There is a key difference between the Emergency Department (ED) physician setting and that of EMS. ED physicians have the availability of nursing staff and a structured setting in which patients are at times left unattended by the physician. This lends itself to a greater flexibility to seek consultation away from the patient’s presence. Paramedics are never permitted to leave the patient until they have been admitted to hospital care. To that end, paramedics that leave patient attendance once having accepted care are guilty of abandonment.

While Iserson et al. (1995) use the term “test” to apply steps of analysis in the process of ethical decision-making, the model was adapted for the study as a way of understanding paramedic perceptions of the concepts associated with it. For example, the research is intended to elicit data about paramedic perceptions of ethical dilemmas when considerations of impartiality; “Would I want this done to me?,” universalizability; “Have I made similar decisions?,” and interpersonal justifiability; “How would I defend my decision?”

In addition to the adaptations of the Iserson Model for interviewing, data analysis was performed with consideration of the conceptual framework for themes consistent with 1) use of prior decisions/experiences in current dilemmas, 2) use of consultation to determine a course of action or decision, 3) consideration of impartiality, considering one’s self in the place of the patient, 4) universalizability, the use of prior ethical experiences for support, and 5) interpersonal justifiability, the use of similar ethical experiences in defense of a decision.

With exploratory case studies it is important for the researcher to be open to findings outside of the conceptual framework. The following diagram offers a visual schematic to suggest the relationship of Iserson’s Model for ethical decision-making in the context of situation and priority.

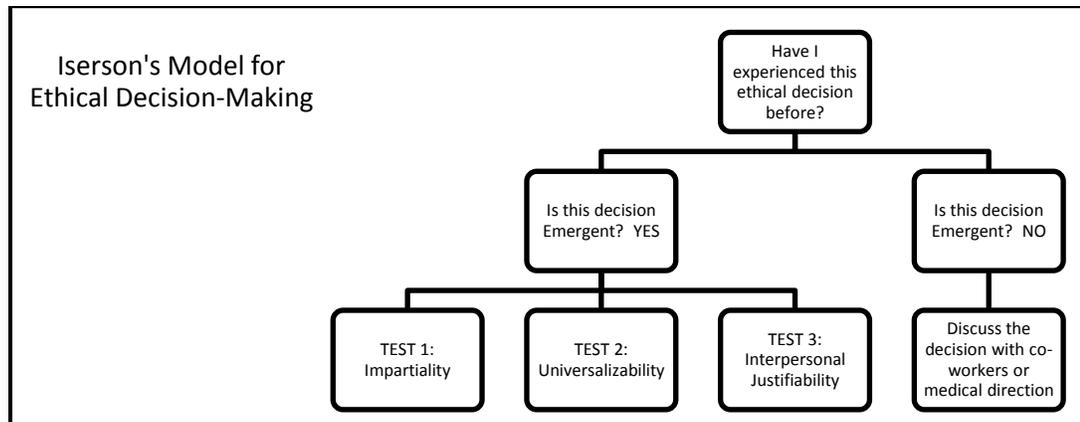


Figure 1 - Iserson's Model for Ethical Decision-Making

Research Design

This research is developed within the tradition of qualitative research, specifically the case study method of inquiry. The constructivist orientation is echoed in the experiential learning perspective, as stated by Merriam and Cafferella (2007), “learning is a process of making meaning” (p. 291) and that of feminist ethics theory “moral explanations are socially constructed, created through our interactions with others,” (Kittay & Meyers, 1987, p. 87). The research design has been developed to explore the meaning made by paramedic in practice, with the understanding that the researcher is a member of the profession. In the sections that follow, I will discuss my role as the research instrument through statements of

positionality and subjectivity, and further develop the explanation of the study design within the tenets of qualitative study and case study methods.

Statement of positionality. As a qualitative researcher that shares an identity with research participants as an active paramedic, and who teaches paramedic curriculum through an approved North Carolina initial training program, I am a guardian of a “secret.”

Sometimes unethical practice occurs in Emergency Medical Services. It is an idea that can be quite unnerving to the unsuspecting public entrusted to the care of EMS. Yet to get to the core of the phenomenon of how paramedics experience and learn ethical decision-making requires me, as the researcher, to position myself as one that “knows.” While some participants are comfortable engaging in a conversation about unethical practice or the stress endured during the process of making an ethical decision, paramedics are seldom willing to tarnish the image of heroic service by competent professionals. Chavez (2008) describes this dilemma as:

The advantage we have in knowing the community may be weakened or strengthened based on the ways in which our various social identities may shift during interaction with participants, or based on the degree of perceived or real closeness to participants as a result of shared experience or social identities (p. 476).

As an EMS educator and paramedic, I am positioned among those I chose to research. To gain trust with this position is also to break the trust by exposing truths about paramedic practice that protect the individual identity, but risk exposing the profession in a negative light. While I believe the research community will benefit from understanding ethical decision-making as a learned behavior, it must be recognized that any loss of confidence in

the EMS system could have an untoward effect on the perception of paramedic care, in contrast to the professional and pride I have modeled through my professional career.

Statement of subjectivity. I am a researcher deeply immersed as both paramedic and Emergency Medical Services (EMS) educator. While I have always believed my practice to be ethical, I have struggled in the role of an educator and administrator in recent years to impress the need for ethical behavior upon my students. Further frustration arises from a lack of educational materials and teaching objectives directed toward ethical practice. While educational material is limited, practical application, clinical experience for students and affective domain evaluation are not represented in National curriculum. Unethical paramedic practice can negatively impact so many lives (perhaps no one more than the patient) and yet we don't know the best way to teach students to navigate ethical situations in the field. To move beyond the educator regurgitating ethical theory, or the administrator tired of punishing a host of practices, research is needed to determine how ethical decision-making in practice is learned so that future teaching can be evidence based.

I believe that I learned ethics from my teacher and mentor, Dr. Barbara Larson-Lovin, yet I don't remember ever having heard a lecture, watching a video or even reading about theory. Dr. Lovin was the program director and primary instructor for my undergraduate work in emergency medical care, leading to my paramedic certification. While learning in classroom and clinical environment shaped my paramedic practice, no formal training for ethical practice or ethical decision-making occurred. I believe as a practicing paramedic, I have made ethically sound decisions when faced with perilous decisions. What if I hadn't? I

engaged in this study because of the minimal role ethical decision-making holds in current curriculum, yet enormous role in patient care.

“The assumption is that personal values necessarily influence any investigation. Thus the relationship between researchers and subjects is inherently subjective” (Tome, 2000, p. 178). Ethics is very personal to me and is therefore identified in my research as a strong belief system that was obvious to my participants. I believe in the importance of ethics in practice. I believe that EMS educators should make teaching ethical behavior in practice a priority. I am truly embedded in both aspects of my research as a current EMS educator and a practicing paramedic. Tome (2000) states that “what makes subjective data good, is close involvement between researchers and subjects” (p. 177). My relationship to those in the study is that of colleague as a North Carolina certified paramedic.

Researcher role. As a practicing paramedic, understanding the language and being identified as a member of the context of paramedic practice allowed for a more intensive exploration of the research question. In addition, it served as both a point of connection and as a limitation that my roles as a researcher, paramedic educator, and paramedic created overlapping identities with the study participants.

As a qualitative researcher, my involvement stretches beyond design. My interest in this research study stemmed from my own interactions as a paramedic educator. My practice led to the identification of the existing gap in relevant literature to address current paramedic education as it relates to ethical practice, and believing that formal paramedic education has a responsibility to offer the most effective training in this context. I believe current training should be informed by research that considers how paramedics learn ethical practice.

Creswell (2007) suggests that using interpretative inquiry recognizes the researcher connection to the study. “The researcher’s interpretation cannot be separated from their own background, history, context and prior understandings” (Creswell (2007, p. 39).

Qualitative Paradigm

This research study was developed within the tenant of the qualitative research tradition. Merriam (2009) states, “qualitative researchers are interested in understanding how people interpret their experiences, how they construct their worlds, and what meaning they attribute to their experiences” (p. 5). In order for qualitative research to allow the participants and the context under study to emerge in the findings, the selection of an appropriate methodology and design is needed to achieve the stated goal for the study and lend credibility to the outcome. Stake (2010) suggests that “qualitative inquiry is distinguished by its emphasis on holistic treatment of phenomena” (p. 31). Research design in the qualitative tradition is an in-depth and deliberate process that links existing literature based research, participant voices within context, and researcher expertise in order to address the research question.

A great deal of medical practice is informed by research offering quantitative support for efficacy. When we over-rely on one type of empirical data to make critical and universally applicable decisions about given populations, we admittedly miss many of the social or other dimensions associated with the provision of care. Creswell (2007) states that “besides dialogue and understanding, a qualitative study may fill a void existing in literature, establish a new line of thinking, or assess an issue with an understudied group” (p. 102).

This study addresses not just this void in literature, but further reveals the paramedic practitioner community as an understudied group. As Bloomberg (2008) suggests, “qualitative research reports include detailed descriptions of the study and clearly express the participant’s voices (p. 12). In the spirit of exploration, “qualitative approaches to inquiry are uniquely suited to uncovering the unexpected and exploring new avenues” (Marshall, 2006, p. 38). Within the qualitative approach to inquiry, the selection and application of a method allows the researcher to guide the study toward the research purpose, and offer credibility through the use of accepted traditions of research. The case study method was selected as the qualitative approach in this study, as there is little existing literature and understanding of paramedic perceptions of ethical practice. This is a first exploratory step in a larger need for applied research which focuses upon the experiences that have formed understandings of ethical practice.

Case Study Method

Case study was selected because it facilitates a depth of discovery within a bounded context. Respected in the medical community as a valid methodology, this design offers a means to expand understandings through exploration of a professional context. Yin (2009) writes, “you would use case study method because you wanted to understand a real life phenomenon in depth, but such an understanding encompassed important contextual conditions- because they were highly pertinent to your phenomenon of study” (p. 18). The choice of case study methodology ideally framed this study in a manner that maximizes the possibility that the findings truly relate to the phenomenon and accomplished the intent of the research question. Merriam (1998) states “the bounded system, or case, might be selected

because it is an instance of some concern, issue, or hypothesis” (p, 28). Case study methods are particularly appropriate when the researcher is a member of the context of study, and as such, has accessibility through member acceptance and an understanding of terminology.

Merriam (2009) suggests that there are three special features to the case study method. The term “particularistic, means that case studies focus on a particular situation, event, program or phenomenon” and “this specificity of focus makes it an especially good design for practical problems for questions, situations, of puzzling occurrences arising from everyday practice” (Merriam, 2009, p. 43). Furthermore, “descriptive means that the end product of a case study is rich, thick description of the phenomenon under study” (Merriam, 2009, p. 43). Finally, in agreement with the “heuristic means” suggested by Merriam (2009), this case study seeks to illuminate the readers understanding of the phenomenon of ethical decision-making in paramedic practice (p. 43). Stake (1995) describes the qualitative case study as a quest for a greater understanding of the case, “we want to appreciate the uniqueness and complexity of its embeddedness and interaction with its contexts” (Stake, 1995, p. 16). Merriam (1998) suggests that there are four disciplinary orientations for the case study research method: ethnographic, historical, psychological, and sociological. While previous case study research existed as “variations of experimental designs and statistical methods”, it “wasn’t until the evolution of qualitative research methods that case studies received attention from the methodological perspective,” (Merriam, 2009, p. 39). The approach for this study followed the sociological orientation. Merriam (1998) suggests that “case studies in education might also draw upon theory and technique from sociology” (p. 37). “Rather than focusing on an individual, the past, or on culture, sociological case studies

attend to the constructs of society and socialization in studying educational phenomena” (Merriam, 1998, p. 37). Merriam (1998) considers her work, and the contributions of Stake (1988) and Yin (1984) as instrumental in the recognition of case study as a research methodology.

The term phenomenon is echoed in Yin’s (2009) definition, “a case study is an empirical inquiry that investigates a contemporary phenomenon in depth and with its real life context, especially when the boundaries between phenomenon and context are not readily evident” (Yin, 2009, p. 18). Merriam (1998) describes Yin’s definition as directed “in terms of the research process” (p. 27). Wilson (1979) also “conceptualizes the case study as a process which tries to describe and analyze some entity in qualitative, complex and comprehensive terms not infrequently as it unfolds over a period of time” (Merriam, 1998, p. 29).

For Merriam (1998) and Stake (1995), the case study is less about process, but rather involves framing a unit of study (Stake) or an end product (Merriam). Stake (1995) states the “case study is the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances” (p. xi). Merriam (1998) originally defined the case study as “an intensive, holistic description and analysis of a single instance, phenomenon or social unit” (p. 27), but has since revised her definition. “I have concluded, however, that the single most defining characteristic of case study research lies in delimiting that object of study, the case” (p. 40). The case, according to Merriam (2009), is an in depth description and analysis of a bounded system, described as “a single entity, a unit around which there are boundaries” (Merriam, 2009, p. 40). Intent that the case study method is

appropriate only when a bounded system exists, Merriam (1998) further suggests the “uniqueness of a case study lies not so much in the methods employed (although these are important) as in the questions asked and their relationship to the end product” (p. 31). A case that is well defined by circumstances and contextual nuances allows an in depth exploration of the phenomenon, having refined the object of study. Creswell (2007) agrees, stating that “case study research involves the study of an issue explored through one or more cases within a bounded system” (p. 73). While the defining of case boundaries is a key to any solid case study design, Yin (1981) suggests that, “as a research strategy, the distinguishing characteristic of the case study is that it attempts to examine: a) a contemporary phenomenon in its real life context, especially when b) the boundaries between phenomenon and context are not clearly evident” (p. 59). Thus, case study is ideally suited when the phenomenon specifically exists in relationship to the context.

Justification for case study method. This study sought to understand the paramedic within a specific context of practice, and even further situated to the act of making decisions within a social group, in emergent medical situations. The consideration of a specific type of case study design further refines the process and clarifies the purpose. In keeping the stated research question and purpose for study, this case study is both descriptive and exploratory. Marshall and Rossman (2006) suggest a commonality in these terms in that “they build rich descriptions of complex circumstances that are unexplained in the literature” (p. 33). No theoretical assumptions exist in literature to explain how paramedics make ethical decisions in practice. This specific aspect of patient care exists in the complex circumstances referred to by Marshall and Rossman, and is best illuminated by the stories offered by practicing

paramedics. MacDonald and Walker (1977) as cited by Merriam (1998), add further dimension and define case study as “the examination of an instance in action” (p. 29). Merriam states that Lincoln and Guba (1981) also include “instance” in their definition of the case study, defining it as “to reveal the properties of the class to which the instance being studied belongs” (Merriam et al., 1998, p. 29). Truly the phenomenon (learning to make ethical decisions) cannot be extricated from the context and its characteristics.

Yin (1981) and Stake (1995) have each advanced their own typologies regarding the case study method. Tellis (1997) states that “Yin (1993) has identified some specific types of case studies: Exploratory, Explanatory, and Descriptive” (Tellis, 1997, p. 1). Tellis (1997) also states “Stake (1995) included three others: Intrinsic - when the researcher has an interest in the case; Instrumental - when the case is used to understand more than what is obvious to the observer; Collective - when a group of cases is studied” (Tellis, 1997, p. 1). Marshall and Rossman (2006) suggest that when the case study purpose is to “explain patterns related to the phenomenon in questions, or to identify plausible relationships shaping the phenomenon, the best design fit is the explanatory” (p. 34).

Research Process

Having designed the exploratory case study to answer the stated research question, the research process addressed specific information and procedures important to the study.

Setting. The setting for ethical paramedic practice as it relates to patient care exists in ditches where cars have been overturned, suspending injured motorists with the need for rapid patient assessment and transport decisions must be delivered while minutes tick away, possibly increasing mortality and morbidity. The setting also exists at the bedside of an

elderly patient nearing the end of life, with family nearby exhibiting various stages of grief, and with the paramedic responsible for assessing the legality of paperwork meant to answer “do we attempt to resuscitate?” The settings of patient care described in the preceding descriptions are intended to demonstrate the limitless and diverse nature for ethics in paramedic practice. No emergency knows the bounds of scheduled interviews. The setting of paramedic patient care experiences mixed with red lights and urgency, blood and screams, made capturing the true setting of experience for interview a challenge. While the proximity to this “setting” enhances the participant observation through visual and special cues, observations in such an environment are not practical nor ideal for confidentiality. In order to ensure confidentiality, interviews were conducted in a private setting while participants were off-duty. Measures to ensure confidentiality were strictly practiced, so that any patient information, participant identity, and EMS service identifiers were handled appropriately.

Sampling. Participant selection was based upon several criteria. First, participants were selected as veteran paramedics with at least five years of emergency practice in an Emergency Medical Care setting, and secondly, participants received their EMS education within the state of North Carolina. Five years of experience as a paramedic suggests that the participant has had ample opportunity, having responded to a variety of emergent situations, to have experienced ethical applications in practice. Paramedics that have completed North Carolina education programs adhere to the National Standard curriculum described in this research study, and thus the data analysis has integrity. Participants were chosen based upon their willingness to participate and availability for interviews.

The potential pool of paramedics for participation in this study was gathered through a information supplied on the North Carolina Office of EMS website. Letters were sent to paramedic level county directors and training officers requesting the referral of “seasoned” paramedics with at least five years of emergency response paramedic care in a lead role. Using the list of potential participants, contact letters disclosing the nature of the study and soliciting voluntary participation for a single interview of ninety minutes in length were sent. Demographic data was collected as part of a pre-interview discussion and used in the development of participant profiles. Thirteen participants were interviewed, comprised of nine men and four women. These participants represented a geographic cross section of North Carolina from coast to mountains. Experience ranged from five years of service to over thirty. While most were graduates of certificate or Associate’s Degree paramedic programs, two held a Bachelor’s Degree, and one had a graduate degree. All received initial training in North Carolina so that there was a basis for understanding their initial ethics training. The interview yielded approximately twenty five contact hours. The interview process and protocols are explained in detail below.

Data collection. Face to face interviews were audio-recorded with permission from the participants so that the researcher could actively participate in the interview. Interviews were conducted with maximum privacy due to the sensitive subject matter. The protocol relied upon a narrative conversational style. Drawing upon the experience of the researcher as not just a paramedic, but one trained in crisis intervention, patient confidentiality, and peer review of patient encounters, the interview sought the essence of the experiences while carefully avoiding probes that would have revealed patient identity.

Interview recordings were transcribed using a combination of Dragon speech recognition software and direct transcription using headphones. Transcriptions were reviewed by the researcher for accuracy and comparison to field notes. To enhance the authenticity of transcripts, participants were encouraged to contact the researcher post interview for any additions or changes subsequent to each interview. This informal method of member checking was inclusive of error correction and additional information to clarify commentary or to delete information erroneous or irrelevant. Member checks further the trust between researcher and participant in that the participants feel a sense of control over information and authority in granting permission to use of the interview content. Transcripts were maintained in a database with password security. Backup copies of transcribed data were maintained with external drive support.

Interview protocol. Face to face interviews were conducted using voluntary participants that were practicing North Carolina paramedics. “The semi-structured interview is used when the researcher knows most of the questions to ask but cannot predict the answers” (Morse & Field, 1995, p. 94). Each participant was asked the same open-ended questions, while the prompts varied based upon participant response. The use of a semi-structured interview allowed for variation among participant responses where the “freedom to respond and illustrate concepts” (Morse & Field, 1995, p. 94) achieved the depth of response important to this research. Of particular benefit, summary questions such as “tell me about the worst call you ever had” elicited meaningful insight. Paramedics seldom identify with decisions made in critical incidents of an ethical nature. When asked about decisions, they typically recant medical decision such as medication choices. Several

participants described ethical dilemmas as they described their worst calls and some even commented on not realizing the ethical nature of the call until they told the story in interview. While the focus of this study was not stress or painful memories associated with calls, the inclusion of these descriptors in open-ended interview questions yielded rich data surrounding navigation of ethical decision-making. The interview protocol is further addressed in the Appendix D.

Data analysis. Coffey and Atkinson (1996) suggest that “most fundamentally, analysis is about the representation or reconstruction of social phenomenon” (p. 108). The intended approach to the case study is the use of interpretative description. Thorne, Kirkman and O’Flynn-Magee (2004) suggest that “nurses and others in the applied disciplines have found interpretative description to provide a logical structure and philosophic rationale for the design decisions made in qualitative inquiries” (p. 3). In keeping with the conceptual theories advanced for consideration in this study, the interpretative description is respected in allied health research and finds the heart of the paramedic’s story in situation and interaction. To bring life to the intensity of paramedic lived experience in such context, it is important to be respectful and inclusive of stories as told for continuity of past, present and future. While Miles and Huberman (1994) caution that “conceptual frameworks are simply the current version of the researcher’s map of the territory being investigated” (p. 20), they lend support to the research questions. The research question is meant to solicit the stories of paramedics inclusive of descriptive language and evoking personal experiences of ethical care and decisions related to situations of intense stress and emotion. Analysis using the response to ethical decision-making that is inclusive and descriptive of the nature of such practice further

strengthens the purpose of the research. Thorne et al (2004) suggest “by virtue of its reliance on interpretation, interpretative description cannot yield facts, but rather constructed truths” (Thorne, Kirkman & O’Flynn-Magee, 2004, p. 13). Seeking the experience as related through situations described by practicing paramedics allows the individuals to become the bounded case through which they relate stories and perception of ethics in practice. These private constructions typically mesh with a community of life stories” (Riessman, 1993, p. 2). In order to accomplish analysis of such experiences, varied coding strategies were used.

Coding strategies. This study utilized two primary coding methods for data analysis: open-coding and framework coding. Saldaña (2009) suggests that “initial coding is breaking down qualitative data into discrete parts, closely examining them, and comparing them for similarities and differences” (p. 81). The first level coding was accomplished using open-coding to generate insights from the data obtained from participant interviews without constraint. The researcher used a compilation of field notes to suggest initial coding themes. Merriam (2009) describes the process of open-coding as “being open to anything is possible” (p. 178). A cursory review of documents provided structure for initial codes that were described in simple statements. Each transcript was analyzed using both coding strategies with open-coding first to develop themes and subthemes, followed by framework coding. This second level coding yielded framework codes that were developed from the primary concepts of Iserson’s Rapid Approach to Ethical Problems in an Emergency model to include: impartiality, universalizability, and interpersonal justifiability. The interview was structured around the model developed by Iserson et al. (1995) utilizing a three question approach and including three tests for practitioners to use in emergent decision-making

situations. Coding themes were represented graphically on poster board in order to demonstrate the number and identity of participants that aligned with each theme, both during open coding and framework coding. Notes were kept during the coding process that included line number reference to each theme and subtheme by code number. The use of framework coding was of particular importance for a data analysis using my conceptual framework.

Research Protocol

The researcher sought to gain the trust of participants as an “insider” early in the interview process. The protection of identity was essential and lent an aspect of trust, and depth of response in experience disclosures. Member checking was accomplished following interviews, by allowing participants to make changes or add information post interview.

Ethical concerns. The inclusion of practice related examples of ethical behavior is difficult in that ethics in paramedic practice may be directly related to patient mortality and morbidity. Confidentiality is essential to consideration of such data. By studying the understanding of ethics without pre-conceived notions as to what conceptions of ethical practice exist, there is a possibility that negative feedback could occur based on study results. The perception of unethical behavior is dangerous to a public dependent on care, while incumbent on the practicing community to ensure ethical competency. Paramedics are often reluctant to divulge information that could expose inadequacies in ethical decision-making. Students and practicing paramedics may feel a similar reluctance to be forthcoming about ethical practice situations for fear of a negative consequence. The participants of this study

are truly champions of that cause to better the paramedic profession and believed that “telling the story” and promoting research would help future paramedics.

Issues of trustworthiness and validity. Trustworthiness of a study suggests to the scholarly community that through the research design, data collection and analysis, and presentation of findings, the research will contribute to the body of literature with rigor and validity. Validating qualitative research requires the researcher to expose aspects of the research with attention to detail and gain the readers trust through total disclosure of every aspect of the study. In his text, Creswell (2007) suggests eight procedures for validating research: prolonged engagement and persistent observation, triangulation, peer review or debriefing, negative case analysis, clarifying researcher bias from the outset, member checking, rich thick descriptions, and external audits. After examining the procedures, he further suggests that for any study, the qualitative researcher should “engage in at least two of them in any given study” (p. 208). After careful consideration, I selected “clarifying researcher bias from the outset of the study” (Creswell, 2007, p. 208). In agreement with Creswell (2007), I have further employed the use of “rich, thick descriptions that allow readers to make decisions regarding transferability” and member-checking (p. 209) as the areas that are most important to me to establish the validity of this study. My bias as a researcher was readily disclosed to both participant and reader, and I used reflective strategies to responsibly manage researcher perspective during the data analysis and data expression phases of this study. The interview strategy allowed for rich, thick descriptions. Member-checking was accomplished following transcription. Participants were asked to contact the researcher with any changes or additions following the interview. Interview

transcripts were available, if requested so that participants could check the documents for accuracy and additional thoughts for inclusion. Member-checking followed transcription and a preliminary review of coding themes to insure that statements related to the initial coding process were captured in the summary.

Angen (2000) suggests that there are two approaches to establishing validity in interpretive research: ethical validation and substantive validation. Sanjek (1990) by suggesting that we respect the ethical traditions of good qualitative research when we “creatively combine our own experiences with the inquiry process to produce valuable new interpretations” (cited in Angen, 2000, p. 389). Like ethical validation, substantive validation requiring the researcher to assess “one’s biases in the early stages through considering how they are changed by one’s engagement with the topic to giving a written account to the final product” (Angen, 2000, p. 391). This research has been designed with the researcher as a member of the community under study. The researcher has identified bias and subjectivity as a paramedic with experience in ethical patient care encounters to substantiate validity. Data is presented in the rich descriptive words of the participants at a level of intensity that allows the reader to make decisions regarding the transferability of the findings in a similar context.

The disclosure of personal bias is also essential to the research process. The gravity of ethical decisions in paramedic practice has been an experience of the researcher that drives a motivation to understand the phenomena being explored. It also raises conscious awareness during the interview process. Stake (1978) states:

I believe that it is reasonable to conclude that one of the more effective means of adding to understanding for all readers will be by approximating through the words and illustrations of our reports the natural experience acquired in ordinary personal involvement (p. 280).

Personal involvement allows for a depth of understanding and trust in the interview process. I used intentional reflection between interviews to remain conscious of my own insights. At times participant experiences reminded me of my own. In order to respect the boundaries of insider status and yet use “personal involvement” advantageously, I carefully framed questions to avoid reference to my experience or suggestion of my own descriptive terms. I used a straight forward approach to questioning, careful not to lead with wording or framing. A depth of insight from participant response was achieved, while my own influence was strictly limited through continued awareness and reflective measures.

Limitations of study. True to the nature of qualitative research, this study cannot be used as a generalized account of paramedic perceptions. Deliberately seeking the voice of paramedics with beliefs that true learning occurs in situations of ethical decision-making has contributed to the goals of this study. In addition, further framing of the study with consideration to the development of moral ideals that impact the experience and stories of paramedics making these decisions offers yet another conceptual lens. The suggestion that ethics in paramedic practice is rooted to moral development and enhanced through relationship to situations is exclusive of other theoretical considerations and therefore limiting to the findings and implications. While individual stories add strength to the content of this inquiry, they should not be considered representative of paramedic perceptions on a

wide scale, and certainly not in care settings where policy and training lead to the possibility of different experiences and understandings. While offering strength to a community lacking literature related to ethical practice, and certainly lacking paramedic context understanding, there is inherent limitation in that this study does not position within similar work.

Strengths of study. While there are acknowledged limitations to this study, there are also strengths inherent to the design and to my experience as both a practicing North Carolina paramedic, and as an educator, certified to teach North Carolina paramedics. While restricting the selection of participants to thirteen North Carolina paramedics may be seen as a limitation, the richness of data that was collected, allows the focus from a single state that utilizes the National Standard Paramedic Curriculum to provide important data for other systems.

Another strength of this research is the accomplishment of the intended goal, which is to illuminate an area of pre-hospital medicine not represented in the literature, to inform the research community, and to provide an understanding from which future research can lend to the development of enhanced instructional and training techniques.

Finally, a significant strength of this research is the insider voice. I was able to gather the rich data that lead to strong findings because of a position of trust gained from years of shared paramedic experience with the participants. The insider voice further allowed paramedics to tell stories to “one of their own” without a loss in interpretation from professional jargon, acronyms, abbreviations, or medical terminology. The data is presented as told, with explanations offered so that readers without a paramedic background can read and find their own conclusions.

Presentation of participant data. The criterion for participant selection was years of experience and educational background, and these were verified for each participant. In order to protect participant identity and encourage descriptive interview responses, participants will be identified by pseudonyms. Given the bounded nature of this case study to experienced practicing paramedics educated in North Carolina, a focused representation of variables with no planned relationship to the study allowed further dimension to the inquiry and a comparison of participants within the case.

Summary

Conducting research in the qualitative paradigm allows the focus to turn toward “understanding ‘human beings’ richly textured experience and reflections about those experiences” (Jackson, Drummond, & Camara, 2012, p. 22). Recognizing the researcher as a member of the social context under study considers the constructivist approach to making meaning from a collection of lived experiences. I further believe that the case study method literature supports this position. The healthcare community has for many decades been represented by this quantitative research paradigm. The recent shift, predominantly by the nursing profession, has created a noticeable impact on the number of qualitative studies, yet there are relatively no qualitative studies that pertain to emergency medical services. This study will inform the literature through a study designed within the tenets of case study methodology. The case study research design methodology selected for this study is designed to elicit and develop the stories of paramedics in practice. In the next chapter, Research Findings, the researcher will retell these stories so that the reader may construct meaning from their lived experiences in the practice of ethical patient care.

CHAPTER 4: RESEARCH FINDINGS

Introduction

This exploratory qualitative case study research is designed to explore paramedic perceptions of ethical practice, with a specific focus on understanding paramedic perceptions of ethical decision-making and the navigation of such situations. The study investigated the following research question: What are paramedic perceptions of ethical decision-making in practice? The study's conceptual framework was adapted from the Iserson Model for ethical decision-making, as found in the current Paramedic Textbook by Sanders (2012).

The participants are presented both as a collective overview of profile, and also as individual profiles. Following profiles, the findings are presented first in an open coding thematic structure and followed by a second reporting based on the relationship of the data to the conceptual framework. Data is reported largely in the form of stories and the stories are told using a paramedic terminology that has been explained for the purposes of revealing participant voice in a commonly understood language. Participants and the geographic area in which they practice are strictly protected so that any inference to a patient incident is avoided, allowing for an increased level of anonymity for both paramedic and patient. Four themes are derived from the initial open-coding process and are noted as dimensions of ethical paramedic practice, to include: ethical values, accountability, professional identify, and decision stress. These themes differ from results found during the Iserson Framework inquiry. Framework coding using the Iserson Model is presented in the second part of this chapter, followed by a summary of both types of findings, and similarities noted using both forms of data analysis.

Collective Participant Profiles

The participants for data collection in this study are practicing paramedics who were educated under North Carolina paramedic curriculum requirements as established by the North Carolina Office of EMS. All are currently certified as North Carolina paramedics. All have served in Emergency Medical Services in full-time positions for at least five years, although several were working in EMS as volunteers or part-time employees at the time of interview. The reported years of practice may include years at the current position, as well as previous experience.

While research participants shared common experiences in Emergency Medical Services, other key commonalities stood out during the data analysis. Most notably, all of the participants shared stories of the cumulative effects of personal and professional stress related to navigating the ethical situations/difficult decision-making during their years of practice. This was particularly evident in situations involving the resuscitation of elderly or terminally ill patients, and the death of a child. Many of the participants volunteered to participate in this study believing that as Laura states, “telling the story is important.” Most of the participants voiced the significance of having a career dedicated to helping others and of assuming the role of a hero. While the hero identity was a common theme, participants also shared their need for someone outside of EMS to see the personal cost of such heroism and the toll of making difficult ethical decisions in trying situations with no formal training. Brian states, “I wish the world could see what we go through on a day-to-day basis, what it’s like to be a paramedic and make these decisions.” Most participants also wanted to do something which would help the profession just as much as they expressed the desire to help

the patients they care for. James states, “anything that helps others understand what we do and why we make the decisions we do and what goes into those decisions is so important.” They all expressed a connection between their experiences as paramedics and their feelings toward loved ones, particularly in feelings of safety and mortality. Participants expressed the feeling that EMS had evolved in a positive way from days of old where paramedics felt their “hands were tied behind their backs” in contrast to the current standing order protocol, where they have a great deal of freedom to treat their patients. This evolution in care is related to a shift in training. Particularly, participants with greater than ten years of experience, such as Rick, suggest that “it was like cook-book type medicine and you could not think for yourself... but sometimes you have to think on the fly, and outside the box to save someone’s life. Now you can think outside the box, back then, you could not.” Currently, paramedics are trained to understand the pathophysiology of both the disease and the wide array of treatments within their scope of practice. Furthermore, the techniques and equipment used to assess injury and illness with modern treatment have advanced. The care provider may now make appropriate and emergent decisions without having to call the physician for orders. All participants related the feelings of stress and anxiety associated with this increased responsibility and autonomy. Michelle recalls a difficult ethical decision she made regarding resuscitation and one of the crew members addressed her stating “it is on you.” Paramedics, as the highest medical authority in the pre-hospital environment are accountable for such decisions. Michelle adds, “It is an absolute understatement that paramedics make life and death decisions every day.” While treatment decisions as a part of

paramedic care are a given, Michelle speaks to the stress associated with navigating ethical decisions in critical situations.

While many commonalities emerged, key differences among the participants were also noted. For instance, participants noted a need for closure after failed resuscitation attempts with patients, and even suggested that attending funerals benefited them. James attended the funeral for a boy, recalling:

I faced the family and do not know if that helped bring closure to them or it was my coping mechanism, but I do remember the being at the funeral home and the little brother looks at me with disgust because I did not save his family member.

In contrast, Michelle states “there are certain things as a paramedic you should never go to, and that is the funeral of a patient.” Some of the paramedics interviewed related stories of “crying along with the patient” and “carrying them with me,” while others were resolute that they needed to disconnect from the patient. When asked if he has a call that still bothers him, Scott states, “Nope, I’m fortunate, babies will shake me for a couple of days, but for whatever reason, I have the ability to lock it away and leave it there.” Some embraced the opportunity to talk about regrets or ethical decisions that they would change if given the opportunity, while other participants kept a stoic affect.

There were differences among the participants as to patient demographics that elicited a feeling of empathy. While Scott feels an increased empathy for the loss of “babies,” James feels less empathetic in the loss of an infant, “they don’t go to school, they don’t have friends, they don’t drive a car, they are not looking forward to prom, no boyfriend/girlfriend, getting married, their parents have had them less than a year and yes, they are attached and

they love them, but they are not as attached to the ones they have been with 20 to 30 years.” Empathy as it relates to decision-making is discussed in more depth in the findings related to the Iserson Model framework.

Given the nature of this research study, as a researcher it was necessary to achieve a “member” status in order to gain the insights associated with an in-depth exploration of a sensitive topic. Interview questions were structured not only to elicit a level of depth in shared stories, but to allow participants to share stories that they may not explicitly identify or recall as ethical dilemmas or typically discuss with others. Ethical situations and the difficult decisions that often accompany them include areas of emergent care without a clear right or wrong answer, or those situations in which the right ethical action is perceived as the wrong action for the patient. Participants were encouraged to tell stories of situations that excluded medical treatment decisions, but rather focused on decisions such as whether or not to resuscitate a dying patient, or treat a patient against their will. Arguably, some of the richest reflections of ethical situations in practice came from broad and open ended questions such as “tell me about the worst call that you ever had” or “why does that call still bother you so much?” An important link was established between challenging ethical decisions and the associated stress of wondering if the right decision was made, or a feeling of regret for the circumstances that surrounded the decision. As an example, John recalls a very difficult call from the year 2000 when he ordered a crew member to perform a skill he was not certified to perform. While a student may have completed all of the advanced training to become a paramedic, until tested and certified by the administrative authority, in this case the North Carolina Office of EMS, the provider cannot provide skills or treatment at the level. In this

case, John was the only certified paramedic on a scene and when another provider arrived to assist, he ordered him to provide a paramedic level airway skill, something that he was not yet certified to provide. The incident was remembered as a terrible call involving the death of a child with not enough resources to offer optimum care. As John continues to discuss the call he realizes that he has made an ethical decision, ordering a non-certified trained provider to perform an advanced skill, in an effort to save the child that could have jeopardized his own as well as the other care giver's certification.

Individual Participant Profiles

Based on my interaction with the participants during the interviews, individual profiles describing each participant are as follows.

Rick. I met Rick in an old portion of the rescue building that he had served as a volunteer in since 1970. Recently retired, Rick tells the story of the early days of EMS and paramedics in his part of the state. It is apparent that he both misses and loves the paramedic profession. Occasionally, as we talk, distant tones sound from the new EMS building and Rick pauses, bends his ear toward the window and continues. Remembering his earliest days of EMS, Rick says that there were no paramedics. He had grown up a poor local farm boy and wanted to help at the local rescue squad. After he graduated from high school he began employment with the water treatment plant. Rick says that he was nearly drafted to Vietnam and had that happened, he would have chosen to be a medic. Rick says so "I stayed here and did it!" After 20 years of volunteering as an EMT Basic or Intermediate, he returned to an accelerated Paramedic program in 1992 and transitioned full-time employment from the town water plant to EMS.

As we talk about the situations he has faced and the decisions that Rick has made through his years of service, Rick's approach became apparent in one particular instance. Rick describes a critical cardiac call with a patient that he felt would not survive a 30 minute transport to the emergency department. He called twice to get orders for the drug that he knew she needed, and both times the physician told him to hold off. Finally, as she began to deteriorate further, he gave the drug, saving the life, but jeopardizing his career, "I was taking a big chance." Once at the hospital, the doctor realized the severity of the patient and as Rick explains, "he didn't say anything about the Dopamine, because the patient was so sick, he ended up increasing the dopamine."

As Rick reflects on patient stories, he appears deeply thoughtful at the power of his interaction with others' lives. In one particular story, he had responded to a motor vehicle accident with seven victims. A female patient's legs had gone through the floor of the vehicle and as Rick assessed for signs of circulation. He found that her legs were cold, pulseless and lifeless. He determined her to be a "black tag" or non-viable patient and began care on the others. When firefighters moved the vehicle off of the victim, she began to breathe. Rick relates that "two years later we were called to her house. She had compression spinal fractures and she lived. I got her into the back of the truck and she tells me she remembers my voice." Rick explains that the woman says that "I remember you telling them to get the car off me and telling them that I was alive." With a smile and shake of the head, Rick then seems to acknowledge heaviness, the responsibility of some ethical decisions. He relates that he has trouble sleeping since retirement. "I do not see the calls, I just think about them. Now I wake up feeling like I have missed a call, but I am at home."

Rick, now 59, lives on the land where he grew up on with his wife. He never had children, but says “EMS has pretty much been my life and I consider that to have been my kids, a lot of kids.” Rick, like other participants, relates a strong sense of community allegiance to the citizens he has cared for through his year of practice in a small town. “A lot of the people in the community today will ask you ‘do you remember that time you picked me up? I really appreciate it.’” As the interview ends, I tell Rick that I have appreciated his time.

Laura. Laura is a 47 year old woman who begins the interview with explaining that her splinted right arm is the result of a mishap that occurred with her beloved pet. She has been “off the truck” healing from the injury and values the time to talk about EMS. Laura never married, and has lived and served in the same county where she was raised by a single mother of three. With an obvious love and admiration for her mother, her patient care seems a reflection, “I always think of how I would want my mother to be treated.” She has a brother that is also a paramedic and has motivated her to move up from volunteering to paid paramedic positions, and also to pursue a bachelor’s degree in EMS. She completed a certificate paramedic program through the local community college and has been practicing since 1999.

In the early years of her certification she volunteered while working a retail job. As she tells me about those years, she comments, “After the incident with Mitchell I went back into retail for a while.” I ask her to tell me about Mitchell. Laura relates that her partner, Mitchell, was the driver of the convalescent ambulance (non-emergency) while she attended the patient in the back. They were on a long transport, moving the patient from a smaller

hospital to a larger teaching hospital. Along the way they stopped at an accident scene to assist. While Laura remained with the patient in the ambulance, Mitchell was hit and killed instantly. Mitchell, realizing an unsecured truck was moving toward the ambulance stepped toward it. As she utters the following words, you sense that the their impact has changed her life.:

They tell you never to leave your partner and I did. It was a difficult situation, I had to leave him out there and it was a freak accident and he was trying to protect me and he lost his life.

Laura goes on to explain that she had to leave her partner on the scene and continue the patient transport once authorities arrived on the scene. Emergency services professionals use the term “never leave your partner” to remind you that there is greater safety in looking out for each other. Struggling in the years that followed with survivor’s guilt, Laura returned to retail. When she returned to EMS full time is was because, “I knew he would want me to get back in it and here I am.”

Laura describes a call that still worries about. She recalls approaching a 16 year-old motor vehicle accident victim with no apparent injuries, “I heard someone say she was breathing and then she is not and it was a situation where we had to get the girl out.” Electing to rapidly remove the patient and so that they could offer ventilations, “I told the fireman to get her out.” Laura later learned that the patient died and it had been determined that she had a cervical spine fracture. Replaying the call, “my thought was what if we could have prevented this during the removal of the girl from the car?” Assured by physicians that the patient outcome wouldn’t have changed, Laura also says she wouldn’t have changed her

decision. Nearing the end of the interview now, Laura reminded, states “I can say I would not have left my partner on the highway if I could go back. That is probably the biggest one.”

Like other participants, Laura echoes that being a paramedic isn't about being cool, “if people were to actually understand the gravity of what we do, they would understand what we do, maybe take it a bit more serious.” She worries for the next generations, describing herself as an older paramedic that has “told the younger ones that they need to think about what they are allowed to do in the field.” Laura believes this responsibility and accountability for actions also extends to her community, “I love the part of being there when someone needs someone the most. Being in this community for 15 years, there are so many people here in my town that know my name that ask for me.” Laura then thoughtfully adds, “which of course has a downside because when it gets to that bad time and they are in cardiac arrest and I cannot help them, it is hard.” As my time with Laura ends, her smile and the enthusiasm she has offered her agreement to participate suggest that her patients are likely greeted by the same friendly care provider. “I love people and I do not care who you are, or where you have been.”

James. James began his EMS career at that age of fifteen as an EMS cadet at the local squad. After graduating high school, James became an EMT-Basic in 1994 and volunteered at the same local agency while attending a university. He says his college career was short lived as he “got the EMT bug” and pursued higher EMS certification levels until achieving a paramedic certification in 1999. James relates his identity as a caring and competent “street smart” paramedic to those early years when he rode with a variety of well-seasoned paramedics in urban areas, “My first influences were professional EMS and they

did it for a career.” James goes on to describe people that pioneered the first paramedic-level EMS in North Carolina. He offers an example, “I rode with the first woman in the EMS department in a big county, great influences in my decision and they were good people, they were street medics and they had strong medics and treated people well.” James describes the paramedics that had taught him in those days as calm heroes, “They never let that chaos get to them. They did their job and did it well. They were leaders.” Not surprisingly, James feels that “being calm and collected” is an important quality in a good paramedic.

James sits before me in a clean and pressed uniform, clean shaven, and closely shorn haircut. Having just ended his shift, his duty radio was still clipped to his belt. He says that one of his favorite things about being a paramedic is that “everyone gets sick and needs help and to me EMS is the noblest profession on the earth because we do not discriminate. We have no limitations on whether we can provide a patient with care, I think that is the greatest thing.” Further iterating his point, James says we treat chest pain from the jails to the nicest houses without discrimination, but this right comes with a responsibility. James believes that respect requires a professional presentation, going on to say:

The image that some of our paramedics portray such as those that walk into a patient’s house with their shirt untucked, holes in their clothes, that are disrespectful and they do not speak proper English and they have chewing tobacco hanging out their mouth that just portrays us in a negative light regardless of whether or not they are a good care provider.

Perhaps the pride in his profession, the memory of the pioneers of EMS he describes with admiration, or his own personal values, James summarizes, “I have compassion and patience for my patients but not for sorry paramedics.”

James is from the county where he still lives and works as a paramedic. While he has never married, he is close to his family and spends time and shares meals with them weekly. When asked about how he has learned to manage patient care decisions, James thoughtfully considers, and then answers, “How would I want my parent treated and what would I want done in a situation with my parents?” Treating patients with this personal consideration has come with an emotional price. James remembers the early days of volunteering when paramedics were in short supply and ambulances were stretched thin across the county. “We survived it by knowing that is our job that a volunteer rescue person was to be a neighbor helping neighbor that was to be the mentality of volunteer rescue work.” He describes his early years in EMS as maintaining a distance. “You carry people you know.” He goes on to list instances of interaction through the years: “My own sister has been in a wreck before, you have been to family members, I have been to people I went to high school with that blew their brains out, I have seen all that stuff.” While seemingly emotionless, as the conversation continues, the toll of years of caring for a community becomes more evident. “I have been to my friends’ house when their parents have died and been to several wrecks where several friends were killed. I never shed a tear.” Suddenly looking up from the fixed gaze at the table, he asks, “At what point does something change in you that you suddenly begin to cry? At what point does that change? I don’t know.” Presently, James realizes his connection to patients and the distance has changed. “I can ride by every house and I can picture the

people in there. I had a little girl drown in the fountain one time and I can drive by that fountain and remember that girl.” He comments, “It’s sadder now than it was then.” James describes a night waiting roadside with a twenty year old deceased victim of a motor vehicle collision that had been put in a body bag. He explains that “I waited, made sure he was treated respectfully and helped the funeral home pick him up,” adding that maybe we have enough help now, or maybe we are different. “ At some point you went from being a hard ass all the time with your fake shell that was around you to now... your shell is gone and you are allowed to be human.”

Ben. As Ben casually walks up and introduces himself, it is obvious by his friendly smile, warm handshake, and casual running attire, that this will be a relaxed interview. Responses to questions are very thoughtful, as though he deeply desires to give the best answer he possibly can, and yet be forth-coming. As Ben shares the stories of his paramedic career, it is very apparent that his devotion to the profession and the patients he cares for motivates him to communicate openly about paramedic practice.

Ben became a paramedic in the late 90’s after coming up through the ranks as a firefighter since his adolescence. His interest in caring for patients grew from his experiences as a firefighter. In the city in which he worked, fire crews were frequently dispatched to EMS calls to assist. Through the years, assisting with patient care, he found that he had learned enough to often have his own ideas on how the patient should be treated, both with regard to kindness and medicine. Ben remembers one call in particular when a patient’s husband was caring for his confused diabetic wife and asked the paramedic if he should give his wife a shot of insulin before they transported her to the local hospital for

evaluation. Ben states that the paramedic immediately replied, “yeah, why don’t you go ahead?” Knowing that giving insulin to a patient with low blood sugar would be critical, he stopped him saying, “what if the sugar is low?” He recalls that when the blood sugar was checked and found to be low, not to mention the cause of the patient’s confusion, “I thought, I could have been doing this job.” Motivated to provide quality patient care, Ben attended a local community college program to achieve his paramedic certification. He feels that through his years of service, he has remained a compassionate caregiver. Having experienced both good and bad partners, he states the “one thing that I take pride in is that I try to offer, no matter how bad I have had a day or night of, I still try to treat someone as an individual.”

Ben, now 44 years old, grew up in the area where he has worked as a paramedic for nearly fifteen years. He is the proud father of a sixteen year old daughter. He and his wife attend church regularly. Ben relates that his career has brought him a lot of happiness, but he also feels that he is “doing what God wants me to do.” Serving in the area where he and his family are from led to the memory that he relates as the most difficult call he ever experienced. He remembers the day clearly, although the event occurred in May 2000, beginning the story with where he was when the dispatch came over the radio. Serving as the area supervisor, he heard the address for the call and listened to the nearest ambulance respond. The crew requested a helicopter to transport the child. Four to five minutes elapsed when he realized that he knew the address, it was a family members house. When he arrived he found the fatally injured two-year old little boy, whom his daughter (only a month different in age) had played with, to be the patient. The child died after the flight to the local

trauma center. This call presents an ethical dilemma. When Ben discloses his relationship to the child in a subsequent debriefing, he is told by supervisors that paramedics are not to treat family members. As he recalls this event as his most difficult call, he still feels that he was meant to be there and care for the child because he was later able to help the child's mother with questions that resulted from the death.

Patients, from the elderly to the immigrant, would likely find this soft-spoken, gentle paramedic to offer the compassion he feels patients want most, saying that he "honestly thinks a lot of times that people just need some TLC and that is one of my things to give them." Strongly believing in such care for all patients, Ben feels he respects people of all ethnicities and backgrounds, "there is good and bad in any color or in any social background or anything like that, so I will look at somebody's condition and form an opinion a lot quicker than I will look at their color." As we talk, he admits that he has a disdain for alcoholism. Ben relates that he was raised by parents that drank and that his brother is an alcoholic. He states, "I do not do well with drunks, I don't like alcohol and I do not drink. If there is anything that I have predisposed myself for not liking, it is dealing with alcohol." Throughout our interview Ben relates to his practice of caring for patients with fulfillment associated with caring for all people, and yet seems to come back to his own realized lack of compassion for drunks stating, "if there is a time when I am not going to buddy somebody or coddle them is when they have alcohol in their system, I do not know what to do about that."

Ben doesn't feel that he learned empathetic patient care from the classroom. He relates that his years of experience have better prepared him to provide good care and he hopes that in some way, working with students as they ride with him, and participating in

studies such as this one will further benefit the profession he loves. Ben states, “sometimes you can really tell you have made a difference and that just gives me a good feeling.”

Michael. I met Michael before his shift in a training room. With a very genuine and professional demeanor, he greets me and he seems anxious to get started. When I ask, “Why were you interested in participating in this study?” Michael enthusiastically replied, “I have never seen anyone do a study on ethics or morals or whatever you want to call it, on EMS personnel. I’m excited to be a part of it.” As we proceed with questions, it’s obvious that ethics are an important topic to Michael. He feels the qualities of a good paramedic are “honesty and integrity in your patient care and in who you are as a person.” Michael goes on to say that who you are as a person can be viewed as both “internally, and personality, being who you are externally.” Michael and his wife have no children of their own, but have adopted, and fostered children. Working in a wide variety of settings, from rural to urban, volunteer to paid, Michael has 21 years of experience as a paramedic. His training was through a community college program. While Michael does not hold a degree in EMS, he holds several advanced degrees in religious studies and has worked part-time in various aspects in ministry, particularly with youth.

Michael believes that his faith is a big part of paramedic practice. He feels that he has changed with age and says this about his views toward the patient, “its total person care, I’ve been around for 20 some years, and it’s taking care of the patient physically, mentally, socially and spiritually. That’s the whole package.” Michael references the realization that patients have lives that extend beyond our care, saying “I can get your heart to stop hurting by giving you nitro or morphine, and I can get you to the right facility to care for your heart.”

Going on, he reflects “I started looking at what’s going to happen to this patient when they get to the hospital and when they go home from the hospital and that to me is a big difference from when I started.” No longer focused simply on the patient’s treatment, Michael now sees patient as a much bigger picture outside of the 9-1-1 interaction.

Concern for a patient’s well-being is reflected again as I ask him to tell me about a difficult call. Michael reflects on a call that we have already discussed. This call seems particularly haunting in many ways. He has been called to the residence to an elderly man. The man had been discharged from the hospital ten days prior. The man is quite ill, but despite his efforts, Michael is unable to convince him to go to the hospital to be cared for, the old man repeating, “No, if I’m going to die, I am going to die in my own home.” The patient became threatening, striking him with a cane. Reluctantly Michael and his partner left after securing the proper paperwork allowing him to refuse. Later that same shift, Michael was called to the same house for the man in cardiac arrest. The patient’s son meets Michael and says “I’m hurting right now because my dad is dead and there’s nothing you can do for him. He said at this point, don’t do anything.” In those days, before legal “Do Not Resuscitate” orders could be honored by EMS crews, paramedics were supposed to begin resuscitation measures on all cardiac arrest patients. Michael continued to implore the son to allow him to work on his father, while the son continued to deny him. Finally, with no other options, Michael called for the police. He continues the story, “So I called the cops, and then we worked the code. We didn’t get him back.” He describes having to err on the side of his training, and follow procedure, however, when I ask “what would have been best for the patient?” he replies, “to leave him there and not have called anyone.” As Michael relates the

story it is apparent that the memory still evokes powerful emotions related to this very difficult situation. I ask, “Why do you remember this one so much?” He quietly replies, “The hurt it caused, the hurt in my heart. It still bothers me. I still remember the house and every time I go by, I remember that call.”

Brian. Brian is a man of color, 40 years old, with a pleasant Caribbean accent. Brian is a single man whose family has relocated to North Carolina from his native country. He and a twin brother have pursued careers in emergency services after watching their father killed in a motor vehicle collision with a drunk driver. Brian recalls the feeling of helplessness, in his native country there was little emergency response. Brian describes the impact of his father’s tragic death, “living with that for years, still living with it, it made me just want to try and help people.” He has lived in North Carolina since 1992, and been a paramedic for the last fifteen years. Brian still hopes that one day his education and experience will help the people in his native country. He returns twice a year and says, “right now I’m working on getting an EMS organization up and running out there.” Brian says that he has had to adjust to some cultural differences. He particularly cites, “the work ethic is totally different,” he continues, “where I come from it is a privilege to have a job, so shut up and go on with it.” Brian says that he has been here long enough that he is used to it, but he still doesn’t like “complaining” in the workplace.

A hard worker and man of pride, Brian moves on to tell me about a difficult experience that he had. New to his full time job, he responded to an elderly woman with respiratory distress. As he approached the residence with his equipment, a first responder that had arrived on scene first met him in the yard and said “you don’t want to go inside, let

your partner go inside.” Feeling responsible for the call, Brian went into the residence to find his patient “in severe respiratory distress, gray face but still able to talk even though she was in distress.” He said, “ma’am can I help you, it seems like you’re having some problems breathing.” The patient shook her head denying him consent to treat her. When a family member told Brian that she would not allow him to treat her because he was black male, and used “some language”, he replied, “ma’am I know your situation but, I really don’t give a damn right now whether I’m black or not. I’m going to treat you right now.” Brian relates that the patient shook her head no again. He states that “I looked around and the family member was shaking their head, saying ‘she is from the old era’.” Brian now chuckles as he continues, “I said, ‘that’s fine, but she needs to get treatment and if she doesn’t get treatment she’s going to die’.” He describes the emotions of the day and his determination, saying, “I did not allow it to prevent me from doing what I’m supposed to do, so I did cross the barrier and I assisted her,” and “she was mad, but in the end she thanked me.” Brian refers to the “barrier” in reference to crossing an ethical line by treating a patient against her will. Brian states “that was a culture shock, a big Bam!, it was the first time I had experienced that, the first time I had ever experienced racism and I didn’t know it was that bad.” I ask how many years have passed since that incident had occurred, and Brian replies, “many,” with a smile. I ask, “and now?” to which he replies:

To me race is not an issue, I know it’s out there, me and you are the same, same, same, we may do things differently but, race is just an excuse because of ignorance, so no! I don’t let it influence me, I really don’t.

He nods his head in affirmation of his decision not to let issues such a race deter him from his desire to save lives. Such determination predisposes Brian to further dilemmas each time this type of situation arises.

In closing, I ask about a difficult call that he had, perhaps one that he still struggles with. Brian takes a deep sighing breath and says “oh yeah” and begins to describe an early morning call on an interstate when he and his partner were the first on scene. Multiple cars and a semi-truck were involved. He remembers the darkness, but mostly the quiet, “everything was quiet, there was no noise, no nothing.” Letting that statement fill the air, he hesitates and then continues. “I got out and stood there, I can’t move because I am spinning,” I remember “there were lights from another truck, but it was about two or three minutes out, but I was just froze, bodies lying on the road.” He describes the scene:

That was the first time I’ve really seen a serious, serious fatality, and multiple kids and adults. Everyone asked me if I wanted to go to the PTSD meeting and I said ‘no I’m fine’ they asked again, and I said ‘no I’m fine’ and just I listen to my music and I went home, but I should’ve gone, but it’s all good.

Kevin. Kevin is the proud father of five year old twin little girls. He beams with pride as he shows a picture of them. Tall and large framed, this 34 year old has a sense of humor that appears as strong as he does. Yet, he offers the sense that as a paramedic, he would immediately put you at ease, making you feel well cared for. Kevin says his favorite thing about being a paramedic is that, “every person you come into contact with, you have the chance to make their life better and that’s what I mostly enjoy.” When asked what he least likes about the profession, he replies, “being gone so much from home is hell on my

family.” Paramedics in his county, like most, work twenty-four hour shifts. To make ends meet, most work two full-time jobs or take part-time shifts. Kevin chuckles, and relates, “my children learned their colors from the colors of ambulances I was on.”

As we talk about the challenges of practice, Kevin says he experiences particular stress surrounding resuscitation termination decisions. A paramedic for ten years, Kevin recalls that in his earliest years as a paramedic cardiac arrest patients were transported to the hospital where the doctor “called the code” or terminated resuscitation efforts. Current science has proven that EMS resuscitation measures are just as effective as those conducted in the emergency room and the minimized movement of patient enhances survival rates. Therefore, most EMS systems favor paramedics “working the code,” resuscitating, on scene and then terminating efforts if the patient does not respond. Paramedics are then faced with the disheartening task of informing the family of the patient’s death. Kevin recalls the first time he made this decision in field, many years ago, on a Christmas Eve night, “the hard adjustment was taking on the decision process knowing the finality of the decision, knowing that I walk into someone’s house and then I walk out and they are dead.” Kevin further suggests that he best deals with the “ethical burden” associated with the difficult decisions surrounding termination of efforts on the scene by knowing that he has consistently done all that he can.

The burden goes back to me knowing I have to do this because it is right for the patient and right for me as a coping mechanism taking the call that when I come back I will not be ‘what if-ing’ myself and beat myself up after the fact.

Kevin calls this his “100% Rule” suggesting that he takes comfort in knowing he has done all that he can for his patient.

Kevin says that pediatric calls are particularly challenging for him. “One of the worst calls of my career was a child that was ejected due to not being restrained. It was obvious that the child was dead and that there was nothing that could be done just by the presentation of the child. That call has haunted me for years and there is nothing that could have been done.” Kevin remembers another that he also describes as haunting. “We had a pre-hospital birth with a 21-22 week old child which was still born. It was a very taxing situation for all involved (family, crew, fire department) it was a terrible situation.” Kevin says that this call was particularly upsetting because:

Less than a year prior I lost my son at around the same age and the situation was very similar, so I was able to be really empathetic towards that family, towards the mother, father and I could relate to them in their situation of need and help them cope.

After a brief pause, Kevin offers summary, “critically ill children, it’s just because I have small children at home and thus it is difficult emotionally.”

As we conclude the interview, Kevin relates that the greatest transition in his thinking from a newly certified and inexperienced paramedic to his views over a decade later, are “going from the mentality that everything is black and white and cut and dry to saying that there is a whole lot of gray.” As if to have arrived at a new realization having spent the hour talking and reliving traumatic calls that required difficult decisions to be made, Kevin relates, “morals and ethics are what make you a pre-hospital provider because there is no one looking over your shoulder.”

Michelle. I met Michelle over a huge Dunkin Doughnuts box of doughnuts and a pot of coffee. This is a tough and energetic married, mother of three that immediately made me feel as though I should expect a fast paced, emotional interview. Michelle has been a paramedic for six years, although paramedic training is her second formal training program. Raised in the southwestern part of the United States by a single mother who was a trauma nurse and EMT, she went into the military after graduating from high school and trained as an engineer. Michelle continued this training as a civilian, but then decided she wanted to do something different. She considered nursing, but when she became pregnant with her third child, plans changed again. In 2006, with three children, Michelle decided to become a paramedic. Today, she says she most loves the camaraderie with patients and partners, but dislikes the politics associated with being a paramedic.

We move on in the interview to questions of patient care and Michelle tells me about a recent dilemma that redefined her thoughts about being a paramedic. Called to respond to a cardiac arrest late one evening, Michelle gets an update from the 9-1-1 dispatcher while enroute alerting her that the patient's family is frantically looking for the patient's "Do Not Resuscitate" or DNR orders. As Michelle and her partner approach the residence, she continues to learn the details of the precarious situation that she is about to face. The patient, an elderly woman with cancer, has been discharged to the care of Hospice. Before the Hospice nurse can arrive at the residence, two family members, a son and daughter, are attending the patient. While the patient peacefully dies, her son nervously calls 9-1-1 against the wishes of this mother and sister. Michelle makes the decision to assess the situation without including her partner and arriving rescue personnel. This is not an accepted practice.

With no legal DNR in place, Michelle enters the patient's bedroom to find that she has recently deceased. "I cannot explain that look on the daughters face when she asked not to torture her mother. I had never looked at my job as torture but there it was." Michelle faced a very difficult ethical dilemma about whether to go against protocol and honor the daughter's wishes. She is confronted by the patient's son, angry and threatening her job if she does not begin resuscitation. Michelle proceeds and tells the fire department to cancel their assistance and her partner to return to the ambulance.

All I could think of was my job and my credentials and I cancelled all response and I called in a DOA. I had a daughter stating that I will torture her mother if I try to resuscitate her. I kept thinking that if she was my mother what I would have done. Still remembering the faces that night as she retells the story, Michelle knows that her concept of being a paramedic was redefined that night with the word "torture." Jeopardizing her job in an effort to do what she believed to be ethically right for the patient and family, is something she still relives. She describes that moment by repeating the words that seem to haunt her, "Please do not torture my mother." Michelle pauses and then adds, "it changed my career, I was only five years in." Quiet again fills the room as Michelle refills her coffee cup and wipes tears away.

After a brief break, we talk about more patient encounters. One in particular becomes particularly emotional. Michelle is at her daughter's high school football game when a player goes down on the field. She runs toward the field and offers assistance. The patient is transported to the hospital in cardiac arrest and is later declared dead. When she returns to the high school and meets her daughter at the field, "and she asked if we can go see him and I

told her that he died, she did not speak to me for three days.” Michelle relates that her daughter looked at her as though everything should have been ok because you took care of him. “Knowing that my daughter looked at me as if I failed her and that boy and I remember feeling that same way when my mom was working.” Michelle refers to her own feelings growing up, idolizing her mother as an emergency services worker.

John. John chooses to meet in the training room of a local fire department. Our interview is a long one, full of stories of patients, bad calls, and hard decisions all told with an obvious passion for care. What strikes me most as John thoughtfully relates his memories is the deep love he has for emergency services and the belief that citizens, no matter who or why, they deserve our best. John is committed to openly discussing what it is like to make critical ethical decisions in EMS, and appears to feel a great deal of pride associated with the years of challenging calls.

John is a native of the town where he works as a shift paramedic for a county agency. He and his wife, daughters, and step daughter live near the area where he grew up. Like other participants, he feels a strong connection to his community and this connection is evident as he describes his experiences as a paramedic. While he feels protective of the citizens that he serves, he also appears to feel accountable to them. John describes situations where he has been on a call and the loved one of a family that he knew personally died, stating it “creates a big lump in the back of my throat. They put confidence in you to save their family member and you have to tell that there is nothing that can be done. It is hard.” John describes a morning at the church he had attended all of his life, when he learned that the unrecognized dead patient from the night before was his best friend in high school. “I

had to black tag my buddy, the one that was the playground bully in third grade but somehow I managed to become best friends with him until he dropped out of high school.” He recalls that when he had arrived on the scene of high speed motor vehicle collision with two vehicles and three patients. As the first paramedic on the scene, he was directed to assess the victims for priority of care, a concept called triage. The first two were critical, and as he approached the third victim, a front seat passenger of a vehicle with so much damage that he could only access that patient from the rear seat, he felt no carotid pulse. Following triage protocol for a pulseless trauma patient with two others demanding resources, he determined the victim dead, or “black tagged” and moved on to treat the other two. The realization that the dead accident victim had been his friend left John to reconsider:

I wonder if I had known it was him would I have put effort into saving him and would that have affected the efforts with the other two patients. When you look back on your years of experience you knew he was dead on impact and that you would have used valuable time and resources that were in turn used to save the other two patients life.

John has served in various aspects of both EMS and firefighting for 26 years, both paid and as volunteer. He has supervised a large municipal EMS department and teaches part-time. When asked specifically about what he most likes about paramedic practice, he replies “the feeling that I am making a difference as an individual.” He states that his understanding and care of patients has changed with experience, “confidence has been the thing that has changed the most and is the complete pathway that makes me feel better about how I handle the situation.” John relates confidence to time in reflection of patient

experiences, but moreover, a passion for the patient. He states “it’s not about the glory.” John relates his passion for caring to combination of what he has learned in the field and the “morals he was raised up with.” This passion and experience are evident in the gravity of expression as John relates the stories of patient care in his community. “You see faces and you can remember the moment and the expressions and remember their cries and screams.”

As we end the interview with a final question “Would you like to add anything?”

After a long pause, John replies:

I have had quite a career. You spend enough time in this field you have a lot of stories and if I had put it all in a journal what I have done on the job for all these years there would be so much to read and more to learn. It would show the true life of a paramedic and the lives that you save and it has never been chronicled successfully before, and needs to be. I think people would be surprised by what they would read and what we do on a call.

Meagan. I traveled to the Eastern side of North Carolina to meet with Meagan in a reserved room at the community college where she works part-time teaching CPR. Meagan is a fifty-one year old mother of three, and grandmother of two. As she describes her journey to becoming a paramedic, her respect for the profession is evident. She explains that she went through a community college based program first, but didn’t complete it. She finally gained the courage to try again and successfully certified as a paramedic five years ago.

Meagan describes her feelings of trepidation.

I literally cried when I got the certificate in the mail and it said I passed, I cried, I said

I cannot understand how I could have passed it. I just felt so insecure about what I

knew and even with this time around taking the medic class you know you are always going to have some insecurity.

As we talk about her motivation to become a paramedic, Meagan relates that her desire to help others began at an early age.

My daddy would chase the ambulances just to see where they were going and he would have all of us with him and so we would get there and it's not the lights that fascinated me it was the fact that these people that didn't have any clue who these people were out there helping them and I thought I would like to do that.

Still the focus of her practice, Meagan believes that she offers the best care to patients that she can.

I was always taught to treat people the way I wanted to be treated, so when I go in to take care of somebody, I always try to look at them and try to think about how would I want myself or my family done if I was in that situation.

As Meagan recalls difficult experiences through the last five years, it is evident that patient care philosophy is extended into each challenging decision.

There were like times when I was working a code or something like that, looking at the medical history, and I would ask myself 'would I want someone to resuscitate me with this type of medical history?' and 'what kind of life would they have if they are resuscitated?'

With each account of patient care experiences, Meagan relates compassion, primarily in her recollection. Stories seem to stand out in her mind, not necessarily for the challenge they presented, but for the concern and interaction with someone in need. She recalls a night

when her crew was called to a man having a heart attack. The patient was critical and Meagan drove the ambulance as they transported that patient to the nearest hospital. She recalls hearing the paramedic attending the patient ask if there was anything else that she could do and “the patient replied with ‘will you just hold my hands’, so the medic held his hand.” Meagan relates her emotions, watching in the rearview mirror and listening as she heard the patient request that the paramedic “tell my wife I love her with all my heart.” Meagan followed the patient progress through emergency surgery and visited him in the Intensive Care Unit to share with him her delight that he would be okay and reunited with his wife.

As we conclude the interview, Meagan summarizes her experience as a paramedic, “I have had some of the worst calls you could ever ask for as a medic.” She goes on to say that in the years of experience she has gained the confidence she lacked when first certified, “some things I seem to be more at ease with, you can pick up on things that are wrong quicker, thus the experience has made the decisions easier.”

Amanda. Amanda is a fifty-three year old woman that had been a licensed practical nurse for twenty years when she “decided to go back to school when I came here and I got an associate’s degree in EMS,” finishing in 2005. When asked about the motivation for such a decision so late in her career as a nurse, she relates. “You always had to ask a doctor’s permission to give what the patient needed. It was frustrating knowing what you needed to do to help that patient.” She adds “sometimes, depending upon what was going on, the patient needed it immediately with no time to sit there and wait for a doctor to call you back depending upon what mood they were in.” Amanda says she most enjoys helping people, as a nurse and as a paramedic, but prefers the freedom of decision-making as a paramedic. “If I

had known about this sooner I would probably have taken this venue first.” This mother of four grown children, two girls and two boys, believes the most important qualities to being a good paramedic are “compassion and honesty, and honesty should be number one.”

As Amanda and I talk, it becomes apparent that the calls she struggles most with, are those involving incompetence or dishonesty among EMS providers. Describing a recent cardiac arrest call that she was called to respond for paramedic support, Amanda relates that the 9-1-1 dispatch reported the patient’s address in the wrong county, adding ten minutes to the response. When Amanda arrived on scene, the family was angered that the patient was receiving CPR in bed, with no oxygen or defibrillation. Amanda attempted resuscitation, but to no avail due to the extended “down time.” Amanda describes her interaction with the family as “extremely hostile, which I don’t blame them. They are threatening legal action which I don’t blame them.” On another recent call, Amanda describes assisting a paramedic to move a man from his bathroom where he had fallen and badly broken both bones of the lower leg. Amanda states that the man had lost a great deal of blood and was in shock, and yet the paramedic falsified documents suggesting that there was minimal blood loss and that the patient had stable vital signs to cover his own incompetent patient care and decision-making. With a chuckle of irony, Amanda refers to the topic of our interview, navigating ethical situations, and states, “I think it was funny that it was ethics, because we were just talking about that with a patient.”

Amanda relates that she struggles with calls that involve children, “I have a hard time with kids. I like kids. I have a lot of kids. I have 7 grandchildren and another one coming. But I have hard time with kids.” She continues, “I get frustrated with drug abusers and the

alcoholics. I get very frustrated with that, but I have that in my family so I get very frustrated with that because that is the choice that they make.” Offering an example, Amanda relates:

The other day I had a patient who had taken too much Xanax and passed out in the back yard, face down in the dirt and her husband just left her out there for three hours.

It was the neighbor that called 9-1-1.

Amanda shakes her head as though in disbelief. It was hotter than the outer rings of hell out there and the husband had covered her up with a blanket, and I say to myself, ‘really? You are such a nice guy.’ She then adds, “sometimes it is hard to bite your tongue.”

Amanda states that the most difficult part of her job is “the families, having to tell the families. That is the hardest part and I don’t think that will ever get easy.” Recalling an experience where she had arrived on the scene of a man critically ill and unresponsive. “He was under hospice care and had a Do Not Resuscitate order. There was nothing that I could do for him. You really wouldn’t want that kind of thing. He did not want that.” Amanda continues, “the man’s wife was so distraught and upset,” that she called 9-1-1 for help, when we arrived, “she was telling the family on the phone that we wouldn’t do anything for him.” Amanda states that she waited until the woman calmed down to explain to her that “there was nothing that we could do for him because his heart stopped working.” She adds that while dealing with families is hard, she is also saddened by patients that die alone. “You get called for a recovery kind of thing and they have been dead for several days and nobody knew, and that is sad. Nobody should die alone I don’t think.” She grows quiet and draws a deep sigh.

As we close the interview, I ask if there are any final thoughts. Amanda smiles and nods. “You have to find what works best for you in the back of that truck. You have to find your own rhythm, because what works for someone else may not work for you.”

Scott. Scott was one of the first paramedics to serve the small town where he continues to work. In 2001, a small group of firefighters attended the first paramedic program offered at the local community college. The small group then approached the town saying “we are all going to go get this schooling and we will all get certified in this state and we would kind of like you to support us and purchase the rest of the equipment.” When asked why he wanted to be a part of the group that approached the town officials, Scott replies, “the ability to help people. I learned a long time ago that I don’t have to stick needles in and I don’t have to give medicine to help people, sometimes all you got to do is hold a hand, for some of them that is all they need.” Scott has now been working with the town as both firefighter and paramedic, for twenty-three years. Prior to his firefighting career he worked for a center for “the mentally retarded and physically handicapped.” Scott believes this experience has helped him work with people as a paramedic.

Scott believes that his patients deserve a quality of life that is compromised by aging, diseases such as Alzheimer’s, and nursing home residence. As he shares some strong opinions on the topic, it is evident that the years of resuscitating patients in cases of advanced age, advanced illness, and long term nursing home residence, have affected his perceptions of such situations. Scott states:

If you are going into a nursing home to stay, not to rehabilitate, but because this is where life has taken you, I think there should be a Do Not Resuscitate Order. I think

it should be part of the entry paperwork, if there is not a possibility of you getting out of this location... is that really a life?

Scott goes on to say that the trend toward not resuscitating terminal patients or terminating efforts in the field have improved paramedic care. He recalls a recent 9-1-1 call for a woman in cardiac arrest. When they arrived, the husband stated that his wife had terminal cancer and did not wish to be resuscitated. The elderly gentleman had Alzheimer's and could not remember where the safe was that contained the DNR order. Ordinarily, this situation would require the paramedic to begin efforts to resuscitate. Scott called the Emergency Room physician and explained the situation, requesting permission to allow the woman to die peacefully. Scott states, "By our protocol they should have, beyond a shadow of a doubt, done CPR. But... right, wrong, or indifferent, I will stop for a second and say 'if that was my mom or my dad what would I want?'" On a similar call, Scott relates his frustration with caring for an elderly patient with multiple terminal diseases and no Do Not Resuscitate order. Scott believes families should be responsible to take care of the paperwork to avoid such situations, saying "I hate it. I hate it for them and I hate it for the family but, then I get pissed because people are just being really selfish. Usually you find out that people don't come to visit." Adding, "I don't know if it is them not taking care of the paperwork, I don't know if they get subsidy checks, I have never asked, but I think some people just aren't willing to let go."

Scott believes in treating patients with respect. He says that it angers him when he sees EMS crew talk down to patients. He recalls a patient that was morbidly obese that wanted to go to that hospital:

Went to pick her up and the first thing she said to me ‘you’re not going to cuss me,’ I was appalled. I looked at her and I said why? What would give me the right to cuss at you for calling for help?

Scott relates that on the way to the hospital, the patient told him about prior interactions with EMS and fire-rescue personnel that were mean to her. “She said that they cuss me every single time they come in to pick me up.” Scott states, “I think that for whoever was picking her up there was a lack of empathy, somewhere along the way they forgot that is a human laying there.” Scott takes pride in being kind to his patients and treating them as he would like to be treated.

Edwin. Edwin is a tall, large framed man with a jovial laugh. As I begin the interview with opening questions about his career choice, he smiles and with an animated chuckle replies, “I wanted to become a paramedic ever since I saw Johnny and Roy roll out of station 51. I am old school, I saw it, I loved it, it is the only thing I ever really wanted to do.” Referring to the popular TV show of the 1970’s that depicted the early days of the paramedic profession. He smiles and adds, “Didn’t that make everyone want to be a paramedic?” Opting to turn away from a scholarship to study business, Edwin began his career in EMS with an EMT Basic course followed by four years of volunteer work. By 1993 he had earned his Paramedic certification. Edwin adds:

I love what I do, I enjoy where I live. I haven’t worked in a long time because I love what I do I think that is probably one of the best things I had learned is early on in life is that when you enjoy what you do, you don’t work you have a career.

Not surprising, Edwin believes that the most important quality of a good paramedic is “the ability to relate to people. You have to be able to relate no matter what.” Relating to people through the EMS profession can be both positive and negative as paramedics experience the joy of saving lives as well as the frustrations associated with loss. When asked about a dilemma he faced, Edwin recalls:

The very first call I ever ran as a paramedic was a shaken baby. I mean the ink on the card is still wet. I got the card (Paramedic certification) in the mail on Tuesday, and my shift is Wednesday. I showed up for work and just after breakfast we get a call to a less than one year old infant having seizures.

Edwin describes the moments that followed a crying mother handing him her infant, explaining the baby had fallen off the couch. “I laid him on my stretcher and we cut away his little ‘onesie’ and you could see the two thumbprints on his front, and we rolled him and you could see the fingerprints on his back.” At the hospital, tests confirmed the worst, the baby had severe brain damage. Edwin relates that as he sat in a room nearby to write his report, the mother is overheard talking with police and confessing that the baby had been shaken by his father. Edwin now intently looks at the floor between his feet as he continues his story:

So I am sitting there writing my report up and you know I am six foot two and at the time I was about 402 pounds, watching this 108 pound greasy haired moron come in all concerned about his baby that he shook, crying.

After a brief glance upward:

My dilemma was that I was coming out of that room and I was going to show him what it was like when somebody four to five times your size commences to shaking you, and it took my partner, the other crew, a police officer and a nurse sitting on my chest to pin me down.

In subsequent years Edwin and his crew would return to the residence of the infant, who persisted in a vegetative state. Edwin remembers that day with a chuckle and says, “I had forgotten that vengeance is mine sayeth the Lord, and I thought ‘Oh No God! I got this one for you. Let me hook him up.’”

Collective Overview

The participants in this study all met the general criteria for selection that included being a NC educated paramedic with five years of EMS experience. The most critical element of the criteria was that each participant has had practical experience in the setting of Emergency Medical Services. While all participants have worked as Paramedics in a municipal Emergency Medical Services (9-1-1) system, the vast majority have also worked in related positions such as instructor, supervisor, dispatcher and critical care paramedic. All of the participants in this study expressed that they have wrestled with ethical situations related to patient care. While the depth of these experiences may be quite different, each participant was able to share the circumstances that were important to them. It should be noted that throughout the presentation of participant responses and the respective explanation, several terms are used that express the components of emergency services. The term “emergency services” for the purpose of this document refers to the coordinated response of police, fire department, and EMS. While each profession brings a different

expertise to the emergency situation, all three may be utilized on the same situation, interacting as necessary and coordinated through a 9-1-1 dispatch center. All three are coordinated on scenes through the same incident command systems. Paramedics that function in EMS are the specific focus of this study. However, it is important to establish the relationship between other areas of emergency services, as they are referenced in participant response.

Open-Coding Findings

This section presents the key findings from the experiences and understandings of paramedics as they encounter ethical situations and decision-making in the practice of EMS. Data analysis was achieved using two primary coding approaches, open-coding and framework coding. General themes with subsequent subthemes associated with open-coding thematic analysis are outlined in the following table:

Table 1- Themes and Subthemes

- I.** Paramedic Ethical Values
 - A. Morals
 - i. Unethical Practice
 - B. Religious beliefs
 - C. Prayer in Practice
 - i. Prayers for Assistance
 - ii. Prayers for Guidance
 - iii. Prayers for the Patient

- II.** Accountability
 - A. Differences in Concept
 - B. Professional Accountability
 - i. Medical Director
 - ii. Supervisor
 - iii. Partner
 - iv. Patient
 - C. Personal Accountability
 - i. Myself
 - ii. Family
 - iii. God
 - D. Autonomy

- III.** Professional Identity
 - A. More pay/More respect for the profession
 - i. Politics of EMS
 - B. Embarrassment
 - C. Hero and the Hand-holder
 - D. Bad Outcomes
 - i. Torture
 - ii. Paramedic Assisted Death

- IV.** Decision Stress
 - A. Cumulative Stress
 - B. Community
 - i. Knowing the patient
 - ii. Reminders
 - C. Regrets
 - D. Resuscitation
 - i. Termination
 - ii. Show Codes
 - E. Tunnel Vision

Paramedic ethical values. The theme presented is described as Paramedic Ethical Values and includes subthemes: 1) Morals, 2) Religious Beliefs, and 3) Prayer in Practice. Paramedics function in a closely guarded community where the telling of war stories and sharing of difficult calls builds respect and camaraderie. Trust is important within the community and outsiders don't enter in until they have proven themselves to be competent in patient care, often through stories of their own, and also able to guard the stories of others. The paramedics interviewed represent a common ideal within the profession. They entered the profession to save lives and are seen as heroes within their communities. Yet, all that want to don the uniform and enter into this community of practitioners seek to guard the image of one that would sacrifice to save others. It appeared through my interviews that these men and women desperately love to save lives and be counted on as the community heroes, and yet they seemed to wish someone would really understand the weight of the job without disparaging the nobility of the profession. The influence of such service over the years of practice is evident in the responses that follow. As a researcher that has served many years as a practicing paramedic, I felt this burden as well, to be trusted with the "story" and to bring it to those outside of the EMS community, meant that the privilege was offered in the spirit of helping the profession. Many spoke of helping the next generation of paramedics through participation in research and telling "the story." It is as though an unspoken label accompanies those in the field, that "this one gets it". This paramedic researcher understands both the horrors and the joy of the job. This paramedic researcher understands the anxiety of deciding life and death dilemmas at 2:00 am. This paramedic has seen the very heroic side of the EMS profession and the less than heroic side perhaps

associated with poor ethical decisions, and knows how to adhere to the accepted code of “what happens in EMS, stays in EMS” for the good of the public that depends on the service. How much of the story gets told? Paramedics want to be heroes, and yet we are human. Some calls seem all but heroic and they call into question your own belief systems, morals, and self-confidence.

Just as trust and respect within the profession are an earned privilege, the loss of confidence and trust among the EMS community is long lived and accompanied by a great deal of humiliation. Paramedics who are associated with inferior care, poor ethical decisions, or who disparage the “uniform” within the EMS community or hospital staff and physicians, feel embarrassment and scorn from peers. Performance in the field of EMS is widely known through word of mouth, and yet is a tightly guarded secret within the profession. Paramedics that call the hospital for assistance or to alert the staff of an impending patient do so over the radio that is heard by peers across the county. Brian uses a term common to his local EMS community that is used to describe someone uncertain of his next steps in a critical decision process, “I was very confused and I did not know what to do, as they say, us medical folks, I was spinning.” The perception that a paramedic “spun” and wasn’t able to handle the call in a calm manner, or didn’t deliver effective care, travels quickly through the EMS community. Information about ethical practice for this first theme was derived through analysis of the data. In this case, paramedics were not asked for feelings of belief or perception of ethical behavior. Participant responses associated with the first theme were excerpts from perceptions as paramedics told stories of their practice. The three subthemes

associated with the general theme of Paramedic Ethical Values: 1) Morals, 2) Religious Beliefs, and 3) Prayer in Practice are presented in subsequent sections.

Morals. Each of the participants shared stories of how their personal experiences as paramedics making difficult ethical decisions were related to their own moral foundation. Laura suggests that providing ethical care is related to respect. Stating that to “have respect for their (patient) dignity and the general public is a difficult thing in today’s society. People have a hard enough time respecting themselves, let alone someone else.” As John describes how and why he made difficult ethical decisions in practice he stated, “all of mine always fell back on the morals and everything that I was brought up on and raised by and the type of person I am.” Kevin suggests that “you take on so many more roles than just paramedic. You are a spiritual leader, patient advocate, and counselor for the family.” These participants identify not just with the need for moral behavior to perform ethical paramedic care, but also with the many aspects of being a caregiver.” Just as paramedics often equate the quality of their ethical decision-making to the quality of their own personal morals, they also associate the poor ethical decisions or poor patient care with a lack of personal morals. For example, participants voiced a connection between unethical behaviors, such as falsifying a document to protect themselves, with a lack of moral teaching in upbringing. These participant responses are presented in the subsequent section to offer deeper description within the subtheme of morals.

Unethical practice. Several participants drew the conclusion that substandard paramedic patient care or unethical decisions are related to personal morals. Amanda states that “when you look at morals and ethics, I am still continually surprised by people’s

dishonesty.” At the time of this interview, Amanda had been asked to write a statement for an investigation into allegations that paramedic co-workers had lied in a patient care report to cover poor patient care. Amanda describes the situation in which a patient received poor patient care and the crew lied to cover it up. It has “to do with their personality traits more than anything.” She further relates that she was brought up by strict parent that taught her “you tell the truth. You tell the truth and you won’t get in as much trouble for telling a lie.” Edwin also notes that paramedics should have high ethical standards, and any compromise suggests that there is an inability to behave ethically or be trusted. He also relates the story of a paramedic that falsified a patient care report and states that “if you will lie on a patient care report then you will steal a patient’s money, you will steal from me, you will lie about narcotics administration.”

Data also suggest that not all unethical decisions are viewed in the same way by peer paramedics, supervisors, or supervising medical directors. Unethical decisions, those made against the standard of expected behavior and perceived as detrimental to the patient or profession, are viewed differently than those in which the paramedic has “crossed the ethical line” in order to save the patient’s life. The latter of these was commonly referenced when a paramedic had defied an order or failed to ask for permission in the interest of time and offering critical patient care. Examples of situations of unethical decisions perceived as necessary to save a patient are presented in the framework coding section, whereas the findings associated a moral relationship to poor judgment are presented here.

Religious beliefs. The second subtheme within the general theme “paramedic ethical values” is religious beliefs. Most of the paramedic participants described their profession as

far more than a vocation, but as a calling. Many relate to their faith in higher power when they describe their service to the community through EMS. Many also rely on their belief system in times of struggle associated with the burden of making critical decisions.

Ten of the thirteen participants openly associated an active connection between their decision-making practices and a belief in a higher power. Religious belief is the second subtheme noted among participants. Reference to religious beliefs related to two categories: 1) paramedics referred to their profession as a calling from God, and often associated care given as being God's work, and 2) paramedic's often reference God as a higher power responsible for patient outcomes.

Some of the participants attributed their profession as a calling, ordained by the higher power they believe in. As Ben states "I really feel like I am doing what God wants me to do." Laura has a similar view.

Being a paramedic is my calling, I feel like it is what God put me here to do, it took time to get to it, but that is what I am here for and I will do it as long as He (God) will let me.

John believes that his ability to perform as a paramedic is a talent ordained by a higher power, "believing in a higher power, that there is something there and why we are here... to serve that purpose of why he has given these gifts and talents." Yet another participant seems to feel that as a paramedic, her connection to higher power is served not only by life-saving skills, but through her ability to comfort the dying patient and their families. Meagan associates her practice as a paramedic with the opportunity to assist those at the end of their life. "If I could help somebody on their death bed or something that I could do to comfort

them, like maybe even leading them to the Lord, that's what I wanted to do.” Of similar note, Laura states, “being a paramedic is my calling, I feel like that is what God put me here to do. It took time to get to it, but that is what I am here for and I will do it as long as he will let me.” With a chuckle she adds, “I will be with my cane and walker saying ‘let’s get in the truck.’” While belief in a higher power is associated with the calling to paramedic practice, the association of assistance from that higher power is also a strong theme in participants.

Beyond belief in a higher power, some participants described active prayer in some aspect of their professional practice. Prayer in Practice is the final subtheme presented in the theme “paramedic ethical values.”

Prayer in practice. The third and final subtheme presented in “religious beliefs” is prayers in practice. Several participants referenced feeling as though their belief in a higher power served to guide them in challenging ethical situations, while others seemed to reference the higher power belief as a guiding or protective force. For example, Ben states, “I know that when I do have issues, that God is there for me.” Some participants voiced using their beliefs to offer assurance to patients or their families. Meagan remembers trying to comfort a family who had just lost their daughter in a motor vehicle accident by telling them, “this little girl was active in church and she lived a good life and so they knew where she was going to be.” Within the subtheme “prayer in practice” there are three concepts presented separately in the subsequent sections.

Prayers for assistance. Participants that discussed prayer in relationship to help in decision-making varied in their timing. For example, Michael states, “On any call I go on when I get the dispatch to a call, this is just me, first thing I do is pray”. Michael states that

he has a customary practice of asking, “God guide me to see the thing that I need to see and treat the thing I need to treat. Bring back my memory, anything that I need to know so that I can see it,” before each call. Michael states that at times he further engages in prayer during patient care, “I did the same with the patient, same prayer. God guide me. Guide my hands, guide my mouth to do and say the things I am supposed to do.” James also remembers a time when he prayed for help during a call. He was called to assist a rescue crew in a rural community. In this case, the crew was only able to function at an EMT-Intermediate level of care. This is a common practice in rural settings, used to spare paramedic resources. Ambulances may be stationed in rural areas with paid or volunteer crews that respond to calls and then request paramedic response as needed. This is usually accomplished by offering the paramedic as a resource using a QRV (quick response vehicle) which carries the additional equipment the paramedic would need. Paramedics that are dispatched to meet Intermediate or Basic crews may do so from a greater distance, often centrally located in the town or city. James describes the call. “The ambulance had arrived at the farm of a family they had known for many years to find a young boy in cardiac arrest for a crushing injury to his chest.” The crew had moved the patient to the ambulance and initiated patient care while awaiting the James to arrive on scene. When James arrived at the farm, he opened the back door of the ambulance to find the crew with “tears running down their faces because it was somebody that they knew.” Recalling that day, “it didn’t stop them from doing what they needed to do.” Remembering that the crew kept talking to the victim, encouraging him to wake up, and “I knew looking at the situation that the patient was not waking up.” James goes on to describe his desperate attempts to save the child, “I intubated the child (an

advanced airway used to ventilate) and I opened the blue box (drug box) and was hoping there was something I could give to the child, but there was nothing I could do.” While frantically caring for the young boy, James states, “I remember praying to God to give me something to give these people hope, and the kid a chance.” This statement supports the theme “prayer in practice” in the most trying to circumstance. After a quiet pause, James reveals the ending to his patient encounter. “I remember when they declared him dead at the hospital you could hear the mother screaming when they told her.”

Recalling that another participant referenced having to work on a family member that was fatally injured, the responding crew in this situation also faced an ethical dilemma in that they knew the patient, though not directly related. EMS crews may not have the luxury of calling for additional resources when they face knowing the patient. The stress associated with knowing your patient will be more thoroughly addressed in a subsequent theme. While the term “guide” is common to both subthemes, “prayers for guidance” differs from this subtheme, “prayers for assistance” in that participants are not actively seeking assistance with a situation, but rather attribute a higher power or “guiding” force to positive outcome. Some considered this to be a positive outcome for the patient, while others expressed the feeling that a higher power had looked out for them and helped them to avoid errors in judgment.

Prayers for guidance. This subtheme closely aligns with the previous in that paramedics associate ethical patient care with religious belief. This subtheme specifically deals with reference to guidance in handling critical situations, and for assurance and patient’s well-being. Some of the participants reference belief in a higher power as a guide,

or guardian. Without directly stating they have requested such intervention, it appears that they believe positive outcomes in critical or challenging situations to be attributed to such oversight by a higher power. As Brian describes, “I do the best I can. I just turn to the man above and say lead me in the right way.” Recalling a patient that he met in a downtown park, living homeless and known as a frequent patient to EMS, Brian recalls that he began to talk with him as he always had. The man rarely wanted to be transported to the hospital, and following a brief assessment of his status, was often allowed to remain on his favorite park bench. As Brian relates the story of treating this inter-city homeless man, he states, “maybe it was the man on my shoulder saying ‘let’s do something different’.” While the man didn’t want care, Brian convinced him to allow his vital signs to be taken. Brian had almost allowed the man to refuse his care and when he touched the man’s hands, they were “ice cold”. When Brian put the patient on the cardiac monitor, he found him to have a deadly arrhythmia and a heart rate of 260. Brian again smiles as he restates, “was the man on my shoulder,” in reference to a higher power guiding him to look further until he found a life threatening condition, nearly missed. “Tunnel vision” is presented as a theme later in this chapter and is described as making assumptions about your patient due to prior experiences, demographics or cultural disparities, or mitigating factors such as alcohol. While it is a normal occurrence to develop opinions about a situation based on prior experiences, paramedics consider tunnel vision a fatal mistake. It is potentially fatal to the patient and to the paramedic’s career. In this statement Brian references his higher power looking out for him so that he did not make assumptions that accompany the typical drunk homeless presentation and lose sight of the patient’s serious condition.

Laura discusses a dilemma she has faced more than once, trying to decide whether or not to follow protocol, even if she didn't believe it was best for the patient. As she describes these situations, she states, "so far they have worked in my favor, I guess God is watching out for me." Laura believes that these difficult moments she has had to make have had positive outcomes because through her belief in a higher power, she has been guided. Laura references a particular call when she feared the patient was not stable enough to make it to the "stroke center," a specialty care center for cerebrovascular emergencies that was an hour away. Rather, Laura went against protocol to transport to the local hospital. In a story that aligns with several themes, Laura states "my patient showed signs of a stroke, but she was not stable." While she considered a negative reaction from the medical director due to her disregard for protocol to transport to the stroke center, Laura opts to take the patient to the nearest hospital. She later called the medical director to discuss the call with him and she reports "he assured me that he had the utmost confidence in me." Again, relating positive outcomes to a divine intervention, Laura states "I would be blessed if I made that decision again and it turned out to be the right one again," As she continues to relate this story of the stroke patient, it is evident that there are concerns beyond the patient's stability at play in her decision. Laura states:

I want my patient stable before I make a run at 80 miles an hour towards a hospital and have to pull over in a code (cardiac arrest), I have lost one partner and I will have not have that happen again.

In this statement, Laura references the day that her partner was killed in a traffic accident when they pulled over to the side of the road to assist with an accident on a busy highway.

Laura was attending a patient in the back of the ambulance when her partner exited the ambulance and was subsequently hit by a truck unable to brake in time. The impact of this story is noted throughout the interview with Laura. It aligns with data that will be presented in subsequent themes, such as accountability and regrets.

Prayers for the patient. Participants that referenced prayer for patient well-being expressed this interaction as both prayer they have engaged in with the patient, and encouraging the patient to pray for themselves. As John reflects over his years of patient encounters, he relates, “I have had plenty of patients that I could have just about sit there and cried with them, and I have prayed with them.”

Rick describes a call where he tells a critical patient “I will do all I can for you but, I suggest that if you believe in a higher power, turn to that higher power, because you need all the help you can get.” As this story unfolds it is obvious that this patient has touched his life as much as he has touched the patient. Called to care for a man burned over 90% of his body surface area having climbed out of a vehicle with his clothing and hair on fire, Rick describes his frantic attempts to care for the man as they prepare to fly him to the burn center. Rick had previously believed the man had little chance to survive. Rick recounts his amazement that nine months later the man returns to the EMS station, while he is on duty, to thank him. The man speaks of many months of difficult treatments during his lengthy hospital stay. He recalls hearing Rick while in the ambulance afraid for his life and relates that as a result of this life altering experience, “he says ‘every day I witness to God and how he affected me and how you helped me.’” Rick struggles to speak with tears in his eyes as he states, “we never know that impact we have on people’s lives.” Rick refers to his suggestion of prayer

as the man began to lose consciousness in a fight for his life as being a transformational moment for the patient.

While some common themes were noted among the participants as they relate to their beliefs about morals and religion, other profound stories suggest the connection between beliefs in a higher power, and yet are best coded in the general theme of “Ethical Values.”

Meagan states that the thing that helps her most in navigating difficult situations “mainly with me it has to be my Christian background, the way I was raised. Wanting to do what was best for people because I was taught to treat people that way I wanted to be treated.” While Meagan seems to find a simple comfort in that belief, Michelle’s interaction with her faith and patient care is complex at times.

Michelle recalls a critically ill patient that she encountered on Christmas. The patient was terminally ill with cancer and her fifteen year old son had called 9-1-1. As Michelle and her crew attempt to resuscitate the woman in cardiac arrest in another room, she visualizes the woman’s son waiting patiently beside the lit Christmas tree. Confronting her own faith as she enters the living room to tell the woman’s son that they were doing all they good do, and his mother was not responding to treatment, Michelle states “I have a problem being bold with the Lord because I think of the positions he has put me in and I don’t think it’s funny, but here this kid sits in front of the Christmas tree.” Michelle further describes the scene with choked emotion as she states, “I kneel down in front of this kid and I am about to tell him that I have done everything I can and it didn’t work, your Mom is dead.” Now in tears, Michelle explains that as a paramedic, “we are told not to candy coat it, you don’t say they have passed on, you don’t say that we have lost them, you say ‘I am sorry, but your mother is

dead.” She pauses to add, “It’s Christmas, and it’s not fair.” As she begins to talk with the teenager, she is surprised at his maturity and composure. Just as she is about to tell the boy that they are about to stop CPR and ask if any arrangements had been made, she is summoned to the patient’s room. While the woman remained critically ill, she had been resuscitated and was no longer in cardiac arrest. As they prepare to transport the woman to the hospital, she returns to the chair beside the Christmas tree to update the woman’s son. She recalls, “I had just went and told that kid that I couldn’t do anything else for her and his response was ‘that is because you didn’t do it, you did your job and God did the rest.’” As though she struggles with her own faith, the young boys’ faith and her role in this patient’s care, she implores, “but am I supposed to play God? He was right. That’s the time that you realize that no matter what you do, it’s not up to you.” Later at the hospital, she found the young man sitting in a special waiting room designed for families of critical patients. Again, she is surprised by his calm faith in a tragic situation, “I tell him his momma is still living and that we had done all we could do and just as I am about to say ‘it’s in God’s hands now’, he looks at me says ‘it’s in God’s hands now.’” Shaking her head, she states, “It’s not the lesson I felt like learning.” The mother was taken to the intensive care unit where she died the next day. Michelle concludes, “they had enough time for the family and everyone to come say goodbye.” Michelle acknowledges a sense of peace from knowing that EMS had done all it could and that the patient’s son accepted the outcome with reference to his own faith. The interaction between faith, patient’s family members, and partners is noted again in the accountability theme. The value of such relationships seems to underscore the priority in which paramedic relate their accountability in practice.

Accountability. The second of four themes presented is that of accountability. These data findings differ from the former theme in that participants were asked a direct question, “Who are you accountable to?” Framed as an open-ended question, “who are you accountable to as a paramedic” participants were given the opportunity to consider and offer their own views of accountability. Chapleau, Burba, Pons, and Page (2012) seem to simplify the ability to function as ethically accountable paramedics, by further stating, “by always doing what is in the best interest of your patient, you will fulfill your duty to be accountable to every patient you encounter” (p. 54). The findings of this study suggest that the converse is often true, that paramedics who consider what they believe to be in the best interest of the patient often find themselves in a “gray area” or in defiance to the Medical Director and protocols. While many participants identified with the concept of accountability to your profession, the defining characteristics of the profession varied. Nine of the thirteen participants identified a sense of accountability to themselves or families. While no inclusion of self, or family exists in standard curriculum and text, it is noteworthy that the majority held themselves accountable, and often prioritized self-accountability as the primary. Finally, paramedics frequently referenced the burden of autonomy associated with paramedic ethical decision-making. Not only did they describe being accountable, but they further associated any breach of accountability with a personal responsibility. There are three subthemes related to paramedics’ perceptions of accountability that emerged from the data and include: 1) differences in concept, 2) professional, 3) personal, and 4) accountability as it relates to autonomy.

Differences in concept. The first subtheme in accountability demonstrates with wide variation in participants responses, despite similar training. Participants for this research were selected with one of the inclusion criteria being completion of a North Carolina Office of EMS Advanced Teaching Institution. This commonality in training offers means to compare participant response to a standardized curriculum. In the responses associated with participant perception of accountability, it is noted that participants differed considerably in both concept and how they prioritized elements of accountability, despite similar training. Chapleau et al. (2012) describe the concept of accountability in the most recent edition of a paramedic textbook by stating, “Paramedics are ethically accountable to the public, their patients, Medical Director, and EMS system” (p. 54). While most participants included the aforementioned elements in their responses, inclusion of self, family, religion, and partner were included. Some participants deliberated the order of their response and some offered commentary on how they came to choose the assignment of priority in their responses. Elements of accountability are further presented in the second and third subthemes, professional and personal accountability. Finally, the fourth concept of accountability, autonomy in practice, underscores the importance of understanding the process and critical nature of ethical decision-making. Autonomy is presented as the fourth and final subtheme of accountability, as participants discuss the gravity of making difficult decisions with sole responsibility.

Professional accountability. Professional accountability is described in the following sections to clarify the order and importance participants used to describe the following dominant themes: Medical Director, Supervisor, Partner, and Patient.

Medical Director. The physician medical director is a required component of the EMS system, providing oversight and defining standing orders for paramedics that function as an extension of the physician license. While the medical director may or may not chose a management role within the system, his authority over patient care and the paramedics that provide such care supersedes all other. It is through medical direction and limited to medical direction approval that certified paramedics are allowed to practice. For this reason, it is not surprising that many of the participants relate accountability to their medical director as a primary influence. Rick notes, “I am accountable to the medical director whose license I function under, if he would be pleased with the decisions I make, then I am making the right one.” Meagan responds, first I am accountable to the patient and their family, and then I would say the medical director since it is that person’s license I am practicing under.” While medical direction is referred to as an earned right that paramedics often express a need to protect their continued right to practice under a given medical director’s license, Scott also notes the “I would like to think I do the right things if for nothing else to protect him.” With this statement, Scott seems to suggest that the relationship or “right and the privilege to practice medicine under his (medical director) license,” was one of mutual benefit.

Supervisor. Emergency Medical Services may be offered to the public using a variety of resources, to include: hospital based operation, municipal, fire department based, county government, volunteer squad with local funding, corporate, and in some cases federally supported. As the type of funding and organization vary, so do the management structures. Common to the uniformed emergency services, to include the fire and law enforcement professions, a system of hierarchy is the established norm for rank and reporting. Amanda

offered a unique perspective as she shared her concept of accountability. While the concept of the “chain of command” is important within EMS and relates to communication with organizations, Amanda was the only participant to cite the chain of command as her own professional accountability. When asked “who are you accountable to?” Amanda responds with a detailed, as if rehearsed description of her “chain of command.” Of note, Amanda is the only participant that describes her upbringing within a military family. “Our chain of command is that you go to the senior medic first, then you go to the operations supervisor.”

One participant, Ben, notes “I am most accountable to the folks in the ER and that’s the people I have to hand off to.” This unique perspective seems to suggest that his own performance as a paramedic improves the jobs of those who will receive his patient. While not in supervisory roles, the Emergency Department is seen as the next in the chain of patient care. Historically the Emergency Department staff played a role in EMS oversight.

Partner. The strong relationship between partners in EMS is noted in other themes presented in this chapter. Of note, the concept of the partner relationship is also noted as it relates to accountability. Sandman and Nordmark (2006) describe this relationship by stating “the professional self-identity of prehospital emergency care providers is strong... they work in teams at a distance from other resources and staff, thus creating a group identity” (p. 603). Taught that for safety sake, “never leave your partner,” two participants voiced consideration for their partner’s well-being as they described the concept of accountability.

Laura notes “you are accountable to the chain of command (your chiefs), the medical director, and your partners.” Brian notes “your partner is your first one (accountability), to make sure they are fine.” After further consideration, he chuckles and continues, “I put my

patient first.” While consideration of avoiding an instance of being left alone or leaving your partner alone in a potentially dangerous situation is formally taught as part of scene safety in paramedic training curriculum, of note, some participants attached this concept to their own professional accountability. Two participants noted their priority in accountability as their partner. Of note, both of the participants referenced the concept of safety on scene associated with looking out for your partner. Both participants noted stories during their interviews where either their own, or their partner’s safety had been compromised.

Patient. Perhaps the most common response noted among participants was that of accountability to the patient. Participants voiced patient accountability as their primary professional responsibility, many offered the sense that this commitment was very personal. Brian states, “I am accountable to my patient. I got to make sure my patient arrive.” Brian goes on to say that accountability is more taking a patient to the hospital, “I try to do a little more beyond my protocol, I want you to feel comfortable and that you have help out there.” This response received the first order in most participant responses. James emphatically states, “I am accountable to the patient.” Rick agrees, stating that “you are accountable to the patient first, the system you work for and then, you are accountable to yourself.” Meagan states, “my first thing is I am accountable to the patient and their family.” Scott responds with a similar statement, “I am accountable first to the patient and then over that, basically my medial director.” In the subsequent theme, personal accountability, note that “patient” continues to dominate in concepts of accountability, with a more personal nature in that participants often feel as though they are entrusted with the care of the patient through a direct interaction.

Personal accountability. Many participants answered my question regarding accountability in an ordered fashion suggesting that the first named position listed was of particular importance. Some even changed responses as they answered to clarify an order. As an example, Michael states “I’m accountable to my medical director. I am accountable to myself first, then my medical director and partner. I am accountable to my patients and their families.” After further consideration of the question, “I am accountable to everyone I come in contact with in patient care... at some level I am accountable to everyone.” Personal accountability is further described in the following subsections, specific to assigned priority and importance as described in participant responses: myself, family, and God.

Myself. Ben states, “I am accountable to myself. I want to know when I leave them (patient) I have done everything that needs to be done.” Like most participants, Ben feels accountable to his patient, however, he is the only participant that describes an accountability to the nurses in the ER that receive his patients. By stating that his first accountability is to himself, he seems to suggest that as the paramedic is responsible for all aspects of the patients care and safe delivery to the ER staff, he has considered both elements by holding himself accountable.

Of similar note, Laura states, “I do hold myself accountable for my actions and decisions that I make and my abilities.” A third participant, Edwin, notes self as the foremost accountability states, “I am accountable to the medical director and myself, mostly to myself.” He later adds that he believes his own personal level of accountability is higher than that which his medical director would expect. Common to each response in the theme,

participants believe that they know what right practice is, and by holding themselves to this expectation, all other elements of accountability are met.

Families. Participant responses that included the concept of family considered both accountability to their own family, and the patient's family. Brian notes he feels most accountable to his patient, but adds, "I am accountable to my family." Further associating a sense of pride in ethical practice, Brian believes that he embarrasses his family if he behaves unethically or unprofessionally. John believes that he has been given talent to care for patients by God and therefore "my first accountability lands there, if I have been given this (talent), then I am use it for that (God)." He further states that his second accountability is to the patient and their family. "I owe them the best care that I can give and I don't accept less than that."

God. For several participants the concept of accountability aligned with religious belief. Brian states, "I am accountable for every decision I make from a spiritual aspect." Without hesitation, Laura relates, "I am accountable to God first and then myself for the most part." Michelle thoughtfully considered the question and then replied with a two-fold answer, "legally I am accountable to my medical director and to the state, and morally I am accountable to myself and my creator." Responses presented in this theme are consistent with those offered in the previous findings presentation "Paramedic Ethical Values, and Religious Beliefs." Several participants associated a "calling" to be a paramedic.

Finally, autonomy is presented to delineate findings unique to participants recognizing their own decision-making, but further to note a specific aspect of accountability, independence as the highest pre-hospital care provider, solely responsible.

Concept of autonomy. The fourth subtheme presented is that of the concept of autonomy. The previous subthemes, Differences in Concept, Professional, and Personal Accountability, are findings directly related to the interview question, “Who are you accountable to as a paramedic?” The concept of autonomy has remained central to the research problem statement in that ethical situations in paramedic practice demand critical decisions be made in immediate circumstance in which the paramedic must function without benefit of consult or resource. As John states, “you have to be able to make those decisions without a book telling you or being able to call a person.” The data that follows offers insight into participants’ discussion of feelings surrounding the autonomous nature of EMT practice and decision-making.

Michelle describes her feelings following an ethical decision where she knew she acted in the best interest of the patient, but clearly jeopardized her own career by not beginning resuscitation measures. “That was the defining moment of ‘holy shit, it’s me and only me!’” Describing her feelings as she became a paramedic and realized the gravity of some ethical decisions she stated “they hand you this paramedic credential and they say, ‘here go save lives’ ... okay great, let me go try not to kill somebody.” Meagan remembers the feeling of responsibility she felt when she became a paramedic. “I literally cried when I got the certificate in the mail and it said I passed, I cried.” While it seems reasonable that many paramedics still remember the day they receive news that they have passed the paramedic exam and received their first certification, Meagan speaks to her feelings of trepidation as she realizes that she will be promoted to the level of paramedic with the service she has been working at as an EMT Basic. Acknowledging the fears associated with such

responsibilities, Amanda states “I have always been cognizant of the fact that I am responsible for someone else’s life. You know that is not my life that is their life, of somebody’s loved one’s life. The golden hour, that’s not my time, it’s their time.” Amanda references “the golden hour,” thought to be the standard of care for trauma patients. The goal for treating trauma patients is to transport from the scene within ten minutes and have the patient arrive at a definitive care trauma center within one hour of their traumatic injury.

Autonomy magnifies the level of accountability that the participants experience. Perhaps best summarized in a statement from Michelle as she remembers the night she decided not to resuscitate a terminally ill patient. The fire department had responded to assist with the resuscitation. The paramedic, as the highest certified EMS professional on scene, makes ethical decisions that often carry grave consequences. In the difficult decision to allow a patient’s death without legal recognition of a “Do Not Resuscitate” orders, she cancelled fire department assistance. Having been called to respond to the scene, fire department personnel knew the protocol and risk associated with Michelle’s decision. She recalls:

When I sent the fire department away, they were a little confused. The fire chief got ready to leave and he said ‘it’s all on you’, whether he meant it derogatorily or he meant it with all the confidence in the world, he was right. It was all on me.

While participants noted differing concepts of accountability and how they prioritized their description, all shared a sense of responsibility to those they serve. The third theme, professional further develops and considers this concept as findings associated with the participant sense of professional identity are presented.

Professional identity. Professional identity is the third theme presented from the open coding analysis. As paramedics told stories about their encounters with patients, the importance of professional identity was noted in all transcripts. While some participants spoke of pride associated with their service as paramedics, others spoke of the negative feelings when they felt they had failed the profession or embarrassed themselves among peers. There are four subthemes associated with the participant's perceptions of professional identity: More pay and more respect, Embarrassment, Hero and hand-holder, and Bad outcomes.

More pay and more respect. The EMS profession has enjoyed rapid growth since its inception in the 1960's, both in scientific advancements and in the sophisticated care offered in pre-hospital medicine. Participants suggest that while the level of care offered by the paramedic and the degree of responsibility associated with decisions has been elevated, the two areas that do not reflect these advancements are salary and respect for the profession. Some participants attribute these deficits to a lack of understanding, inferring that if the public knew that paramedics were more than just ambulance drivers, the profession would be regarded in a different light. Some compared professional recognition to other branches of emergency services, such as firefighters or police officers. Brian states "for what we do, I just wish we could be seen or be known so we can get the help that we really should be getting... like firefighters. I just want to have the light on EMS folks." Laura also shares Brian's frustration, stating paramedics are "still recognized as a lesser profession." Describing the disparity she notes that among the allied health professions "we (EMS) do not deserve other people, such as nurses, looking down their noses at us, they don't have to make

the difficult decisions that we do in the course of our profession.” Edwin believes that paramedics in the United States are paid and respected less than foreign counterparts because the investment in higher education is not a universal requirement. Edwin states:

We sell ourselves short as a profession. We want the shortest route to achieve minimal affect... you look at the United Kingdom or Australia or any other country that started paramedic programs after us and they have some of the highest paid health care professionals in the country are paramedics. In Australia the minimal entry requirements to become a paramedic is a Bachelor’s degree, and it is the highest paid healthcare profession next to the physician. Australia started its paramedic program almost a decade after we had a paramedic program at the Los Angeles Fire Department. I ask myself ‘why are they so far ahead of us?’, and it’s because we have spent the last thirty years squabbling like a bunch of whiney children instead of jumping up and saying “yes” I am going to commit myself to education, I am going to commit myself to research.

In response to the interview question, “what do you least like about being a paramedic?” Brian responds, we are “underpaid for all the work that we are doing out there, just not getting paid what we are worth.” Michelle also describes her frustration with low pay. “I started off making \$13.50 an hour and you are like “really?’ all this education and all this crap and I get \$13.50 an hour?”

Politics of EMS. Politics of EMS is identified as a separate section of the subtheme, more pay and more respect. Similar to the concerns expressed for low pay and a lack of respect for the profession, several participants voiced similar concern that EMS does not

receive the respect of politicians that allocate funding and resources. John discusses frustration with disparity in funding for fire and law enforcement in comparison to EMS:

We have made such strides in EMS- we are looking at a forty year run and law enforcement and fire have been around for hundreds of years, they get all of the financial backing, they get all of the political pull, they get all of the grants and money. EMS has caught up and even surpassed them in some ways in a shorter period of time, but the recognition just isn't there.

Michelle's statement is similar. "It's beyond the work hours and the pay. It's that politically, we don't get the equipment we need" describing the often trying relationship between other branches of the emergency services, such as fire or police. EMS rarely gets the tax assistance from residents of the counties or towns they serve.

Scott remembers leading a group of firefighters to the town council to request paramedic service for the town. Having been frustrated with numerous requests to increase the level of care the town could offer citizens and being denied over budgetary issues, a small group completed the first paramedic degree program offered in the town and then approached the town saying, "we are going to be paramedics and they could do what they wanted with that." The town consented and thirteen years later, Scott still serves in the same town.

Embarrassment. As previously discussed, the embarrassment associated with a poor performance or lack of confidence from peers, hospital staff, or medical director is a powerful motivating factor among EMS professionals. As the following responses suggests, paramedics concern themselves continuously with such embarrassment. John states that "the hospital looks at you and the medical staff ridicules you for making an inappropriate

decision.” Michelle suggests that this ridicule extends into peer groups among paramedics. “Now I will tell you that in EMS ...you don’t want to be ridiculed. We suck, we devour each other, we find your weakness and we ride it till there is no tomorrow and enjoy it.” Brian states “you don’t want to go in there and look an idiot.” He further adds, “that kind of hinders us in the field to reach out to others for help... you just don’t want to be embarrassed or be called and asked ‘why did you do this versus this?’” Brian recalls a time that he had a patient situation and called a peer while on the call to ask for guidance, his friend said “what do you mean this is what you’ve got? You are on call?” Later the friend teased him, “He really embarrassed me, but embarrassment helped me to be the paramedic that I am now.”

While embarrassment among peers and hospital staff that is associated with ridicule is a noted concern, two participants voiced fear beyond word of mouth. In the state of North Carolina, each county is required to have a peer-review process to identify deficiencies, errors, and weakness in the EMS service using actual patient encounter reports. Review oversight includes a combination of medical director, management and training personnel. Peer review outcomes are required to be addressed in a meeting format, so that other paramedics can learn from the outcomes or peer performance. Edwin feels he has to be extra vigilant because he serves in a disciplinary role for his county’s peer review process.

“Everybody and their brother has got their eyeballs trained on me and they want to see if I take a short cut, make a mistake, do something halfway.” Beyond the teasing and embarrassment previously addressed, the formal process can have damaging affects to the paramedic’s reputation and such scrutiny is often associated with disciplinary action that can range from additional training to termination and loss of paramedic privileges. Kevin

describes the setting of such peer review meetings where call reports are often displayed as overhead images for all participants to see. “You don’t want to have your call up there on an overhead screen and your peers thinking you are an idiot.” Kevin further states, “when you make your career with your credential in your back pocket, you are one phone call away from litigation and unemployment.” Because the paramedic functions as a credentialed or certified provider under the direction of a licensed medical director, any breach in duty or service in medical care or ethical decision-making can result in the loss of privileges in the county, with referral to the state of North Carolina for the possible permanent loss of privilege and revocation of credential. Laura suggests that this fear associated with loss of reputation and credentialing creates the opportunity for dishonesty. Laura states, “we all make mistakes because we are human and when we do not cover them up, we are doing the right thing. I will always fess up to my mistakes.” As we talk further, I ask, “Why do you think others cover up their mistakes?” Laura replies, “it’s that peer pressure, ‘oh no way did they do that’ and knowing people are going to talk and say ‘what an idiot.’” For me, I do not worry about what others say. If I make a mistake than I will let you know and deal with the consequences.” Ben states that feelings of inadequacy in patient care lead to a personal sense of embarrassment. “When things do not make sense or do not fall into that traditional training we have, I am at a complete loss and that is embarrassing to me.”

The hero and the hand-holder. The third and perhaps most informative of paramedic perceptions of ethical practice is subtheme, “hero and hand-holder.” Most of the participants interviewed spoke directly of the great satisfaction they derived from a sense of helping others. While some feel “called” to serve as a paramedic and associate this service

with their religious belief. This finding is presented as participants that associated paramedic service to “helping others” and within this theme two more specific subthemes are suggested in findings: hero identity and the hand-holding care giver role. John remembers a patient that was exhausted from effort to breathe. “You feel that he is tired and he wants to give up... I just want to say ‘don’t give up, don’t give up’ and you just look at him and say ‘we’re going to help you.’”

Several of the participant stories include references to the sense for enjoyment in helping others as they describe paramedic patient care. Brian notes, “the comfort to know that you’ve done something on each call, positive, to help someone. I don’t think I can compare anything else to that feeling, that I helped someone.” Ben states, “sometime you can really tell that you made a difference and that just gives me a good feeling.” Meagan states, “I never remember names, but I remember faces.” One evening she was at an event when a woman that was working as a caterer caught her attention. She recalls her feelings as the woman thanks her. “I want to thank you and tell you that I appreciate what you.” Meagan had cared for her believing she was bleeding to death from a miscarriage. That evening she also met the woman’s eleven year old daughter. James also describes the feeling of “knowing that you really make a difference and that you get to meet all of these people,” as being the best part of the job. James continues:

Everyone gets sick and need help and to me EMS is the noblest profession on earth because we don’t discriminate, we have no limitations on whether we can provide patient care, I think that is the greatest thing. It’s the only job I know where we treat from the jail to the nicest of homes. We truly do not discriminate.

Hero. Other participants associate the feeling of heroism with their service as a paramedic. Edwin states, “I wanted to become a paramedic ever since I saw Johnny and Roy roll out of Station 51... I’m old school, I saw it, I loved it and it’s the only thing I ever wanted to do.” Edwin refers to the popular television show “Emergency” that portrayed two paramedics at the beginning of the paramedic movement across the United States. Johnny and Roy rode on Squad 51 as part of the Los Angeles Fire Department. The show is thought to accurately represent the origin of paramedic care. The show stimulated such interest in the profession that many paramedics still reference watching it and they discuss their own desire to become a paramedic. John discusses the burden associated with the hero role. He recalls being called to his first pediatric cardiac arrest as a newly credentialed paramedic. “The EMS unit was already there and doing CPR when I arrive and everyone looks at you ‘okay, you are the paramedic, here to save the day’.” He chuckles as he states, “you wish you could say... hey ya’ll, this is my first pediatric code (cardiac arrest).” Michelle relates that a sense of failure feels worse when associated with the hero role. Using the story of the teenage patient that dies at a high school football practice, she recalls her daughter’s words, “Mom, I knew when you got there that everything was going to be alright.” Later, Michelle relates, “she told me after the boy died that I crushed her, I crushed her!” Shaking her head with sadness, “no, no, there is no big ‘S’ on my chest for sure, the glory and the lights were gone.”

Hand-holder. Some of the participants spoke of the realization that at times, the advanced life savings skills were put aside and the true role of the caregiver was “just hold their hand.” Meagan remembers a call involving a critically ill man that was having a massive heart attack. The man needed emergency surgery. As the ambulance raced with red

lights and sirens toward the hospital, the medics asked the patient what else they could do and he replied ‘will you just hold my hands’ so the medic held his hand.” Scott says he enjoys:

Human interaction, just the ability to help people. I learned a long time ago that I don’t have to stick needles in and I don’t have to give medications to help people, sometimes all you got to do is hold a hand. For some, that is all they need.

From heroes to hand-holders, this theme revealed strong reactions among participants whose identity as a paramedic is rooted to the desire to help others. As Laura states, “when you know you have made a difference in the patient’s life that is the most important thing.” She further adds with a warm smile, “I took an EMS class and I was hooked. I bleed EMS blue.” Blue is the color of the star of life, required by the Department of Transportation to identify ambulances.

“Bad Outcomes” is the fourth and final subtheme associated with professional identity.

Bad outcomes. Within the subtheme related to paramedic professional identity, bad outcomes was noted among several participants as they discussed their feelings of both frustration and the sense of failure when the patient had a bad outcome, despite efforts. “Torture” and “paramedic assisted death” are terms assigned to two specific stories within the subtheme.

The presentation of this finding begins with participant stories of frustration. Laura states “I’ve had those patients where I have tried everything and nothing works.” The paramedic functions in a pre-hospital setting and very often with complete autonomy. This

subtheme seems consistent with another presented in the findings associated with the “accountability” theme, that paramedics feel a great deal responsibility to make sound decisions as the only caregiver prior to hospital arrival. In this subtheme it is noted that failure leads to a feeling of frustration. Michelle states, “they don’t tell you in paramedic class that even if you do all the right things, the bad things still happen.” After a deep breath, she adds, “they never told me in school that if everything goes right, we still wind up with a grieving widow over there that wants to know why her husband is dead, and I can’t answer that.” Michelle, throughout her interview, relates to her strong desire to save lives and offer competent care. Through these comments she reveals the frustration associated with giving the best care you can give, and realizing in some patients it just isn’t enough. Meagan describes the thing she least likes about the profession:

When I have a code (cardiac arrest) and I have to tell the family that I have done all I can do and we have to call it... and that is especially rough when it is a young kid... it’s pretty rough.

Many of the participants spoke of frustrations and feelings of disappointment when faced with the daunting task of notifying a family of failed attempts to resuscitate. New treatment guidelines for the cardiac arrest resuscitation have proven that the efforts have a greater success percentage when the patient is resuscitated where found, rather than moved to the hospital during resuscitation. The current method of field resuscitation is commonly called “stay and play” as opposed to the old approach, “load and go.” While science changes and paramedics are trained on the current best practices for resuscitation, little prepares them for the roll of notifying family members of their loved one’s death when the resuscitation effort

has failed. Amanda agrees, the most difficult part of making the decision to terminate efforts is “the families, having to tell the families. That is the hardest part and I don’t think that will ever get easy.” While relating that cardiac arrest calls are difficult when “you do everything you can for them but their outcome is still not good, they still die,” she also relates to frustration in situations of patient death when the patient doesn’t get the best EMS care. She describes a cardiac arrest call where “the patient did not get the care he needed in a timely manner, and if he had, the outcome might have been different.” Amanda responded with a rural rescue squad as the paramedic. The 9-1-1 dispatcher made an error with the address that increased the travel time for paramedic response. Upon arrival the squad had begun sub-standard care. “The family was extremely hostile, which I don’t blame them. The next day I went to my supervisor. That kind of stuff is frustrating to me.”

The second concept associated with this finding is a sense of failure. Brian remembers being faced with an ethical decision when he arrived at the home of critically ill woman in respiratory distress. Legally, a patient of sound mind has the right to refuse medical care. Paramedics that treat patients against their will face litigation that ranges from assault and battery, to kidnapping if they transport. In this case, the patient had the right to refuse his care; however, Brian notes that the patient would have died without it. Brian goes on to explain that the ill patient did not want care from the EMS crew she had summoned because “the patient did not want a man of color to treat her.” Acting in the interest of saving her life, Brian treated the patient. While crossing the line and treating a patient of sound mind against her will, he believed it would have represented his own failure to allow her to die due to the race barrier. “If I walk away, I fail. I fail myself, I fail my family that I was

raised up in. So I said “No, I’m going to stay here’ and the only way I fail is if she dies.” While the woman responded to treatment and later thanked Brian for his care, he notes having made a difficult ethical decision and “crossing the line”.

In reference to her attempts to resuscitate the sixteen year old student that went into cardiac arrest on a high school football field, Michelle describes her feelings of failure when she tells her daughter that the boy was declared dead at the hospital. Believing that because her mother was caring the boy, he would be ok (also note reference in previous subtheme: Hero), Michelle’s daughter becomes angry. Michele states:

Knowing that my sixteen year old looked at me like I failed her and I failed the boy, was hard for me. I didn’t go to the funeral. I let her daddy take her. There are certain thing in EMS you should never do, and that is the funeral of a patient. You don’t need the reminder that everything you did didn’t work.

Two stories conclude the presentation of findings in this subtheme of torture and paramedic assisted death. While these responses were analyzed and aligned with the theme bad outcomes, the researcher believes they offer a unique perspective and terminology.

Torture. Michelle describes an ethical dilemma on a call with a terminal lung cancer patient in cardiac arrest. Without a signed “Do Not Resuscitate” order, Michelle is bound to begin efforts. The patient’s daughter tearfully pleads with Michelle, “Don’t torture my mother.” Reflecting that this was a defining moment in her career, Michelle risked her job to respect the daughter’s wishes. In doing so, she faced the anger of the patient’s son, who called 9-1-1, and the additional emergency personnel dispatched to assist. “All I could think of was that I am going to lose my job and I am going to lose my certifications.” The words

“torture” continued to ring in her head as well as the “look on the daughter’s face.”

“Torture” she repeats, “you are not taught in class that what you do is torture. I had never looked at the job like that until then.” Michelle believes she acted in the best interest of the patient and respected her wishes, but resents that awful ethical decision she made because “the doctor was not quick enough on the yellow piece of paper (DNR).” This encounter had such a profound effect on Michelle, that she compares it to other calls. Michelle describes electrical cardioversion of conscious patients stating that, “it’s real easy to sit in class with a manikin, and practice ‘go ride the lightning’ (a common euphemism about cardioversion.” Cardioversion is an emergency procedure using an electrical shock to convert the heart to a more effective rhythm.

Before I made the decision not to ‘torture that woman’, I used to just make sure I stayed out of a patients reach because sometimes they would hit me when I delivered the shock. I have had people put their arms against their chest after I have shocked and scream... now I think “my God, what have I done?” On one hand you are correct that saving the life is more important than the momentary pain I cause... now I look back at how some of these patients reacted with the word ‘torture’ in my head. I really began to rethink my entire career.

While the term torture graphically demonstrates a painful realization regarding the critical care offered by paramedics as they attempt to save lives, the participant responses that follow further illustrate the intensity of paramedic patient care and ethical decisions that relate to such endeavors.

Paramedic assisted death. Like many other professions, paramedics have their own terminology, sometimes aimed at the stresses endured in patient care and sometimes euphemisms used to make the everyday realities of death endurable. To the observer, the expressions may seem insensitive, and yet as Edwin relates the story of the “worst call of my life,” he further adds that the experience “shaped me into who I am today.” He bluntly begins by stating, “I killed a patient.” The euphemism, “Paramedic Assisted Death (PAD)” is used among EMS professionals as a way to describe situations where a lack of knowledge or error in judgment can cost a patient their life. The term brings to life the intensity of paramedic decision-making, and while it appears to make such serious situations seem light-hearted, Edwin’s description of the encounter suggests that just the opposite is true. The patient was suffering from a heart attack afflicting the right side of her heart. The patient presented with chest pain, typically treated with Nitroglycerine. Nitroglycerine is contraindicated in patients with right-sided heart attack due to potentially unsafe drops in the blood pressure. While the diagnostic capability to determine the afflicted area of the heart is common place for all EMS patients today, the patient that Edwin is describing occurred in 1993. At the time that technology, nor the assessment capabilities “did not even exist in the field at that time.” Edwin describes his patient encounter:

I got her in the back of the truck, I hooked her up to the monitor, dropped a Nitro under her tongue, said this will help your chest pain, we will take a nice short little ride to the hospital. After about 30 seconds after I dropped that under her tongue, she said “I don’t feel so good”. After a minute her eyes rolled back in her head... her pulse went away. 45 minutes later we pronounced her at the Emergency Department.

Although Edwin had followed treatment protocol for chest pain correctly, he is confused by the patient's response. "Just that realization that one nitro had killed her" and decided to consult the physician for an explanation. He describes his feelings when he learned that he should have withheld the Nitroglycerine:

I was ready to crawl under a rock then. I wish I could have consulted with somebody.

That changed the whole shape of my career. I was low and I really thought about was it right for me to even do this (paramedic).

After reflection, Edwin decided to dedicate his career to an in-depth understanding of paramedic practice. Continuing his education and studying continuously propelled his career forward and helped him to feel confident that he can better manage difficult situations. Edwin is a paramedic instructor so that he helps to teach future paramedics and shape training in such a way that his experiences in 1993 would not be repeated. While Edwin clearly intended no malice toward his patient, he still feels that his lack of knowledge "killed that lady and disrupted my whole world." He again turns his gaze to the space of floor between his feet, closes his eyes and says:

I can close my eyes and I can see her face just like it was today, I can see the back of that ambulance just like it was today...and I know I did it. From that experience, my body of experience has grown tremendously. I made a vow to never repeat my mistakes and I would like to think that I have lived up to that vow. As far as I know I have never committed another act of PAD as long as I have lived since then. I have become acutely aware of how my treatment affects people.

Kevin reminisces about current scientific understandings and how he feels about his early years as a paramedic in much the same way as Edwin. “I think about how many I’ve killed because of my lack of paramedic understanding. It was a check early in my career so I would not make those mistakes again.” While both participants relate stories of detrimental treatments that have since improved with enhanced science, they both bare the painful memories, and of note, mention the reminder to be vigilant to such poor patient outcomes.

The preceding results were offered to provide key findings associated with paramedic stories of bad outcomes in patient care. Several ethical decisions were presented within this subtheme. Perhaps a quote from Michelle summarizes the feeling of losing a patient, as “playing rock paper scissors with the grim reaper is not fun because no matter what, someone is going to lose the battle.”

While the stress associated with bad outcomes was noted in participant responses, stress specifically surrounding ethical decisions and concern for navigating such situations is presented in the fourth and final theme associated with open-coding, “decision stress.”

Decision stress. There are five subthemes related to stress associated with ethical decision-making: Cumulative Stress, Community, Regret, Resuscitation, and Tunnel Vision. Each of the subthemes are aptly named through the open-coding process where numerous participants used common terminology that related to stress specifically associated with each description.

This theme presentation begins with four similar participant accounts, all using the term “heavy” to describe their feelings about their work. Perhaps the best introduction to the general theme of Decision Stress can be achieved through a simple word.

James relates the term heaviness to reminders of calls he has been on, and to the stress of taking care of people in the community that he knows. “You carry people you know. My own sister had a wreck. You have been to family members, I have people I went to high school with that blew their brains out, and I have seen all that stuff. I have been to friends’ houses when their parents have died, have been to several wrecks where several of my friends were killed. I never shed a tear. At what point does something change and you suddenly begin to cry? It’s like a heaviness.”

Michelle states, “we see people at their worst and most desperate times and I am the face that they see and I may be the last face that they see. That is a heavy burden to carry.”

Laura describes a time when she had to treat an elderly confused woman against her will. The woman was in poor health and not of sound mind to refuse care. Laura acted on medical director’s orders to give her a sedative by force and transport to the hospital. “I got her to the hospital and promised I would get her something to eat. You do not ever want to treat someone against their will.” The patient would have died of dehydration and starvation without intervention. After a brief and intense sigh, Laura continues, “it’s a heavy feeling, you know you will not be able to go home and rest knowing I left her there.”

Brian remembers a call with a critical patient, at night and in a rural area, as he climbs into the ambulance to attend to his patient, his partner became confused and then became completely unresponsive. Suddenly finding himself with two patients to care for and with no assistance. Remembering the panic he felt, Brian laughs saying that his peer said “once again, you sound calm on the radio.” He states, “no, I was not.” Brian describes “second-guessing” himself during critical calls. Following a horrific motor vehicle accident with

multiple patients, Brian remembers declining to attend a Critical Incident Stress Debriefing designed to help EMS work with post-traumatic effects of stressful calls. He states “they asked again, and I said ‘no, I’m fine... but, I should have gone, it still feels... heavy.’” As the participants relate stories of calls that many have remembered as the worst call they had ever worked, the effect of such experiences seems evident in the emotion and suggestion of what such events must have been like. In the subtheme that follows, the participants discuss feelings that are associated with critical events and difficult decisions over a period of years. Specifically, the results that are presented in the subsequent section differ in that they relate to stress associated with cumulative encounters.

Cumulative stress. Data in this subtheme, cumulative stress, illuminates those feelings of participants as they reflect on years of emergency services. Some note the changes that have taken place in the profession and how those changes have affected their own feelings, while others discuss the changes they note in themselves that relate to years of service.

James offers a unique perspective on the stress associated with the roll of community rescue worker. First, he addresses the emotional toll of a long career in EMS.

My father did this for 20 years before he could just not do it anymore. He said ‘it’s just always somebody you know and I just don’t want to go anymore’ and he walked away after 20 years. At what point does it click that it was good while it lasted and I am done and I don’t want to do it anymore? We recently retired a good friend of mine, a paramedic, with PTSD after 27 years, medically disabled. How long do we experience these situations and make these decisions before they start affecting us

enough to say ‘I’m done’? I think at some point this stress, this cumulative thing builds and builds and you have to be hard to it.

Secondly, James describes the “early days” of working as a community rescue worker. Differences in perception to tragedy in your hometown from earlier decades to the current, present a unique contrast of navigating ethical decision-making.

When I came along we were a volunteer rescue squad so we picked up everyone. A neighbor, friend, school teacher, or the friend of a friend, you know them all, and so it was a different culture that was part of being tough. You were strong because they needed our help, and so you did not show emotion, things were not supposed to bother you. I do not know if I subconsciously made the decision or that was just the accepted way to be and you were tough and you did not let things bother you. You kept your distance. Nothing upset me. Over the years I got more sensitive.

Suggesting that changes in “sensitivity” have affected his response to ethical care, James describes a fatal car accident that he had recently worked.

I had a little boy that was 20 years old and killed in a car wreck. Ten years ago I would have just put him in the body bag and moved on. Too many people hurt and not enough ambulances. This time, I got the body bag and the back board and I had the foreman help me put him in it and you are looking at his license with the highway patrolman and it’s a college kid with his whole life ahead of him lying in the this bag. You think this is so sad. This time I waited with him, made sure he was treated respectfully and helped the funeral home pick him up. At what point did I suddenly become allowed to be human?

Cumulative stress as a subtheme presents an interesting dimension to ethical decision-making as a process. Rick describes the personal effects of a long career in EMS:

I have problems sleeping now. I do not tell people about it. I have gone to the doctor to get sleeping aids. I do not see calls, I just think about them. I try to look at the good stuff and let the bad stuff go.

Rick goes on to tell about his own realization that he has had many calls that could have ended his own life, “over the years I have had time to think about how many times I got close to losing my life to save someone else’s life.” Rick offers an example of such a call.

I had one instance where there was a head on collision and the husband was killed and they were trying to extricate him and I could smell gasoline. The car went up in flames and I reached in and pulled his wife out- the husband was still alive and he was moving in the flames. He got burned alive. The wife saw her husband die. I got burned. I never really knew I was burnt. I didn’t feel anything, the adrenaline was pumping. My hair was singed and my face was red. No scars, but mentally scarred.

Michelle also acknowledges a realization that the years of stress have affected her.

I went to a suicide and the man had hanged himself from a ceiling fan and when I got there, my first sick thought was, ‘who hung that ceiling fan? That is really strong’. I am a little ashamed of that too, because what part of my head and self-sanity is dead that I don’t see the man hanging there. I guess by some token it’s my self-preservation because nobody wants to see a suicide, so I focused on the ceiling fan. I don’t know how I have lasted in the field as long as I have, it amazes me that some medics have been in the field for 20 years and have seen the things they have seen.

All of the participants who are represented in this subtheme discussed the sadness and feelings of inadequacy associated with the loss of a patient in other areas of their interview. Of interest, participants reflect on the need to distance themselves from the pain they have felt, or note that in some instances, there was a noted distance in a situation that perhaps at another time in their career would have evoked stronger emotion. As a researcher, I had the distinct impression that the realization of this “distance” accompanied a sense of sadness.

Community. The second subtheme of decision stress is a sense of “community” and aligns closely with the concept of accountability. Participants that have a strong connection to the community they work in, note an increased responsibility when you care for patients in the neighborhoods or small towns where you live or have been raised. In this presentation of participants’ responses, stories that relates to a strong sense of community are presented as a subtheme of cumulative stress as they clearly enhance the feelings of loss and frustration among the participants. The concept of community also seems to enhance the need to make ethically accountable decisions. John relates that working in the community where you have been raised is particularly hard when the patient is someone familiar to you, “because they’ve put their confidence in you to save their family member, but there is nothing you can do and you have to tell them ‘I’m sorry there is nothing else I can do.’” Michelle notes the added stress of working in your own community. “I always swore I would never work in the same county I lived in, which is funny, because I have only worked in the county I live in.”

Rick discusses his sense of allegiance to his community. “In 1972 I almost got drafted to Vietnam and I knew a lot of men that did. I felt like my job would be to help my community and that would be my service to my country, instead of going to another country,

I would serve my country here.” Now, years later, Rick runs into people in his community that ask “do you remember that time when you picked me up?” Laura notes the sense of gratitude and pride that accompanies that working in your community as a paramedic. “Having someone you save come back and say thank you for doing that,” is such a reward, not because she feels the need to be thanked, but because it represents a success.

I love being there when someone needs help and being in the community for 25 years there are so many people here that know my name and ask for me, I have shown up at their houses and they say “I’m so glad it was you”, which of course has its downside when it gets to that bad time and they are in cardiac arrest and I cannot help them... it’s hard.

James believes that paramedics that have a close connection to the community in which they serve, either by family history or through a community based service, are more invested in patient well-being. He states, “I think that people who are community-oriented or in a community organization are able to provide a better service and make better choices in regards to the patient care.” Having had experience as a paramedic in a large city near the small community he now serves, he states “large city EMS deals with numbers and it’s all about numbers, but if you know you are going to have to see that person again and that they are going to remember you.” He goes on to describe the differences in caring for patients in your own community.

I think that is why I am more kind, because I came up with the mentality where you don’t want the reputation of being hateful to someone’s mom or bruising their

granddaddy. People remember, but if you never interact with them again, you get away with it.

James remembers a call that he responded to in his own community. While eating dinner with his family, his pager alarmed with a request for additional assistance to a call near his home. As was his practice, he jumped into his vehicle and went to the scene. When he arrived, he found a critical receiving poor care from the EMS crew attending the patient in the back of the ambulance. The attending crew appeared frantic, not addressing the need to ventilate the patient, assess circulation, or consider the ECG. The situation did not improve and upon arrival to the receiving hospital, little care had been offered enroute. Later, James would make the decision to “call the powers that be because this is my town and it could have been one of my family members.” James recalls being faced with the difficult situation. He believed he was witnessing negligence- the patient was in cardiac arrest and got minimal care, leading to his death. James remembers being told, “just drive.” Having no authority on the scene, he remembers the frustration of wanting to provide care with a paramedic that was incompetent and became very defensive. With no time to call for legal or supervisory support, he considered the ethical decisions that were evolving with a patient in cardiac arrest, he asks himself:

Do I physically pick them up and move them out of the way? It was such a gray area. Did my lack of action cause harm? It’s that decision-making process. Maybe if I can drive the ambulance at least I can help guide them from the front seat if not from the back... if I can at least get in the truck I can help tell them something to do.

James states that after he reported the incident, it was investigated and he was called to meet with the county medical director to give his account. James states that he learned something that day he had never been taught in training:

The medical director pretty much said you have the right to jump in there, you are the most senior paramedic there and you have the right to stand up and raise hell. I was trying not to step on toes and trying to not hurt feelings. Is there place for that in patient care? Is there a place for not hurting feelings when it comes to doing the right thing for the patient... the end result was no, but at the time my thought process was not to hurt feelings.

When asked if he had the same call again, would he change something, he quickly and emphatically states, "I would have jumped back there and raise hell till they did something!" More specific to the stress of caring for patients in a community is personal knowledge of the patient. In the following subtheme, participants discuss feelings surrounding the care of a patient in such circumstances.

Knowing the patient. Rick recalls a time when he responded to a farm owned by one of the firefighters that he worked with for many years. The firefighter's young son had been riding on a bush-hog tractor with his father when he fell off and was pulled under the machine. When Rick arrived he found:

The bush hog went over the kid and nearly took his arm and leg off. He was still alive when we got there and there were a bunch a fireman, our fireman. The firemen were trying to comfort the kid, but the kid was so far gone he was beyond comfort. I

finally told the firemen they had to back up and let me do what I was trained to do and help him.

Rick felt he had been harsh with father, a co-worker and friend. On the way to the hospital, Rick allowed the father to ride in the back of the ambulance. He recalls:

The kid looked at his dad and asked if he was going to die... now a five year old kid, that is the last thing on a five year olds mind and you can imagine what kind of feeling went through me. My supervisor drove the ambulance with the kid's mom in the front seat. It was 30 miles and we were there in just over 15 minutes.

Rick arrived at the trauma center and describes the moments after the critically injured child had been admitted to the care of the trauma physician and care team. "I held it all in till we were at the hospital and then I had to let it go." Stating that he left the patient room, checked to be sure the equipment and ambulance were put back into service for the next call and then found a restroom to privately sob before he could make the return trip to his service area.

Laura remembers the last time she cared for a patient that she had transported many times. The elderly woman suffered from diabetes and high blood pressure. When the call came in for the familiar address, Laura expected to treat "Miss Amy" in the familiar way and enjoy her smile and sweet grateful disposition during the ride to the hospital. On calls in the past she had enjoyed holding Miss Amy's hand and chatting about grandchildren. This call was different. When Laura arrived, the patient's daughter met her at the door with a panicked look and Laura's glance at "Miss Amy" suggested the situation was grave. Laura explains:

She was bleeding badly, it was difficult because I couldn't get an IV on her and I was crying because I thought she was going to die on the back of my truck and here she was still being so nice and smiling.

When they arrived at the hospital, the patient was in the late stages of shock and went into cardiac arrest. Laura and her partner looked on in horror as “the doctor jumps on her and starts pounding away and they gave her nothing to sedate her and here we were just watching our patient die at the hands of what we thought was supposed to be help.”

John remembers a call when he arrived on a motor vehicle accident scene. As is practice in EMS, the first rescue authority on the scene had established “command” of the scene. This practice assures that when multiple patients are involved with a scene requiring multiple agencies to respond, such as the fire department, EMS, police etc... a trained individual is able to coordinate events that ensure rapid trauma care with a goal of transport to trauma centers within ten minutes of scene arrival. As John reports to the scene commander, he is requested to assess a victim in one of the vehicles, the command stating “I think that one is dead.” Because of the patient's position in the vehicle, John was unable to visualize the victim's face. After a rapid assessment of the patient's pulse and circumstances of the injuries, he determined the victim to be dead. The following morning he attended his church and learned that the victim of accident was a friend he had grown up with. “My hard decision was that I black tagged my buddy.” “Tagging” patients refers to the triage system where multiple accident victims are rapidly assessed so as to allocate recourses for the greatest good, sorting patient based upon stability and chances of survival. Black tag is a

designation reserved for those meeting criteria of death, or morbid injuries not compatible with life. John recalls the decision.

It bothered me in the beginning, but as I look back through the years, I have been able to live with those decisions because it was the one decision that is best for the whole situation, and not one individual. That is what we are all about is to just make as much right as we can and of course do no more harm and as well we have a short period of time to make those critical decisions that we have to save as many as we can.

Kevin remembers a “call that has haunted me for years and there is nothing that could have been done.” The call refers to is a child that he had to pronounce dead on scene after massive head injuries associated with being ejected from a vehicle during an accident. The child was unrestrained. Kevin later found out that he attended his nephew’s kindergarten class.

Ben discusses the difficulty in working in the community where he was raised, and his friends and family still live. “I have worked on a lot of people that I know, some really bad.” He describes the most difficult call he ever had as a day when he took care of a three-year old family member. The child died of a head injury that he sustained while playing at his grandfather’s house. Ben states “I have seen my share of dead, it was the hardest because of the emotional connection.” As Ben continues he notes that with the family connection he has constant reminders of the call. “I don’t get around them (family) without thinking about it. There is no way I could.” The concept of reminders to bad calls is discussed specifically in the next subtheme.

Reminders. Participants voiced visual reminders of past calls that caused them to relive the stress and sadness of the memory. James states:

I can ride by every house and I can picture the people in there. I had a little girl drown in a fountain one time, and every time I drive by the fountain and remember that girl, I can remember the children that died at this intersection and now it's sadder than it was then.

Michael states, "I still remember that house every time I go by it." Michael was called to a critically ill man that refused his care. The man became abusive, striking at Michael and his partner with a cane. Michael reluctantly left the patient's house, only to be called to return later when the man had gone into cardiac arrest. This time, the man's son did not wish to have his father resuscitated stating, "he wanted to die at home." Following his protocol, Michael had to call law enforcement and "work the code." Michael still remembers the stress of the decision and in reflection, believes that "to leave him there and not have called anyone" would have been the most empathetic decision.

John states, "You see faces, I mean you go back through it just like you are living it again." He goes on to state that he can drive through intersections where accidents have occurred, or past a house where someone died.

You can remember the moment, you can remember the expression, you can remember the cries or their scream you know and when we work in the communities where we grew up and there is a high percentage of the calls you go on where you are going to know the people.

John remembers a call involving an elderly woman who ran over six children at a school. As he made a difficult ethical decision that could have ended his own, and the career of a not yet credentialed paramedic... he considers saving a child. The young boy was laying at the feet of his father, dying, when John orders an uncertified provider to deliver advanced care. The provider had completed paramedic class, but not yet taken the exam to gain the legal recognition needed to treat as a paramedic. The realization that John had jeopardized the man's career weighs upon his mind. As he recalls the story, he also relates that he passed the place where the dying boy lay when he took his own children to that school in the years that followed. John relates:

There is a walkway going in the front door and a bench made, with a plaque for this small child with his picture so that every time I walk into that school I get a flash back to that day, laying on the ground in front of that van was that little boy and the decisions I had to make to try to save his life as well as his classmates. To try to figure out how are we going to divide up to save them all.

John shakes his head and states, "I put him in a predicament that having him do what he knew he shouldn't do and that could have prevented him from being a paramedic. He could have said 'sorry, I can't do it.'" John relates this difficult call with the realization that he has made an ethical decision in opposition to the operating procedure by ordering an EMS provider to give care at a level they are not certified by the state of North Carolina to give. This can result in the suspension of privileges for both involved, and is termed "practicing medicine without a license," a felony.

Michelle describes being reminded of bad calls stating “I have them that trigger things.” She continues:

I did have a 16 year old (patient), my daughter was 14 at the time. Her momma had just died and she decided it was better to take a handful of Lithium pills, I’m guessing to deal with the pain. She (16 year old patient) was going to die. Lithium unfortunately is not one of those drugs that kills you right away, it take time. I remember going home that night and climbing into bed with my daughter saying to myself, “I just can’t do this job anymore.”

Michelle states it was “just really sad.” While there was little field treatment that could be offered for the Lithium overdose patient, Michelle held her hand and states “all I could think of is this could be my kid.”

Regrets. The third subtheme of “decision stress” is regrets. While some of the interview questions asked were followed by a time period of reflection and even uncertainty, there were questions that in some participants evoked a quick and confident response. “Have you ever made a decision that you regret?” was such a question. Several participants seemed to have ethical decisions that they regretted or would have made differently, no matter how many years since the incident, at close hand in their memory. John recalls a decision that he regrets:

A hurricane came through and there was a gentleman that decided to drive through a flooded road, he was sitting on the back of the trunk of his car. We called for the National Guard helicopter and they wouldn’t do a pick off... you could see the water level rising. We considered sending a boat. We considered a tractor. Finally we

decided to allow a farmer to drive his tractor into the water and float a boat from it.

We had helicopters in the air in case one of our men fell in. If I ever had that to do again, I would never do it again because what if that road had washed away before we had affected our rescue... we were lucky, but I saw what could have happened. So I would never make that decision again, to put those people in danger.

James describes a call the he remembers “very vividly” involving a six month old baby. James found the baby in the kitchen sink, being held by the mother with water running over his head. She reported to James that the child “could not breathe and we thought splashing water on his face would help.” The baby was in cardiac arrest. James states “I scooped the kid out of sink and did chest compressions and mouth to mouth.” James remembers attempting to put an endotracheal tube in three times. “I think back on that call, if we knew then what we know now and I would have just used a bag-valve mask (a non-invasive device used to ventilate the patient) and concentrate on other things. Would he still be alive? Maybe I could have done better CPR and used more aggressive medication.” James references current trends in pediatric resuscitation and regrets that he now knows more that could have been done. “I think about that call a lot.” While James regrets that more treatment wasn’t offered to the baby, he states, “there are a lot of things I do not regret.” James relates that he performed mouth-to-mouth resuscitation on the baby to the amazement of his crew. James states that he knew the baby was dying and he didn’t want to delay CPR while finding his airway equipment. “There was no time and I am going to do all I can for the patient not worrying about what I will catch,” referring to the risk of disease transmission

associated with mouth to mouth contact. “I’m the one that has got to sleep at night so if the good Lord strikes me down with some disease, then so be it.”

Michelle regrets a decision she made regarding a patient’s care. The patient had been involved in a “fender bender” at two o’clock in the morning with minor damage to the vehicle and yet she was hysterical. The patient would not allow Michelle to touch her neck or put a cervical collar on. The woman continually screams and strikes at Michelle stating “you don’t understand anything”. Michelle finally opted to let her stand up from the car and sit on her stretcher for transport to the hospital. Later she found out that the patient “had a C3 and C4 fracture and I dropped her off at the hospital like she had nothing, like she was bothering me. I had just justified that fact that she wouldn’t let me palpate her neck... I slacked that night because I was irritated. I didn’t do any harm, but I did not help. I could have easily killed her, easily. I would love to say that was not a slap in the face, but it damn sure was.”

When asked if there is a call that still bothers her, Laura recalls a similar call involving a 16 year old motor vehicle accident victim. The girl is breathing when Laura first assesses her and then respiratory effort stops. “I told the firemen, ‘get her out!’ and the only injury I could see was her elbow.” Later, Laura learned from hospital staff that the patient “ended up with a C1 fracture... there was nothing we could have done, but it still replays itself... what if we had done more c-spine precautions when during the extrication? But at that time it was life over limb.” C1 is an abbreviation for the first cervical vertebrae, found just below the skull and the spinal column in the neck descends. Spinal cord injuries at this level are not compatible with life. Perhaps the most emotionally charged response I received

came as Laura concluded her previous statements. I asked, “has there been a decision that you would change if you could?” and Laura replies, “I can say I would not have left my partner on the highway if I could go back. That is probably the biggest one. They tell you never leave your partner, and I did.” With this comment, Laura references an expression shared within EMS, “never leave your partner.” Laura recalls the day her partner was killed in the line of duty on an interstate as he attempted to help an accident victim. Laura believes that her partner left the parked ambulance to assist the accident victim, and then decided to return to the parked ambulance to assure the safety of his partner and patient when he was hit by an oncoming truck. After being hit and killed, Laura notes that she believes she should have stayed with his body, “never leave your partner.” This story has been reflected in other areas of this chapter, it is again mentioned as a specific response to an interview question regarding regret. In the course of the interview, Laura refers to the loss of her partner three separate times, perhaps giving testimony to unity among paramedics and her own grief associated with the loss.

Resuscitation. The fourth subtheme of “decision stress” is resuscitation. A new and dominant presence in EMS literature, the science surrounding current trends in EMS to manage and terminate efforts in the field is similarly noted in the participant responses describing difficult ethical situations. Resuscitation is a term that has been used previously in this chapter as it relates to participant stories of difficult calls and difficult decisions. Specifically, in this subtheme of decision stress, responses relate to the emotions surrounding patient in cardiac arrest, commonly called a “code.” The most critical of patients are those in cardiac arrest. Seconds can contribute to patient survivability. Treatment protocols are

intense and demanding to learn and practice. As a paramedic, leading the cardiac arrest management team requires rapid decisions, leadership, and communication skills that are practiced more than any other patient scenario. A combination of trained personnel come together in the cardiac arrest event to quickly make decisions, first regarding viability and the appropriateness of resuscitation efforts, and then the execution of perhaps the most aggressively researched and rapidly advancing area of medicine - cardiac arrest resuscitation. Scientific research has indeed led to some of the most impressive changes in field patient management over the last two decades. At one time, paramedics were not permitted to assess and determine the need to begin resuscitative efforts. All patients in cardiac arrest were “worked.” At one time, cardiac arrest resuscitation required the patient to be moved rapidly to the nearest hospital for further treatment and the termination of effort. In current cardiac arrest management, paramedics make the decision to initiate resuscitation efforts. This includes all of the liability and ethical deliberation, as well as the emotional cost accompanying such a decision. This aggressive approach is particularly difficult for paramedics that recall a time when there was always a higher authority to make the decision, the physician. Cardiac arrest calls are now “worked” on the scene. Research suggest and patient survival rates have proven that cardiac arrest management offered by paramedics is just as effective as that offered in the emergency room and that care uninterrupted by patient transport has a higher success rate. This shifts the focus of patient movement to rapid field resuscitation. Efforts may continue for an extended time period, also new to the paramedic approach to management. Patients that are resuscitated are transported to the appropriate facility that can care for “return of spontaneous circulation” patients. Patients that do not

respond to resuscitative efforts are now “called” on scene. In this case, the paramedic had made the difficult decision to terminate efforts, determining the patient to be dead and subsequently notifying family and authorities. Again, a new level of stress accompanies such decisions and the ethical concerns that are associated. While training and education curricula reflect the advances in cardiac arrest management, it does not reflect the skills necessary to make such ethical decisions, nor does it address the impact of such decisions on the practicing paramedic emotionally. The findings in this theme, relate specifically to such emotions and the stories surrounding resuscitation calls. The first findings presented relate to the general term “resuscitation.” There are two specific sections within the resuscitation theme: termination and show codes. Each is presented with an explanation following the more generalized participant responses of the subtheme.

Michelle describes events during a transport of a young patient in cardiac arrest. The ambulance is enroute to a heart center and the patient’s mother is riding in the front. The patient is a victim of sudden cardiac arrest on a football field. Michelle states that at one point she looked up to view the open road in front of the ambulance as it barreled down the highway, to determine how close to the hospital they were. As she relates the story, her head is hung and tears fill her eyes:

I saw his mother looking back at us with a horrified look on her face. It occurs to me that he is not dead yet. I told her to talk to him, he is with us and he can hear you. She started to talk to the boy about when he was little and loved to hear the sirens, ‘you loved sirens, Can you hear them?’ I can’t ever forget that.

As a researcher I have the sense that she wishes she could describe that overwhelming emotion associated with the mother's reference to the sirens. She is quiet, and then continues the story of how the boy's care continued at the hospital.

Rick also relates that "I talk to my patients when working a code (cardiac arrest), they remember if they come back." Having assessed a lady in a motor vehicle accident, whose leg had gone through the dashboard and into the engine, Rick determine that was a "black tag" because she was not breathing and her legs were ice cold. Following triage protocol, Rick describes his decision. "She was at the bottom of the car and pinned, I said 'put a black tag on this one and start treating the others.'" After the car was cut apart and the victim had been freed, Rick noted that she was breathing.

I started treating her. Two years later we were called to her house, she had compressed spinal fractures and she lived. She told me that she remembers my voice and asks if I was the one on the wreck and says, "I remember you telling them to get the car off me and then... she is alive." She thanks me for saving her life.

Termination. Michael states "for years we could never call codes on the scene, and I had a hard time processing the thought of playing God versus evidence-based medicine." He describes recent evidence-based changes to trauma protocol that reflect the dismal statistics regarding traumatic cardiac arrest, and uses the term that is common to the paramedic profession, "calling the code", to refer to termination of efforts.

I always thought of doctors as a God complex, they were the ones that chose who lived and who died, paramedic were the ones that brought them into the emergency room. Now it's the paramedic, it's progressed and now it's our decision and that

probably is one of the most trying decisions I have had as a paramedic. Do you call a code as fast for a child? Age is a big thing. It did get easier in my head but my heart cried or I had to go have time by myself to make sure that I'm in this job for the right reasons. So it really hurt every time I had to call a code.

Kevin also relates to the stress of field termination of efforts.

I had a very hard time wrapping my head around that, I was training to throw the patient in the back of the ambulance and do whatever it took to keep them alive with the lights and sirens going on the way to the hospital...it was so ingrained that it was tough to break.

Michelle further discusses an extremely difficult call, previously discussed in the subtheme: torture. Having made the decision not to resuscitate a terminally ill cancer patient in cardiac arrest, Michelle had also opposed standard of care and withheld efforts for a patient without legal "Do Not Resuscitate" documents. She recalls that patient's family interaction on scene, "now I have a fight on my hands and the daughter is screaming 'we are not doing anything, you are from out of town and you are never here and you don't know anything.'" Michelle, voice raised and sitting on the edge of her chair, demonstrates with her own posture, "the son points his finger at me and says 'you are supposed to do your [expletive deleted] job, I called 9-1-1 for a reason.'" Michelle shaking her head adds, "I say 'I can't. I have a mother and don't know that I could do what you want me to do even to my own mother' and he says 'well then God help your mother' and he walked away."

John describes the response of his co-workers on a critical car accident scene when he elected to "fake" saving a young dead patient's life. "Everybody looked at me like I was

crazy.” Having been the first to arrive on the scene of a motor vehicle accident involving high school girls, John describes his initial thoughts as he assesses a fatally injured patient,. “You have split seconds to make a decision and everyone is looking at you while you feel for the pulse wondering, ‘what are we going to do?’” John determines that the young girl is dead and elects to buy time and not tell the girls that their friend is dead. “I’m not telling them the whole story,” referring to the other girls trapped in the vehicle. He tells them the “she is not breathing right now, so we are breathing for her. We have to get her out so we can assess her.” John remembers a decision not to tell the other passengers in a motor vehicle accident that their friend was dead. The decision was made in a critical event, with no time for consideration. “Do you make their situation worse by telling them their friend is dead and they can’t get away from her,” because she is trapped in the vehicle with them. “They would have feared for their own lives... and I think their own medical conditions would have declined.” The decision opposes the accepted standard of care, offering a futile treatment to a deceased patient until such a time that the patient can be moved to the privacy of an ambulance to stop treatment. John summarizes, “so that was one of those decision you make, a critical gage of whether you can do anything or not.” While comprehensive cardiac arrest and trauma treatment were not initiated, only ventilations, treatments were terminated in field. This account offers perhaps the appropriate transition to the next set of findings associated with resuscitation - show codes.

Show codes. A term commonly heard within the EMS profession is “show code” or “sympathy code”. This refers to cardiac arrest resuscitation efforts that are performed in situations when the patient has no chance of recovery, and yet treatment is initiated. The

concept is often accompanied by strong debate in that treatment protocol and the laws are often seen as “black and white.” Either you begin resuscitation and offer the absolute most aggressive care possible, or you do not. Show codes seem to exist as yet another ethical “gray area” in that they are resuscitations that are performed on deceased patient for the appearance of efforts being made on the patient’s behalf. Bremer and Sandman (2011) suggest that “professionals might have difficulty in facing the emotional trauma of the family, experience stress during the death notification of the family and find it easier if someone else takes care of the significant others or want to avoid explaining to the significant others why CPR is being terminated” (p. 503). Often “show codes” are performed in situations of young patients or on situations with complicating factors or family situations. The following responses present participant feelings both for and against “show code” resuscitation.

Kevin states, “I do not work sympathetic codes. A sympathetic code is one that you work for the family.” Kevin believes that performing resuscitations has to be a complete effort and that those done for show bring into question the effectiveness of care offered. “Our effort to resuscitate the patient cannot be done for the family’s state of being or be half way, ethically you cannot do it that way.” Michael alternatively describes a cardiac arrest call where a man had suddenly collapsed in an office. Many bystanders were upset by the situation and CPR was being attempted. The man had been in cardiac arrest for more than ten minutes. By the county protocol, Michael could have “called the code” and elected not to continue efforts. He states, “it was one of those situations where you knew he was dead, but there was a roomful of people. So what do you do?” For the benefit of onlookers and co-

workers that had initiated CPR, Michael states, “I made the decision to work him to the truck. Then I called it once I got to the truck. We stopped.”

Tunnel vision. The fifth and final subtheme of the “decision stress” theme is tunnel vision. The Merriam and Webster’s collegiate dictionary (1993) provides an interesting definition for tunnel vision. In the first notation, the medical association for the term refers to a loss of peripheral vision, a condition in which you can see things that are straight ahead of you but not to the side. In the second notation, tunnel vision is referred to as the tendency to think about only one thing and to ignore everything else. The term is widely used among EMS professionals, noting that the focus on an obvious assessment finding may lead you miss something underlying or critical to the patient’s well-being. Paramedics are trained to avoid such tunnel vision. Brian describes a call when he took care of a homeless man expecting him to present the same way he had the countless times he had been called to an inter-city park to care for him. In a previous subtheme, religious beliefs, Brian is quoted with crediting “the man on my shoulder” in reference to his faith in God guiding him to avoid the dangerous effects of tunnel vision. Brian assessed the man and found him to be in grave danger of cardiac arrest. “For some reason somebody just said, maybe it’s my years, maybe, let’s just put him on the cardiac monitor... and Holy Crap!” Whether belief in the guiding force of a higher power or the voice of experience, Brian describes the dangers in EMS of believing you have the explanation for the patient presentation, and failing to look further to find a possible life threat. Michael states, “I call it tunnel vision. I had tunnel vision as a young paramedic.” Stating that after many years of experience:

I try to sit back for a second and when things are not going the way they usually go, starts off the same but the outcome is a little different than what I expected, I take a deep breath and step back and look at the whole picture.

Further chuckling as he summarizes, “tunnel vision, the blinders are on your eyes.”

It is poignant for a researcher to close a chapter that addresses study findings with a subtheme of tunnel vision. Perhaps the primary intent of qualitative inquiry is to bring stories to life in such a way as to illuminate and inform the research community with a scholarly piece of literature. “To take the blinders off” suggests that in some way, adding to an understanding of a given theory allows those that seek to explore and contribute to adult learning can do so with a more inclusive vision, not one narrowed and void of the peripheral fields. A benefit to qualitative research is that it “implies a direct concern with experience as it is lived or felt or undergone” (Merriam, 1998, p. 6). In this case, allowing paramedics to tell stories using their own language allows the researcher to “reveal how all of the parts work together to form a whole” (Merriam, 1998, p. 6). Understanding not only the term “tunnel vision” as used in participant stories, but to further draw a deeper understanding of how the concept of avoiding tunnel vision informs participant decision-making in critical events contributes to a more holistic view of the research question. Merriam (1998) suggests, “it is assumed that meaning imbedded in peoples experiences and that this meaning is mediated through the investigators own perceptions” (p. 6).

Framework Coding Findings

The second part of this chapter discusses the key findings from the experiences and understandings of paramedics as they practice ethical decision-making in the practice of

EMS, analyzed through the lens of Iserson's framework. The Iserson Model also served as the conceptual framework for this study. Iserson's Model remains the only proposed model for ethical decision-making in emergency medicine literature.

Three themes and several subthemes were used based on the Iserson Model for decision-making for framework coding. The three themes that shaped the presentation of data include: reliance on previous experience, consult, and emergent ethical decision-making using the Iserson Model - Rapid Approach to Ethical Problems. Framework themes and subthemes are outlined in a table on the page following. References are made to the elements of each theme that connect the findings to the participant perspective from which the data was collected.

Table 2 - Conceptual Framework Themes and Subthemes

Conceptual Framework Themes and Subthemes

- I.** Reliance on Previous Experience in Decision-Making
 - A. Influence of experience
 - B. Influence of education and training
 - C. Learning from mentors

 - II.** Consult
 - A. Consult Medical Direction
 - i. Go against orders
 - ii. Limited assistance
 - iii. Shared decision-making responsibility
 - B. Consult Peers
 - i. Negative experiences
 - ii. Positive experiences
 - C. Consult patient's family

 - III.** Emergent Ethical Decision-Making and the Model; Rapid Approach to Ethical Problems
 - A. Test 1: Impartiality; Would you accept the action if you were in the patient's place?
 - i. Myself
 - ii. Loved ones
 - iii. Empathy
 - 1. Elderly
 - 2. Homeless
 - 3. Infants
 - 4. Young
 - 5. Frustrating Patients
 - B. Test 2: Universalizability; Would you feel comfortable having this action applied in similar circumstances?
 - i. Critical reflection
 - C. Test 3: Interpersonal Justifiability; Are you able to find good reasons or justify your actions?
 - i. Community
 - ii. Medical Director
 - iii. Patient well-being
-

Iserson Model as a Conceptual Framework

Common throughout health professions training and education, ethics receives minimal attention in classroom, scenarios-based training, or clinical education in comparison to the knowledge and skills base necessary to care for critical patients. This can, and as is noted in the findings of this research, does leave the emergency practitioner underprepared to deal with difficult ethical decisions. Iserson et al. (1995) compares the approach to clinical decisions to that of ethical decisions stating they are “very similar. Both require action. In both cases, the choice of the appropriate action depends on solving the problem at hand, and the problem solving methods are surprisingly analogous” (p. 40). The training, preparation and practice offered to emergency medical care providers for clinical skills differs considerably to that of ethical decision-making as a skill set. Paramedics spend hours learning algorithms, developed through research and approved by credentialing agencies, so that the approach to emergency patient care situations elicits a consistent, rapid, and competent assessment and treatment response. As a common example, the American Heart Association has prepared a video based-instructor led training curriculum for Cardio-Pulmonary Resuscitation (CPR) certification. This training consistently prepares providers for action with simplified steps and mnemonics to recognize and respond to cardiac arrest. Learners progress through both didactic learning and skills proficiency to the final step of verifying competence through practical and written examination that leads to certification. No such training exists for those who make ethical decisions in emergent situations.

In the absence of a formal, research supported algorithm for paramedics, Iserson et al. (1995) reflects on a method for ethical decision-making adapted from Howard Brody, MD

that suggests a complex method of ethical decision-making steps, “useful only when there is time in which to ponder deeply and weigh alternative courses of action,” (p. 44). The steps: identify ethical problem, list the options, list ethical values and important interests at stake, allow the greatest opportunity for deliberation, and formation of an ethical rule useful in future deliberations. Iserson et al. (1995) states, “the emergency practitioner will find this method extremely useful when working out possible courses of action for common ethical dilemmas ahead of time. It is a useful tool for dissecting and reflecting on past dilemmas” (p. 44). While critical reflection is a finding strongly supported in this research that is linked to ethical decision-making, a model for crisis situations at hand is necessary. Often in emergency medical care situations as faced by physician or paramedic, “there is not time to go through a detailed, systematic process of ethical deliberation” (Iserson et al., 1995, p. 44). For such cases, Iserson developed a rapid approach to decision-making is needed.

The proposed “Rapid Approach to Ethical Problems” by Iserson et al. (1995) suggests that emergency practitioners should first consider, “Is this a type of ethical problem for which I have already worked out a rule?” (p. 44). A rule is described as a general and defensible ethical statement to support decisions. Reliance on previous experience is considered prior to the application of the Iserson Model questions, and is presented as the first theme in the framework coding findings. The three subthemes that emerged are: influence of learning through experience, education/training as preparation for decision-making, and learning from mentors.

Reliance on previous experience in decision-making. When faced with a challenging ethical decision, Iserson et al. (1995) suggest that the practitioner consider

previous experiences of the same nature. Iserson et al. (1995) refer to this as an ethical “rule.” Findings associated with the Iserson Model framework interview questions demonstrate that the participants do not actively consider prior ethical decisions when faced with a dilemma. On-scene consideration of prior experience is limited to treatment considerations. Michael states:

I have treated based on a previous experience.... I remember one guy with respiratory distress from pulmonary edema and he had the same signs and symptoms as another patient I had intubated. I used what I learned on one call on another call to treat the patient.

Findings further suggest that the accumulation of prior experiences becomes a memory that informs patient care, without the need for a step to consider those experiences prior to application, Michael explains:

I look at each individual call for itself, I take the information that I’ve learned from previous calls that are the same... not the same patient... I pull from that information over years of learning and then I look at the current to see how to treat the patient. It happens so fast you don’t think about it.

Readers will recall from the open-coding themes, paramedics often associate the concept of assessment and treatment based on prior experience to be dangerous, referring to it as “tunnel vision.” While paramedics consider prior experiences to avoid prior pitfalls in treatment, participants are reluctant to base decisions on prior experience, feeling they may miss signs and symptoms unique to the new patient encounter. Rick states, “I have started to treat a patient the way I treated another patient and sometimes you have to back up and realize that

this patient does not meet those same criteria... backup and rethink the process.” When Michelle is asked, “do you ask yourself whether you have experienced a similar ethical problem in the past?” she replies, “I think some things are a knee jerk reaction, I don’t know if I ever, in an emergency situation, ‘got to get it right now,’ take the time to say ‘have I ever done this before?’”

Data shows that paramedics do not actively reflect on past calls during an incident, nor do they form a “rule” for future use. However, data does demonstrate that paramedics refer to an accumulation of past experience with patient care and further acknowledge that this wealth of experience is reflected in how they approach and navigate difficult ethical situations.

Influence of experience. The influence of experience in learning to make ethical decisions is profound and noted by all thirteen participants. Experience, as noted in the subtheme, “mentors” was acquired by observing what senior paramedics did in decision-making situations, but also by listening to the stories of other paramedics as they discussed difficult calls. Experience is also referenced by participants as they discuss a feeling of confidence that only comes with repeated exposures to ethical dilemmas. As Brian says “you do things more than once you get better at it.” Edwin describes repeated patient experience by saying “it is part of the learning process. You build a body of experience every time. You know every sick person you see, you catalog stuff.” Michael says, “when it comes to making those difficult decisions of ethics or morals or whatever, the new medics don’t have the years under their belt to make them... how much you have experienced impacts making

the difficult decisions.” While experience does not appear to make navigating ethical situations easier, participants did express a sense of confidence through repeated experience.

Data demonstrates that learning through experience is a powerful tool for use in navigating new and future ethical dilemmas. Both initial training programs through clinical education and continuing education for paramedics should reflect the teaching and development of this strategy. Past experiences in ethical situations and resultant decisions should be used for reflection and built into working practice-based tools for use in future practice.

Influence of education and training. Participants concur that initial education programs, both degree and certificate, do not prepare them to make ethical decisions in the field. John states, “I don’t recall anything I read in a book, a paramedic book or an EMT book to help with any of the ethical decisions.” Two of the participants reiterate the lack of ethical decision and empathy training in initial paramedic programs and further suggest that paramedics are taught to focus on rapid clinical assessment and management. Michael says:

I know I was taught something about ethics in my paramedic (class) because it was a requirement of the state... but I don’t remember anything about ethics and I don’t remember anything in my class about caring for the whole person. My job was to see assess the patient and get them to the hospital, my job was not to take care of little granny and hold her hand on the way to the hospital.

Edwin also agrees that empathetic care was not a focus in his initial training, but notes that paramedics were taught to react to patient situations, rather than reason through them.

Empathy, as defined previously, “is the ability to put yourself in the patient’s shoes”

(Mistovich, 2014, p. 83). While the Mistovich text suggests that the paramedics may not be able to fully experience the plight of the patient, empathy enables an understanding as decisions and patient care are rendered. Iserson et al. (1995) link empathetic care by stating “it asks practitioners to switch their point of view, to take the other person’s perspective. Usually that is useful to do and can at least help to avoid a grievous error” (p. 46). In contrast, “cookbook paramedic” was a term previously noted in the open coding themes that refer to a paramedic that determines patient condition and reacts based on training to identify and follow orders, rather than reason the necessary approach. The current trend in paramedic training and care is to offer a comprehensive foundation for patient care so that paramedics are armed with an understanding and can treat without reliance on the “cookbook” approach. Edwin describes his initial paramedic training by stating:

Empathy was not terribly stressed, it was more cookbook medicine. Not so much ethical decisions... but he (paramedic instructor) taught us to want to be a paramedic. We did not talk too much about ethics, we talked a lot more about you know, do this because of this, do this because of this. I went from being that cookbook reactionary person to becoming a diagnostician and a provider of pre-hospital medicine. Literally, there is that change, the evolution that is out there. We were all taught to react, not to be proactive.

Meagan also refers to a shift in thinking.

Some things I am more at ease with... some calls I can go on scene, you’ve seen similar situations, you can pick up on certain aspects, you can pick up on things that are wrong quicker, thus experience has made the decisions easier. I think the thing

that has changed the most with experience is that I feel like I am doing what is best for the patient, knowing how I would want to be treated. I used to be more protocol driven. Yes, lots of times that works just fine. Now I look at things more from the patient perspective. I still follow the protocol most of the time... but there are times when protocol just doesn't work and so I go and make different decisions based on that.

Participants relate learning to make ethical decisions to lived experiences, both as an observing student and through the experiences of others as told in stories. Participants further relate learning to critically reflect on calls in the same way. Ben says, "I think life experience or work experience trained me more on empathy than anything in school. It's been roughly 14 or 15 years since I went through school and if empathy was taught, I sure don't remember learning it." Laura has a similar response stating, "most of what I have learned has been in the field. You can learn stuff in the classroom, but nothing like hands-on." Laura specifies that especially in cases of ethical decision-making, learning comes "from the actual call, one at a time... training as I go and knowing what I need to do and making the decisions on a patient to patient basis." Laura's statements further demonstrate that the practice of ethical decision-making does not appear to be associated with classroom learning, rather paramedics learn through experiences they observe directly, or in listening to the stories told by other paramedics.

Learning from mentors. Participants indicate that a powerful learning resource for ethical decision-making is that of mentorship, both as students in a clinical internship role and in the observation of more senior paramedics. Learning empathy is also associated with

mentors. James explains that the role of empathy is crucial to making good ethical decisions. “How can you make these decisions without putting yourself in their shoes or their family’s shoes?” James also believes, “we do not spend enough time teaching them how to talk to people and make good decisions.” Describing a similar learning experience, John states:

The ethical decision came from listening to senior people, senior medics give life experiences of situations they were in which was a lot like if I had visited that same situation and so hearing instructors give an example or for instance of a situation.

Michelle says:

When you start paramedic class you have certain ideals and after sitting in class and listening to instructors war stories, because you cannot pass on or express things to people until you give them a scenario of what has happened to you, so I think learning from the other paramedics, it’s the field time. It is the preceptor because even when you have an instructor standing in front of the classroom, I think our questions as students tend to bring out what they did in the back of the truck... we want to know, “can you validate what you are trying to teach me?”

Michael remembers struggling with the concept of calling a code on scene and declaring the patient dead. He states:

It felt like I was playing God. It used to be the earlier days of EMS, you could count on the physician making the final decision. Now I’ve gotten older in EMS and I realize that false hope is just as bad as or even worse than no hope.

Michael remembers his struggles with decisions not to work patients in cardiac arrest and remembers the words of a mentor:

Are you doing this for yourself, or are you doing this for the patient? A lot of times when I treated patient I over treated them, I was doing it for myself, making myself feel like I had done everything I was supposed to do.

Michael tells his mentor, “I know that evidence says she is dead, but my heart wants to work her.” His mentor replies:

Sometimes you have to listen to your heart and sometimes you have to listen to your head... which one is beating you up a little bit more right now and which one is going to win? So, I’ve learned to make decisions watching people around me that I trust, people I consider my mentors.

Ben describes learning by navigating ethical situations.

It’s more experience going down the road which kind of falls back on the fact that I was lucky enough to where I had experienced partners the whole way, whether they were good or bad, I had people that had been it for a while. One of the ways I fall back on experience the most is when I talk to families because you know, that’s the toughest thing you will ever do is tell someone’s family that their loved one is dead.. and you learn.

James describes his early experiences in EMS, as a young volunteer.

My first influences were great, they were good people, they were street medics, they were strong medics and they treated people well. The people I was on the truck with as a student never broke a sweat, never let the chaos get to them’ they did their job and they did it well. They were the ones I wanted to be around. I had quality preceptors who were veterans in EMS and they taught me how to talk to people... I

remember my preceptors telling me when I went into a nursing home to call my patients Sir or Ma'am, saying 'would you want your granddaddy called sugar or buddy?' and I said 'no'. My preceptors were calm and good patient advocates, those things helped me for being ethically intact. I saw the good and the bad and I was able to choose who I wanted to be more like and what we effective in regards to patients.

Scott describes learning by watching others, experiences, and how these methods have impacted him as a preceptor of other paramedic students.

I learn that (making decisions) by doing, unfortunately. I didn't learn a whole lot from the books... I would learn by standing in the corner and keeping my mouth shut, just watching and asking questions. When students come on (the ambulance) I kind of let them make their decisions and some of them, I think, got a little put off by it and I am like, 'why? It's time for you to learn how to do this and you will learn by doing. I am not going to sit here and tell you what to do with your patient because the way you do it might be different than the way I do it, and that is fine, but you still have to get the same outcome. So, I want you to develop your own way of doing it.' Some of them I had to convince that I am here to catch you if you fall, but otherwise, treat your patient and if you are going to hurt them, I will stop you.

As noted, paramedics learn ethical decision-making practices through direct observation, and via their own experiences and hearing about others as they critically reflect or listen to patient care stories. Mentoring, through precepting opportunities with students, or through telling stories as a respected and experienced practitioner, informs the understandings of paramedics and creates a lasting impression. Brian remembers a night when he had a critical

patient and his own partner became unconscious on scene leaving him alone with two critical patients. He called for backup and remembers the feeling of relief as the lights and sirens approached. “Those were the most beautiful lights I had ever seen... they were better than Christmas lights.” Later peers tell him that he handled the situation well and sounded calm on the radio. He chuckles and continues, “I was not calm on the inside.” He goes on to say, “I think I credit my preceptors and co-workers who have been around... it prepared me. Seeing how they do things helps piece things together,” in a difficult situation.

Co-workers, you listen and learn from them... I always reuse that. You know, I learned from my co-workers a lot- just seeing how they do things. I don't think my training prepared me for making decisions. It's just exposure to calls and with the right people around.

One obvious limitation to the approach of asking oneself if there is a previous rule is that it requires prior experiences in ethical decision-making exposure with similarities to the current dilemma and with a suitable outcome. Secondly, it requires time that may not be prudent in emergent situations. Iserson et al. (1995) suggest that if there is a prior experience for which you have previously found a suitable decision outcome, then use it. He further suggests that a delaying tactic be considered, if it poses no risk to the patient. John states:

I don't recall anything that has helped me make an ethical decisions that came from a paramedic book, it all came from experience whether it was experience of another medic that taught me that situation or my own experience. It's those situations where you always fall back on your training and sometimes you can't remember what was training and what was real life because it all training... your everyday experiences are

additional training , on the job training... however you label it, it's on the job training. In situations with my years of experience and being the lead, you arrive and everybody looks at you to make the decisions... so you quickly assess, and you do it. Participants relate stories that demonstrate the strong memories formed from mentoring early in their careers and throughout their experiences as they listen to trusted paramedics, or watch them use ethical decision-making skills. While mentoring is not typically a formally taught or recognized skill and seems to form through personal experiences, these findings suggest that the development and enhancement of such a skill would be beneficial.

Consult. In the event that no previous rule exists, Iserson et al. (1995) suggests that emergency practitioners use “delaying tactics; there may be enough time for consulting with other professionals, including the bioethics committee, talking with family, and developing an ethically appropriate course of action” (p. 45). EMS providers consult peers and medical direction most frequently. While several participants had used consultation on rare occasions, none mentioned the use of a delaying tactic in order to access consult. Only one of the participants spoke of using a delaying tactic to make an ethical decision. While the patient situations may not have be critical, the need for emergency services to make decisions and return to an active status ready for calls is a critical need. Additionally, participants expressed that patient’s, family members, and other EMS co-workers expected immediate decisions. While “buying time” was not a strategy employed by these participants, one participant did use the term “buying time” as he discusses his management of a difficult scene. John recalls a car accident in which the passenger in the front seat was dead upon his

arrival. The victims were high school aged girls, all friends. John recalls that scared and injured girls asking about their dead friend.

If I don't tell them right now, what is going to happen? So you make the move to buy you a little time, I'm not going to tell her right now... to buy you some time to make more parts of the decision so you quickly assess and say "if don't tell them she is dead what is going to happen?" So we are not telling the whole story we are delaying till be get to a concrete decision or separate them... but the problem is, these are still within a few minute decisions... they are not twenty or thirty minute decisions... these are made within seconds to minutes of having to come to the full conclusion. It's that gut instinct, It's that right thing to do for now. The teenage and youth are always hard decisions. When youth are there you handle it differently.

In this case, buying time as a delaying tactic is used to maintain the emotional well-being of the other accident victims, with no benefit to the deceased patient. It should be noted that this decision is outside of accepted care according to protocol, where treatment is based on patient assessment, not to offer a sense of hope to on-lookers.

Arguably all situations faced by paramedics are not emergent as a life threat. Data demonstrates that participants approach ethical decisions as emergent in that they exclude the time for deliberation and act rapidly. Perhaps the need to act is derived from the expectation that emergency services will arrive on scene, immediately move forward with the appropriate decision and return to a "back in service" status for the good of the community. Consult therefore was limited and when exercised, it was limited to infrequent use of medical

direction, peers, and the patient's family for guidance associated with resuscitation wishes. These findings are presented as subsequent subthemes.

Consult medical direction. Medical direction can be a confusing term, having two implications. First, Medical Direction can refer to the orders set forth by a medical director. Readers will recall that each EMS entity, whether it be private, municipal, or hospital-based, must have a physician medical director that oversees and provides written standing order called protocol. Medical direction also refers to time when a paramedic may call by radio or phone for consultation with an Emergency Department (ED) physician. In the latter case, any on duty emergency department physician becomes on-line medical direction, able to give orders. In the stories that follow, participants refer to times when they elected to call the on-duty physician for consult. For clarity, in some systems, the medical director overseeing the system may also be the on-duty Emergency Department physician working a shift at the local hospital.

Laura remembers having to call medical direction for a patient that refused to go to the hospital and hadn't eaten or taken her medication in days. The family was frustrated and the woman, in her 80's, did not want to be touched. Laura smiles and says, "well, I am usually pretty good at talking patients down, but this lady was adamant about not being touched." Concerned for a mental status because she believed that her family was trying to poison her with food and water, Laura elects to call for orders to sedate and transport her against her will. "I got her to the hospital and promised to get her something to eat. I got her water and she drank and drank." Laura continues:

You do not ever want to have to treat someone against their will. Calling the hospital when a patient is refusing helps to get that patient to decide to go. When you know they need to go, I have called medical direction and had the patient talk with the doctor so that the patient understands the gravity of their situation. You know you will not be able to go home and rest knowing that I left them there.

Michael echoes Laura.

I remember this little old lady, no phone in her cabin and had critical Congestive Heart Failure. She didn't want to go. I was able to talk her into going- I've gotten very good over the years that when I have a feeling, being able to talk them into going to the hospital even when they don't want to.

Meagan remembers calling medical direction for assistance with a critical stroke patient and discusses the treatment options of physiology of each. The physician ordered a treatment that Meagan believed would make the patient's stroke worse. After further discussion, she concluded, "okay doc, you are medical control and I am going to go with what you are saying." Medical Control is synonymous with medical direction when describing on-line, or direct conversations for consult.

While Scott did not consult during a call for assistance with a decision, of note, he recalls a time that he had to treat a challenging patient with two etiologies, a heart attack and a collapsed lung. He later asked the ED doctor to talk with him, telling her:

Here is what my thought processes were, should I have thought of something different? She said that I went down the same alley she would have... "okay", I just

wanted to make sure I had done everything, but if I make a mistake, I want to know so if it comes up again.

Data demonstrates that participants often discuss calls and the appropriateness of treatment following patient transfer with peers or the hospital staff receiving the patient. Noted to be a routine practice, this form of critical reflection encourages revisions to ethical decisions, and further develops strategies and confidence for further encounters. Data further demonstrates that participants engage in critical reflection as they process feelings of stress associated with the ethical situation.

Go against orders. Once the paramedic has made the decision to consult a physician, it is expected that the physician's orders will be followed. This can add to the dilemma if the orders are against what the paramedic believes to be in the best interest of the patient. It is also noted that ED physicians may not be familiar with EMS procedures and protocols. Paramedics that do not follow orders, ethically, have broken the relationship between paramedic and physician. Paramedics serve under the license of the physician. In the cases that follow, paramedics have opted not to follow orders in the best interest of the patient.

The concept of duty is a legal designation describing the relationship of paramedic to patient. Paramedics have a "duty to act" when called to the scene of an emergency. That duty is not severed until the patient refuses care (if able) or is delivered to an equal or higher level of care. Iserson et al. (1995) describe duty in an alternate manner, suggesting that even when confronted with the responsibility of patient care, "the resolution of an ethical dilemma requires us to be clear about the scope and limits of our obligations to act in another's interest" (p. 36).

Michelle describes a call when she decides to go against her orders.

I had only been working for the county three weeks when this happened, my job is now on the line and I am about to defy... in my head, I am like 'you are about to defy the one thing you are told to have to do,' I have a duty to act.

Michael had a similar experience with a patient refusing transport. After trying in futility to convince the elderly man to be transported to the Emergency Room, the man said, "No, I am going to die and I am going to die in my own home." Michael remembers:

The hair on the back of my neck was standing up when I walked in his door. He had just been discharged from the hospital for a heart attack. At this point I did not call medical control because I knew they would've told me to handle it myself, 'you cannot make him go, you cannot kidnap him.'

Michael called law enforcement to assist him with persuading the patient, and to witness the conversation should that man ultimately refuse care.

When the police office got there I told him, he's having the same signs and symptoms when he had a heart attack 10 days ago. He does not want to go. The police officer responded, "if he wants to die, he can die... what do you want me to do?"

Michael left with care refusal paperwork signed and witnessed, saying "I do not like this."

Later, he was called to the same residence for the man in cardiac arrest. Illuminating the challenges of ethical decision-making, Michael struggles with the decision to resuscitate.

When he arrives to find the formerly belligerent patient in cardiac arrest, the man's son tells him "you're not going to work him." Knowing the patient wanted to die at home, but having no legal support to allow this, Michael replies, "Sir, I'm going to have to get the police

officer... I don't want to do that." He said, "I don't blame you, do what you have to do."

Michael continues:

So I called the cops and we worked the code. We didn't get him back. I called the police because it was in the best interest of the patient and I was emotionally charged from the previous time that I had been out there before... I don't know whether it was best for him or me. I've never been in that situation before. I've never had a family member tell me they didn't want me to do anything. He was adamant that he didn't want anything done. He said 'my dad has lived through enough and he didn't want anything done'. I felt that working him and not working was of the patient. It sucked either way, but I erred on what I was trained to do for the betterment of the patient and to get the police there. I wondered how do I justify calling it or working it, both ways. I took a deep breath and I thought... I could call it and get away with it. I had already been out there and had a refusal signed. If I do that will the family members think I just let him die? I wondered on my own, did I just let him die because he didn't want to go to the hospital? I did hear the patient say, "if I'm going to die, I get to die at my own house in my chair." At the same time, I had an obligation to work it because we didn't have a DNR order... I had a legal obligation to do my job. That's why I did it.

When asked what he believed was best for the patient, Michael replies, "to leave him there and not have called anyone."

Rick remembers a time when he followed orders and did not treat as he believed would have been in the best interest of the patient. Later he felt frustrated. He was taking

care of a college student involved in a car accident with massive chest trauma. The patient had two collapsed lungs and Rick called medical direction for orders to treat using a needle decompression (procedure to release building air pressure in the chest). Rick was denied the orders and later describes his arrival at the ER. “The doctor decompressed the chest as soon as we walked in and it sounded like steam whistles going off.” The patient was declared dead. The same doctor denied him orders for a drug he believed may have saved the life of a woman in shock. Saying to himself, “this one is going to die if I don’t do something,” he elected to defy orders and give the drug:

I just went with the treatment, I was not going to watch a patient die because I had something in the truck that could help. I documented that I had no orders for it, in fact the ER doc wrote it up too and I had to go before the board and medical director for it. I knew I was crossing the line, but I had to do something to keep this lady alive, that was job, and if I was going to get fired, well then I would just work someplace else. They did not punish me.

At times, limitations of orders, or the inappropriateness of medical direction orders creates a dilemma requiring the paramedic to go against orders and jeopardize his job and certification, or do as he believes is in the best interest of the patient, following his duty to act. Changes and advances in EMS have created autonomy in EMS such that paramedics are able to practice a wide range of assessment and treatment as prescribed in protocol without calling for orders. While this has greatly improved the speed and quality of patient care, it has widened the gap between practicing ED physicians and paramedics considerably as it is no longer incumbent on the ED physician to maintain a current knowledge of EMS protocol.

This issue has become particularly problematic in community hospitals as opposed to larger trauma centers. To compound the gap, EMS agencies function under different protocols, making it nearly impossible for any physician to know the procedures and treatments for each EMS service that transports patients to them.

Data demonstrates that participants do not routinely consult medical direction, nor do they feel the need to. In fact, participants suggest that in the event they receive orders from medical direction that they perceive to be in conflict with the patient's best interest, they will disregard orders. This in and of itself, creates an ethical burden.

Limited assistance. Medical direction has evolved in its role in EMS. While the relationship of paramedic to medical director remains intact, the paramedic functions under the license of a medical director using standing order protocol, or on-line (phone or radio) orders, the reliance on calls for order or assistance has greatly diminished as paramedics are more aptly trained to assess and treat independently. Just two decades ago, it was commonplace for a paramedic to have to call for orders to start an IV (Intravenous line for fluids or medications). It is now commonplace for a paramedic to treat and direct all of the events surrounding cardiac arrest resuscitation in the field to include the termination of efforts, without the assistance or orders of a physician. Stories that follow relate to the limitations of medical direction assistance. For example, James says:

You know I reach out to other paramedics that may know... I have even called the training officer and asked "what do you think about this?" The answer always comes up... when in doubt just drive to (large teaching hospital)... you won't go wrong.

That's really the only time I reach out, when I really just don't know. We still have

people out there that call in for stuff and at what point are you gonna put your big boy panties on and quit calling the hospital every time you need to make a decisions? I don't call medical control. They do not know our protocols and they don't know what we have in our toolbox anymore. There was a time when ER physicians were heavily involved with EMS and then you could put faith in their decisions, now there is no telling what you get if you call in.

James relates the story of a time when he called medical direction for assistance and wishes that he hadn't. James describes a time, earlier in his career, when you could not take a trauma patient past the nearest hospital to a trauma center. That was considered a decision for the doctor to make.

I should have broken all the rules and just delivered him to the trauma center and at least gotten him to a surgeon alive and I could have slept a lot better if I had. It was before you were allowed to do that... so I called medical direction. James repeats his conversation with the medical director, "I have a patient who is trapped in a car, his pelvis is mush, he is bleeding out and he needs blood now, do I think I should go to the trauma center." He said "get him here (local hospital) as fast as you can" His (Medical Director's) only saving grace was that they had blood hanging and ready when I got him there... I made the decision to call, but maybe I should not have and just gone with my gut and carried his ass to a trauma center so a surgeon could have tried to stop the bleeding before he died.

John remembers a time when he called medical control for assistance with a critical patient. "When I heard his name and, 'this is doctor so and so go ahead', it was like he was

always giving bad decisions and things go bad... but he was my only medical advice that I had to go with.” When left to the discretion of the paramedic, a call for consult may be answered by any ED physician working at the time. John states, “sometimes you have time to call and get permission and sometimes you don’t. You have to have a good standing with your medical director.” John further describes a level of trust between the paramedic and the medical director, suggesting that at times the “trusted” paramedic can take additional liberty when consult is necessary.

Michael addresses this relationship of trust remembering as a young medic his insecurities with making difficult decisions. He chuckles and remembers being called in to talk with his medical director. “This is kind of personal, but one time, medical control contacted me. It was years ago when I first started, maybe six or eight months.” Michael states, he called and said:

I need to talk with you. It’s nothing that you are doing bad, it’s the fact that I know you know what you’re doing, but when you call to get orders you are second-guessing yourself. You know what you see, you know how to treat it, and you don’t always have to ask permission... you have protocol. You have standing orders, do it!

Rick remembers calling for orders to bring a sick woman to the ER against her wishes. He was denied orders and told to leave the patient. Feeling uncomfortable and worried that the patient would die, he states, “she was in a gray area, in and out of normal mental status to make competent decisions.” He elected to call a supervisor and with family and the support of the supervisor, they transported the woman to the hospital. Risk relates that the call to the

medical director “was not helpful, I got more help from the family and my supervisor, who agreed that she needed to go, the doctor was irate.”

Edwin recalls a time when he was functioning as a supervisor and an EMS crew called him from a scene. The crew was attending a 57 year old patient with severe nausea and vomiting. After IV fluids and some medication for nausea, the man wanted to refuse transport to the hospital stating that he felt better. The crew followed their protocol at the time and called the physician at the Emergency Room for permission to discontinue treatment and leave the patient at the residence against medical advice. The doctor on duty argued that the patient had to be brought to the ER. In a difficult situation, go against doctor’s orders or treat a patient against his will, they called to consult Edwin. Edwin told the crew, “fully explain to the him (patient) that he needs to understand that if he gets worse to call 9-1-1, that he is severely dehydrated and that he could die from dehydration. Give him a full set of discharge instructions, verbally and in writing and you make him sign it, and you make his wife sign it. I will take care of the doctor.” Edwin smiles recalling the subsequent conversation with the ER doctor, “hey doc, how are you?” and he said, “your paramedics are out there and they are refusing to transport the patient.” Edwin continues, “I understand that and I am telling them that they cannot transport the patient.” The doctor, now outraged, replied, “Are you refusing my orders to transport the patient?” and Edwin, now chuckling replies, “Yes, it is not an order you can give... here in the state of North Carolina you are not allowed to order or facilitate a kidnapping.” After brief pause on the phone line, the doctor replies, “what do you mean?” Edwin continues, “you don’t have the authority to do that, only the magistrate or a judge can issue an order to transport a patient

against their will. He is on duty 24/7/365 over there at the jail, would you like his number?” The doctor hung up and Edwin continues, “the magistrate called me at six o’clock in the morning and said, ‘I knew you were asleep, but I wanted to call and tell you that that damn fool doctor tried to order a kidnapping.’”

Findings suggest that paramedics are not only reluctant to use medical direction, but often see an over reliance on medical direction as a weakness. Participant responses reflect current trends in EMS. Paramedics function with a high degree of autonomy and are expected to be self-sufficient with the exception of atypical encounters. In such situations, current medical direction is of limited assistance and in may be outdated. Physicians are no longer expected to keep up with the varied protocols of surrounding counties that they may be subjected to through EMS units calling via radio for orders. Indeed, Emergency Department physicians may not have a current knowledge of EMS and are therefore not a consistent choice for consult. Participants did note times when they wished to acquire medical direction as an authority in difficult situations. These findings are presented in the subsequent subtheme.

Shared decision-making responsibility. Participants expressed the desire to share the burden of some ethical dilemmas. Paramedics that follow orders share liability with the physician, with the exception of negligence. Paramedics still bare the duty to act and as such are responsible to detrimental decisions, even if ordered. As the “eyes, ears and hands of the physician” they are expected to intervene on the patient’s behalf. Yet, when possible, shared ethical decisions ease the dilemma. John remembers a time that he was working on a pediatric cardiac arrest patient. The child was not responding to any drugs or treatments. It

was his first pediatric cardiac arrest as a paramedic and he called medical control. The doctor, in order to assist in the frantic moment asks John, ‘how much do you guess the patient weighs?’ John reports that the doctor did all of his drug calculations and reported them by radio.

Scott recalls a time when he wanted to treat a patient outside of protocol, I needed to step outside of protocol and it was for the medication I needed to give. It was within the realm of what the medication was used for and I felt rest assured that it was going to be able to help the patient so I called. It was not one of the protocol ways that we use the medication and I asked him, ‘here is what I have got, here is what I think I need to do, what do you think?’ and his response was, ‘go ahead and try that and let me know what happens’.

Michael remembers a time that he treated a patient using a drug, and following protocol, should have transported the patient. The patient had been seen and treated by EMS many times for the same condition. The patient was so familiar with her past treatment that she asked for the drug by name when Michael arrived on scene. After assessing, he administered the drug and worked affectively. The patient then said, “I am going to sign the refusal form.” Michael explained that having given a drug, “you have to go.” The patient responded, “Son, no I don’t, I know my rights and if you give me that medicine and it works, I don’t have to go.” Michael continues:

I called medical control and said, ‘I’m in a dilemma here’. You tell me I have to transport because I’ve given a medication. She is alert and oriented. She knows more about the medication than I know and she says she is not going and she is fine.

The hospital agreed and to reduce the liability, law enforcement responded to the scene to witness the paperwork.

Laura also remembers a time when she was grateful to have medical direction. Called to a cardiac arrest, first responders said that they had seen the patient DNR order on a previous call to the house, but that the DNR cannot be located on the current call. Electing not to start CPR, Laura called the hospital to explain the situation and “was told not to work it.” Laura explains the significance of the order, “protocol wise - without a DNR, I should have worked it.”

While the need for medical direction is diminished and as noted in the prior subtheme, of limited assistance, some participants attest that they have been grateful for a shared responsibility in decision-making. Edwin states, “in retrospect the day I killed that lady. That was the day I wish I could have consulted with somebody.” Referencing a time when he treated a patient appropriately and the side effects of the medication had a lethal effect on his heart attack patient. Despite issues of time, access, the physician’s limited knowledge of EMS, or reliability of consultation, the participants of this study note there are times when medical direction consultation is of benefit. Participants voiced the use of medical direction for challenging calls to share the liability associated with critical decisions. Especially noted in decisions involving resuscitation and termination of efforts, participants viewed the opportunity to share responsibility as a positive experience.

Consult peers. The concept of consulting peers was limited to those who were paramedics, but ranged from friends, old preceptors, to supervisors. Michael says:

I have called people I knew on the way to calls... if I knew I who I was going to see (patient) and it was someone they knew (peer), I have called and asked for help and said 'hey, what do you know about this person we are going to see?'

On another call, Michael was on scene with a child that had been injured and he feared that child abuse was involved.

I did everything I could to talk the mother into letting me take the child and she refused. I had another EMS worker try getting the story to see if it matched what I had been told. I did notify my supervisor to see what I wanted me to do. I consulted. I felt safe, but I didn't feel safe for the baby or the mother. At that point I had already made contact and interacted with the patient. My supervisor told me to 'get her to sign the refusal form and leave the scene'. I found it helpful because of the simple fact that it wasn't my final decision. When it's my final decision I have to live it for the rest of my life. Some of the decisions I've had to make, I did make and still stand by them, but they didn't always turn out the best way they should.

Brian remembers when he first became a paramedic he was called to a cardiac patient.

When you're on your own trying to treat a patient they don't seem so common. The patient was critical and I just had one of those moments, just one of those dumb moments, I was locked up. So I texted one of my old preceptors and said "this is what I've got, A-B and C, what should I do?" and he texted back and said "what do you mean this is what I've got, you are on a call?" and I said "yes, just need your help." He smiles and adds that his friend said "if you are on a call then you already

know how to treat the patient.” I was just in a dilemma and had to reach out to a friend for help. He used to embarrass me... but it made me stronger as a paramedic.

Paramedics that consult with peers tend to select trusted paramedics with whom they also identify a relationship of mentor or instructor, supervisor, or experienced co-worker. While some of the participants relate stories of reaching out to peers for consultation, the assistance they received was reflected as both negative and positive. Two further subthemes are used to further describe findings.

Negative experiences. James remembers a call when he responded to assist with a cardiac arrest patient. Upon arrival the patient was receiving substandard care. He tried to make suggestions and the paramedic on scene became defensive. He elected to call for peer support and says:

Yep, called the person in charge that night and it failed. It met the definition for negligence. Do I have the right or rank? Do I physically pick them up and move them (paramedics) out of the way? I spoke to the supervisor and told him, they are killing the patient and he blew me off.

After an investigation, James states that his medical director told him, “I could step up in there and do something. After the fact it was helpful, but it does not bring the patient back or help the family. It was interesting... that was a decision-making process.” Shaking his head, James continues:

Now, I would have jumped up in there and raised hell till they did something. That is pretty much with the medical director said... you absolutely have the right to jump in there – you are the most senior paramedic in there, you have the right to stand up and

raise hell. I was trying not to step on any toes and trying not to hurt feelings. Is there a place for not hurting feelings when it comes to doing the right thing for a patient? A challenging dilemma, how does a paramedic with no authority step in to intervene on the patient's behalf when inferior care or unethical decisions occur?

Meagan recalls a difficult situation, made worse by an off-duty supervisor. She was called to a patient that had been attacked with a machete with one wound through the scalp to his skull and another through the chest wall exposing lung tissue. The man is combative and required five emergency services providers to hold him down. The decision was made to call for a helicopter to land on scene so that the patient could be "RSI'd" (Rapid Sequence Induction) a procedure that renders a patient unconscious and paralyzed with medication to secure an airway. While the helicopter was enroute, an off-duty supervisor arrived on the scene, having heard the radio communication. He argued vehemently with the crew that the helicopter should be cancelled and the patient transported by ground to the trauma center, one hour away. Once enroute, Meagan asks that the driver of the ambulance call the on-duty supervisor, hoping to transport the patient to the nearest hospital so that the helicopter can meet the patient there. The on-duty supervisor agrees and tells them that she will meet them at the closer hospital. When Meagan calls the closer hospital to give patient report and alert them about the impending arrival, the ED physician responds ordering her to "divert to the trauma center." As the patient continues to deteriorate, Meagan again argues for his care and insists that he needs the closer hospital. Hospital staff via radio respond "who in the hell do you think you are going against medical control, coming straight here, when you have been told to divert?" Meagan responds, "10-4, I'm the person in control of this patient's care and

we are at your back doors.” The hospital staff met the crew in the ambulance bay, refusing to allow them to unload. The patient continues to decline with respiratory distress and profound shock. The on-duty supervisor had not yet arrived and the crew were ordered to continue the transport to the trauma center. Once at the trauma center the physician asks, “the last time I was in your county there was a hospital.” When Meagan advised that they had taken the patient there and the nurse, with hospital security, met them outside to refuse acceptance of the patient. The doctor asked for the names of both nurse and physician. Meagan recalls both were reprimanded for breach of EMTALA (Emergency Medical Treatment and Active Labor Act), a “statute that stipulates that any hospital with an Emergency Department must, within the department’s capability, provide appropriate medical screening to determine whether an emergency medical condition exists in anyone presenting to the department” (Iserson et al., 1995, p. 17). The off-duty supervisor was reprimanded as well, and Meagan recalls being told:

You should have taken the patient into the hospital (first hospital)... you should have just knocked them all down and taken the patient into the hospital... yes, I knew that the patient needed to go into the hospital, but what do you want me to do? Fight with people?

Like James, Meagan felt helpless to fight against the poor decisions of peers in an emergent situation.

Data shows that the embarrassment associated with peer criticism is a powerful force affecting perceptions of practice and willingness to communicate a need for assistance. Data also suggests the disturbing fact that participants often felt helpless in situations when they

were faced with a poor ethical decision involving a peer. No consistent approach to navigating encounters that may produce embarrassment, nor means to confront peers during a critical situations were noted in findings.

Positive experiences. Michelle remembers a time when she called a peer for advice on a call. She was taking care of a woman in her 60's that was lethargic, struggling to breath, and had a low blood pressure. She remembers, "there was something I just couldn't put my finger on with this woman." She feels pressure to treat the ill woman, but isn't sure what to do. When her peer answers her call he begins to ask questions. Remembering with frustration, "he wants to know this whole big synopsis on her and it may have taken only 15 seconds to answer, but it seemed like 'God! Just shut up and tell me what to do.'" After he had asked questions ranging from how do her feet look, to what condition is her house in, this senior medic replied, "Michelle she is trying to die." Michelle shakes her head as she continues, "I said what?" She goes on:

He said think about it, she has oxygen that she won't wear, she conveniently can't find any of her medications and the family said that she takes a whole lot of medications. She has quit taking her medicine. Now, what you have to figure out is how to make her better without killing her. Well ok Great! I knew that.

He gave her some suggestions and then drove to the Emergency Room to meet her. "When I got to the ER he actually came there and met me and said, 'I told you, sometimes you have to sit back on your hands and consider the big picture.'"

As previously noted, data suggests that positive outcomes associated with peer consult closely align with mentoring processes and are described as confidence building

experiences. The following subtheme also presents a reference to consult that add to a feelings of confidence in decision-making.

Consult patient's family. While other participants relate stories of ethical decisions that include the input of patient family, one participant tells a story that indicates he openly sought and followed the consult of family as he made an ethical decision. Scott recalls a time that he was called to a residence for a man found in his car in cardiac arrest. Scott relates that the man had been sitting in his living room with his wife when he said he was going somewhere and went to his car. Thirty minutes later, the car remained in his driveway. "I asked her, 'what is your decision?' and she told me that he had a couple of medical problems, but he has lived a good life, he wouldn't want to be on life support, I think this is good." Scott explains the ethical dilemma; "it's outside of our protocol, and the protocol pretty much plainly states that is there is no rigor mortis or lividity you are supposed to start CPR." On a similar call, Scott recalls responding to the residence of a patient in cardiac arrest. The husband advises that there is a DNR, but he has Alzheimer's disease and is unable to remember the code to the family safe where it is kept. In this situation, Scott stops to call medical direction.

By our protocol beyond the shadow of a doubt we should have done CPR, but right wrong or indifferent, I will stop for a second and say, 'if it was my mom or dad what would I want?' I told medical direction, 'she has not been doing well, they have a living will they just can't put their hands on it, I think it is best to just let her be' and they agreed. To my good fortune, I knew the doctor that day.

While the consideration of family consult in this case led to a decision that Scott believes best represented the patient's wishes, there is no legal precedent and paramedics are reluctant to appear before bystanders and family members as though they are not competent in decision-making. Although the practice of family consult is neither taught nor encouraged, as decisions are to be based on assessment of the situation and protocol, findings suggest that paramedics that engage an understanding of family wishes when making difficult ethical decisions feel less stress and a greater confirmation for the decision they made.

Emergent ethical decision-making and the model: rapid approach to ethical problems. When Amanda is asked, "do you think back on other calls?" she replies:

Not always, no. I just know what I am supposed to do... there have been times when I was not going to stop to take the time to get another paramedic there to RSI them... I was just going to go because it would have taken longer to do that then to get them to definitive care. I remember one, I got him out at the campground one night, and he had fallen out of a golf cart and had a really severe head injury.

Amanda states that she was the only paramedics on the scene. She asked the 9-1-1 dispatcher to alert the ED and began to ready the patient for rapid transport. She continues:

We went in emergency traffic (red lights and sirens) and they (9-1-1) never told the hospital we were coming in. He (patient) probably needed to be RSI's, but I was not going to take the time to get another unit to me because it would have taken ten minutes for them to get there when I could have been at the ER with him.

On this call, Amanda describes opposing protocol for a patient that is critical with conditions that warrant Rapid Sequence Induction (RSI), a procedure to sedate and paralyze a patient in

order to introduce an advanced airway device and ventilate the patient. Protocol requires the assistance of a second paramedic in order to perform the procedure. In another area of this document, James is noted to have performed the procedure alone, against protocol in the interest of saving the patient. In this case, Amanda goes against orders requiring her to wait for a second paramedic and elects to rapidly move the patient to the ED, due to proximity.

The aforementioned participant stories illustrate two situations of similarity: a critical patient needing an airway procedure that required the assistance of a second paramedic. The paramedic in each situation handled the ethical decision to go against protocol in different ways. While neither followed correct procedures, they both acted to save the patient's life in situations where the decision was truly emergent and excluded time for deliberation. Iserson et al. (1995) suggested the question, 'Is this situation emergency?' and if yes, use the model described in the subsequent section. Introducing the need for a rapid approach, Iserson et al. (1995) states:

There are occasions in which the emergency practitioner is confronted with an ethical dilemma about which he has not thought, and he has not time to go through the involved process... in this situation it is necessary to use a more rapid approach to ethical decision-making, (p. 44).

To confound the issue of critical decisions made rapidly, to the exclusion of deliberation, Iserson et al. (1995) suggest that:

Professionals who would provide emergency care are frequently confronted with situations in which they must act quickly, even though they do not have and cannot get, all of the information they would wish to have about the case. Even if they do

have the time to acquire such information, people often do not realize what morally significant details are missing, nor do they know how to get them (p. 6).

Speaking to the challenges inherent to EMS, Iserson et al. (1995) further describes other factors complicating the ethical decision.

Paramedics must sometimes weigh conflicting responsibilities to their patients, base station hospitals, physicians, ambulance companies and police authorities. They often deal with angry, hostile patients who are under the influence of alcohol or other drugs, making it very difficult for them to respect their patient's autonomy while evaluating his competence and his medical condition (p. 7).

Iserson et al. (1995) cite key differences in emergency medicine as compared to other patient care environments. ED staff are usually "confronted with patients whom they do not know, who did not chose them and may have no confidence in them and whose medical history may not be clear" (p. 9). Emergent ethical decisions carry such severe consequences, and yet leave the practitioner in the most desperate of situations, alone, and without time for consideration or consult. In addition, poorly communicative patients who are under a great deal of duress and who have not entered into the professional relationship by choice.

Finding oneself in such a situation poses a frightening position for the paramedic. Iserson et al. (1995) suggest the tests for the practitioner who cannot buy time or consult. In succession, answering the three questions is intended to offer the practitioner a margin of comfort that the decision being made is ethically based. Participant stories are presented as they relate to each "test" individually. Data will demonstrate that participants do not express

a systematic, learned approach to ethical decision-making, nor do they employ a delaying tactic to gain time as they approach such decisions.

Test 1: Impartiality - would you accept the action if you were in the patient's place. Data demonstrates that in situations of emergent ethical decisions, the test of empathy is the only Iserson Model test routinely applied. Whether the consideration is provoked by patient family members, or occurs as an inherent response to the situation, the consideration of “Would I want this done to me or a loved one?” is a frequent consideration. When participants were asked if they ever consider that question, three themes emerged: myself (Would I want this?), loved ones (Would I want this for my own parent?), and empathy. Of note, a specific patient demographic was noted to evoke both feelings of empathy from some participants, and a loss of empathy from others.

Myself. The impartiality test is a version of the “golden rule; do unto others as you would have them do unto you”. To describe this approach, Iserson et al. (1995) quote the work of John Stuart Mill, “the complete spirit of ethics utility” (p. 46). Intended to expediently address concerns of emotion that may complicate the issue at hand, the impartiality test assumes that a person would want the very best decision made on their behalf. Iserson et al. (1995) state, “it is not an infallible rule that will yield a right answer every time. It is, however, intended to correct for one obvious source of moral error - partiality or self-interested bias” (p. 46).

James says:

You know it's a fine line. At what point do you declare someone deceased or decide not to work them? That is one of the hardest decisions EMS people walk into. As a

supervisor I went to many calls where the crew was working on a corpse, the blood has already pooled and this is futile... you ask “why did ya’ll work him?” and they say “we wanted to give the patient the benefit of the doubt.” They have seven different kinds of cancer, with asystole (no electrical activity in the heart), with a down time of more than what their brain can stand and yes, they may still be warm and it is probably within my protocol to work them. Now you have to justify, “I do not have to do this.” A lot of paramedics are afraid to do this, but I am going to do it because I put myself in my patient shoes and ask myself “if I had all those things wrong with me, would I want this (resuscitation) done to me?” A lot of times I put my parents and grandparents in those shoes and of course, I would not want EMS to do that to them.

Ben remembers being called to the home of a patient that was critically ill with infection.

The elderly man lived alone and wished to remain in his own bed. Reluctantly, Ben followed the patient’s wishes after consulting medical control, and left him at his residence. Later, the family found the patient in his bed, deceased, and Ben is called to return to the scene, “I can’t say that when I am that age I won’t want to be in the same boat and have the same outcome.”

He further states:

One thing I hate to do is taking a patient that I know is dead and work them into the hospital. I wouldn’t want that done to me. First responders get there and start CPR, I get there and start looking for reasons not to do more than maybe I should. It gets back to if it’s a 70 year old verses a 40 year old, you know maybe I am thinking of

viability stuff, but I know if I was to die today that I would want to be worked, but if I am 70 then don't do that.

Ben says he feels sorry for nursing home patients when he sees them. "Most people walk right by them sitting in the halls. I try to say 'hey, how are you doing?'" Common as participants describe feelings of empathy for the elderly, especially in situations of resuscitation, Michael says, "the older I get, the more I put myself in the place of the patient." Amanda states, "yeah, I don't think I would want, in code situations, I don't think I would want all of that done. I wouldn't want that done to me (resuscitation)." When asked how these feelings affect decisions about the patient's care, Amanda replies:

It really doesn't, you still have to do your job... but I think about it. You have these 90 and 95 year old ladies that are only this big around (reference to arm circumference) and you are going to jump up and down on their chest and break every rib that they have (CPR), why do you want to do that? Yet, you have to.

When further asked, "does that change decisions whether to resuscitate or not a little easier?" Amanda replies, "I think so. You look at families and say, 'would they really want this?' you wonder what their quality of life will be." Amanda describes a time when she responded to the residence of a dying man under the care of Hospice with a valid DNR. Amanda continues, "there was nothing I could do for him, you really don't want that kind of thing and he did want it." The wife was distraught and phoned family members, "she was on the phone telling family that we wouldn't do anything for him." Amanda states, "I waited until she had calmed down and told her there was nothing we could do for him, his heart had quit working."

Meagan agrees, stating:

There were times when I was working a code (cardiac arrest resuscitation) or something like that, looking at the patient's medical history... would I want someone to resuscitate me with this type of medical history, think about how much pain they must have had with a history like that... think what kind of a life they would have if they were resuscitated? Even though they did not have a DNR (Do Not Resuscitate) order and there is family on scene they always want you to do whatever for the, I am standing there thinking 'would I want this if I was them?'

Meagan admits that there are times when she has begun resuscitation efforts and then called medical direction enroute to review the situation. In this case, medical direction orders the resuscitation effort be terminated enroute.

In summary, considering whether you, yourself, would accept the treatment you are offering the patient is best described by Brian:

When I put myself sometimes in their shoes, I know how they feel and the reason why he or she doesn't want to go to the hospital or have us do certain things. I would never put myself in the patient position and let it hinder me from doing my job... I'm not going to. I'm going to do my job regardless, but I am also sympathetic toward the patient. It helps me personally do the right thing.

Findings suggest that paramedics that consider impartial patient care (care they would accept in the same situation) also draw upon personal perceptions of the quality of life, pain, or trauma associated with such treatments.

Loved ones. While some of the participants voiced a consideration of whether they would want the care they offered given to them, for most, the concept of impartiality was extended to loved ones. Perhaps it becomes easier to picture the position of a loved one, particularly parents, than one self in the ethical care dilemmas described. John states, “What would you want to happen if you were in that situation, or if it was your family member, how would you want them treated?” John remembers caring for a critically ill man, struggling to breathe.

You could see in his eyes that he was getting tired and he was exhausted and you feel sorry for him. You feel he is tired and wants to give up... you want to say ‘don’t give up, we’re going to help you’.

John elected to oppose protocol and offer a treatment not yet approved. John explains:

I knew he was exhausted and my experience with exhausted patients is all of a sudden they give up. I knew what I learned, so I did it. I don’t have time to try to talk to anybody because I don’t know if he has that much energy left in him... he can’t talk, he looks at you, he wants you to do something. You know he isn’t getting any air and you feel he is trying to talk with eyes and say ‘please do something for me’ so I did.

That’s what I would want for my family.

Meagan states, “I pretty much try to have empathy for all of my patients... I try to put myself in their situation. I always try to think, how would I want to be treated, to have my family treated?” Michael states, “I try to treat every patient as I would my own family member.”

Michelle recalls a situation, stating:

‘If that were my mother’ and that is all I kept playing in my head, ‘if this were my mother what would I do?’ I don’t know if I even would have called 9-1-1 if that was my mother, I would have called the funeral home and I would have said ‘she is gone, now what happens?’

This incident Michelle describes was a very difficult call for a woman in cardiac arrest with no DNR paperwork with a diagnosis of stage four terminal cancer, inoperable and metastasized from the pancreas to the brain and lungs. Michelle further explains her ethical dilemma:

Technically speaking there is nothing that should have stopped me from working this woman, but the look on the daughter’s face, I couldn’t do it. My whole world came crashing down, they have gone from looking for the DNR, to they don’t have one, they have spoken to the doctor and they are getting, it doesn’t exist.

James states, “The overriding thing is ‘how would I want my parents treated?’ That’s it at the end of the day.”

As previously noted, participants most often note the consideration of loved ones in the place of the patient as they approach an impartial decision. While this is the most frequently used of the Iserson Model tests, it further aligns with personal beliefs about patient life quality and the perceptions of the harshness of EMS treatment.

Empathy. Of note, empathy for patient, or a lack of empathy, followed demographic lines. While one participant felt a great deal of empathy for a particular population, others felt no empathy and struggled with feelings of frustration for the same population. In the

stories that follow, the participants often revealed coping mechanisms or very personal links to patient populations.

Scott chuckles when asked if he had a call that still bothers him and says:

Nope, I am fortunate. I know people that have had some that have really gotten them, I don't know if it's a defense mechanism or if it is a minor blessing of having some Alzheimer's, every male in my family has Alzheimer's and I am not getting any younger so I know it's coming. Babies will shake me for a couple of days but for whatever reason I have the ability to lock it away and leave it there. Kids are always hard. I was working in the ER when one of the other squads brought in a seven year old and I think I stayed on chest compressions for the next 45 minutes just feeling, I guess whatever... empathy for the whole setup.

When asked, "Do you need a break? No, I don't need a break, I am fine. I just kept going."

Scott goes on to describe differences in cardiac arrest management based on patient age. "On average codes that start in the ER are not going to finish for 45 minutes... it is one thing when you get a little kid." Explaining that resuscitation efforts for elderly patients typically are called in shorter time periods in comparison to cardiac arrests involving children. Scott seems frustrated as he recalls a time when a patient in cardiac arrest was worked in the emergency department for an hour and ten minutes.

The patient was "72 or 73 and he tried resuscitation on her for an hour and ten minutes, and I am like 'for real? Why?' The only thing he could say was that her husband was a PA. 'Okay... why?' She was from the nursing home, unfortunately it

was her time, leave her be. It hard for me to say what I would have done... I am not the one pushing the buttons.

Scott recalls responding to a patient that had fallen down stairs and suffered a badly broken ankle. In an effort to ease her anxiety, he jokes “Wow, you are in a scrape, how did you get there?” He smiles and says she started to laugh and it took her mind off of how painful it was going to be to move her. Scott states that he believes that his decisions regarding resuscitation attempts align with his own idea about the quality of life the patient is experiencing.

Their medical history, sometimes their age, somebody is 80, 90 years old and feeble... they don't have the quality of life that they used to have, is it right for them or not? Some people agree, some disagree, but personally I agree that if you are going into a nursing home to stay, not to rehab, but because this is where life has taken us, I think there should be a DNR. I think it should be part of the entry paperwork if there is not a possibility of you getting out of this location, is that really a life? I don't think so, I know for a fact it is written in my parents wills that they don't either. So I get it straight from them. We have all seen the ones in nursing homes, I have run codes on the ones in the nursing homes... they are full code status and I am like ‘why?’ It makes me feel horrible, I hate it. I hate it for them and I hate it for the family.

Scott goes on to discuss his disdain for patient families that leave loved ones in nursing homes without visiting or completing the proper paperwork, or “maybe they are just

unwilling to let go.” Shaking his head in irritation, he continues, “sometimes I find that people just have not had the time to put it down on paper.”

Brian also feels frustration regarding cardiac arrest resuscitation, saying:

I don't ask myself if I would want this done to me (resuscitation) but I do picture my grandfather... watching the family tearing and crying- that has something to do with it. This was a patient that had been sick with cancer for years and they have no DNR order. You are supposed to do CPR... the family says 'mom had passed on' you can't stand forever and think about it. The right thing for the state, the right thing for our protocol and the right thing for what is going on are three different right things. I believe I did the right thing, I didn't resuscitate. I followed the family wishes based on history. I felt like I did right by the patient- even though the patient was not with us. I listened to the family and I did right by the patient especially considering his history. I did the right thing. I did not have time to call anyone at the time of the decision, but after work I called my friend and described the call and asked what he would have done... he said he would have done the same thing, based on her history. I contacted my supervisor and he didn't have a problem with it... took me a while to write it up in narrative. I explained what happened... I would do it again.

Findings suggest that participants strongly relate questions in critical care decision moments to immediate loved ones and on occasion, to self. The practice seems most notably associated with cardiac arrest and the consideration of their own parents. However, a noted disparity among participants was appreciated regarding perceptions of empathy associated with particular demographics. Data demonstrates that participants based feelings of empathy

on personal biases associated with their own history or beliefs. The following subthemes will show such differences as participants describe those patients they empathized with, and those with whom they struggled to show empathy for.

Elderly. The concept of empathy stretches across two themes in the stories that follow: loved ones and elderly. A separate theme is offered in cases where age of the parent is of particular importance to theme. Laura states, “I don’t so much put myself in their position, but I put my mother in their position. I always think, how would I want my mother to be treated?” She remembers being called to the home of an elderly woman who had fallen and laid on the floor for hours. She had defecated and was embarrassed, not wanting to go to the hospital.

So my partner and I got her off the floor and took her to the bathroom and we helped this lady take a shower, we got her all cleaned up and dressed and then she wanted to go to the hospital. I always think, ‘how would I want my mother treated’.

Chuckling, she adds, “I have told my mother, ‘don’t you wear those slinky pajamas, because we won’t be able to get you up off the floor if you fall, wear some flannel!’” Laura explains her feelings about empathetic care.

Passion is what you love to do, and compassion is what you are there to do. You treat your patient like they are your family member and have respect for their dignity and the general public... I think that is difficult in today’s society, people have a hard enough time respecting themselves, let alone someone else. I love people, I don’t care who you are or where you have been.

Ben feels a particular empathy for elderly patients, “it goes back to my family, if it was my grandfather I would not want him lying there.”

The stories in the subsequent subthemes offer insight into the differences in empathy concepts among paramedics.

Homeless. Michelle describes her care of a homeless man, and her feelings of empathy towards him:

He was a Vietnam Vet and he was dehydrated and his blood sugar was a little low.

You can take homeless people two different ways. You can choose to see what their circumstances are and treat their illness while you sit with them and have a conversation or you can completely blow them off.

After Michelle had given him IV fluid and increased his blood sugar, he said “thank you for being nice to me.” She remembers thinking “I didn’t consider anything I had done to be nice and when he thanked me, my whole demeanor changed.” Michelle replied, “You are welcome, but I am just doing my job.” He replied, “You don’t realize what your job does for me. He said very few people are nice anymore, they just go on about their business.”

Michelle smiles and recalls, “So I decided to listen to his story.” After hearing about his misfortunes following his return from the war, Michelle says:

He makes you see that you can work hard your entire life and still wind up homeless, just waiting for someone to truly do their job. You know I would love to sit here and say that I give every patient 100% of me and that there is no question that everything I have done has been for the benefit, but I can’t say that. So I think when you get a patient that you can relate to and empathize with you really do go past even trying to

make them feel better. I work harder so that the experience with me helps make them feel better, it doesn't make me a miracle worker, and it just makes me someone that has finally listened.

In contrast, Scott relates:

The bother is getting out of bed at 0200 hours for absolutely nothing. Last time we had to pick up a vagrant was because the police didn't want to take him to the hospital. He is drunk and he is sitting on the sidewalk. I said (to police), 'why did you call us?' and he replied 'he (patient) is in pain and wants to go to the hospital'. He just wanted somewhere to lay down, he had no new pain, he had no reason to go to the ER at all and no medical problems, but he was drunk and we can't leave him sitting there on the side of the road. I asked the police, "why don't you take him?" and the officer replies "we can't do that." That aggravated me. I think to further what aggravates me the most is the broke system. We don't have an option of 'no, you (referring to homeless) are not and no we are not going to take you,' here... we pick them up and take them.

Infants. James describes how he has less of a feeling of empathy for the loss of an infant:

My way of reasoning is that sometimes things happen to small babies and it's tragic, but people move on from that... you do not move on from losing somebody that you have spent 50 years with that is a bit different. That is where my empathy kicks in, more with teenagers that have their whole lives ahead of them and things to look forward to, prom, college, career... those are the ones I feel the most empathy for.

By contrast, Kevin feels a great deal of empathy in relationship to his own personal life experiences regarding the loss of an infant. He describes a call:

We had a pre-hospital birth with a 21-22 week (gestation) old child which was stillborn. It was a very taxing situation for all involved: family, crew, fire department, it was a terrible situation. Less than a year prior, I had lost my son at around the same age and the situation was very similar... so I was able to be really empathetic towards that family, towards the mother, after, and I could relate to them in their situation of need and help them cope... I used personal experience to be very empathetic with them and help them to find help to deal with the grief.

Kevin states that he also feels empathetic toward dying patients that want to live long enough to take part in a special event. "I know that if I were in their situation I would want to take part in those moments in my family's life as well, pulls at the heartstrings." While Brian has no children or direct experience, he also says that obstetrical calls bring out a great feeling of empathy from him.

They've lost their baby, I try to make them feel comfortable. Psychological call, folks that think they are losing their mind or that they are stressed out, such as suicide calls. I guess I would say I am more passionate toward those calls... I try to get them to focus on treatment first and once I get them back down to earth... ok I am going to be honest with you, did it help you at all? I try to see why they would go and do something that extreme. I want you to feel comfortable and know you have help out there. Still going to treat you appropriately but I am more concerned, I'm looking at you as my family. I give them the same treatment that I would want a member of my

family to get. We as paramedics, we can do more than anyone else in healthcare because we are the first people on scene.

Young. Aligning with the concept that empathy often runs along demographic lines, Meagan describes her feelings at the loss of a teenage driver involved in a motor vehicle accident.

Everybody wanted to work her because she was young you know, and had not lived very long. I think it is always that way with a kid. You tend to want to work on them and do whatever you can to help in anyway and sometimes you can't do anything... we tried and there was just no way.

Michael describes the effect of repeated experiences saying, "They get easier, it got easier," as he discusses his feelings when he terminates resuscitation in field:

Still, letting go, especially pediatric versus adults... if you've lived until 18 and you've lived a life- maybe not as long as me- but long enough to make a stupid decision. There is an issue... do you call a code just as fast if it's a child? Age is a big thing. It did get easier in my head, but my heart cried or I would have to go have time by myself to make sure I am in this job for the right reasons... so it hurt every time I called a code.

John remembers seeing a man at his church and saying to himself, "I know these folks." After approaching, he realizes it is the father of a child that he cared for when the boy was run over at his school. "I couldn't have told you at the time what he looked like, just that he was by the boy's side saying 'I am his father.' I was focused on the patient, focused on the paramedic student soon to be a paramedic that I said 'I need you to take care of this patient

while I go assess the others.’ John explains that he made a very difficult ethical decision when he broke protocol and ordered an uncertified paramedic to care for the critically ill child. As the only paramedic on the scene, John knew that his resources would be a long wait and elected to err on the side of saving the child.

He can’t practice until he tests and get his privileges... well, I told him, and ‘you know what needs to be done, do it!’ I don’t think I had any other avenue, but I put that student in a very precarious position because as his chief I told him to do it and I have apologized to him since... for putting him in that position. He said that it didn’t bother him because he wanted to do all he could to help. He is a practicing paramedic today, but I put him in a predicament that him doing what we did and shouldn’t have done could have prevented him from ever becoming a paramedic... he could have said “sorry, I can’t do it.”

Amanda states:

I have a hard time with kids. I like kids, I have a lot of kids. I have seven grandkids and another one coming, but I have a hard time with kids. I do what needs to be done, I get done with what they need to have done and I think about it later.

Amanda states she also feels empathy for “the ones that die alone that is sad to me. Nobody should die alone.” Conversely, Michael admits that he often has struggled to feel empathetic to patients between the ages of 18 and 26:

I wish I had had a better attitude. I’m getting older now and I have realized that aged 18 to 26 is the hardest time in any person’s life. They have to make decisions on so many things and they don’t have a process.... I don’t think their brains are working.

I've realized the older I get that I was that age one time too. I did some stupid things too. I'd rather have a paramedic there that was older and would give the person another chance, instead of 'you stupid idiot, you deserve what you get.'

Frustrating patients. John states his basis for empathy has changed through his years of being a paramedic.

Over the years I have learned that if you put extra effort into being nice to your patient you will connect to your patient, you calm your patient, you build trust with your patient, whereas years ago if it was a drunk and they bowed up at me, I bowed up right back at them, but now I have learned that if I am just respectable to my patient and I play into his moment enough, then you will be able to build trust with your patient.

Meagan remembers her frustration on a call involving a vehicle struck by a tractor trailer truck.

Grandma and Grandpa were driving and they were hit by a tractor trailer truck and the infant car seats were not attached to the car. They were in the seats, but the seats were not attached and the babies were thrown from the vehicle. The grandparents were high and it just irritates me. One of the babies did not make it and one of them had a lot of injuries... it bothers me sometimes. To know that the adults were so irresponsible... they pulled through without a problem, just makes me angry sometimes, I would just like to shake them real good.

James says, “when patients become belligerent and fight you of course that is frustrating, but they still need to be handled with care... you can be rude and disrespectful to patients, but there is a line that cannot be crossed.”

Edwin says:

Transporting is a harder decision, how do you decide if someone has free will?

That’s a sticky wicket... how do you look at somebody and say you have had one beer, you have alcohol in your system, you can’t refuse transport. I can assure you that one beer in your system, you are conscious, alert, oriented and cognizant of where you are who you are and what the consequences of your actions are.

Ben says:

If there is a time when I am not going to buddy somebody or coddle them it is when they have alcohol in their system, I do not know what to do about that. I do not do well with drunks- I don’t like alcohol and I don’t drink. If there is anything I have predisposed myself for not liking, its alcohol. I have a brother that is an alcoholic.

Amanda agrees, stating:

I get frustrated with drug abusers and alcoholics. I get very frustrated with that, but I have that in my family... so I get very frustrated with that because that is the choice that they make. My biological father chose alcohol over his family. I have a daughter who has an addiction to alcohol and cocaine. She is clean and sober right now, but you know that could stop at any time, so I have a problem with that. I still do what I am supposed to do, I do my job, but it becomes frustrating because that is the choice they made. Especially with the frequent flyers, you chose to do this.

“Frequent flyers” is a term often used in EMS to describe the patient who chronically calls 9-1-1.

Edwin relates to his feelings of frustration when dealing with a father that has critically injured his infant son by shaking him.

There is momma and she has confessed to the police officer that dad has shaken the baby, well the story that we first got (on scene) was that the baby fell off the couch. The couch is less than a foot a high. I am sitting at the hospital writing my report... this 108 pound soaking wet greasy haired moron comes in all concerned about the baby he shook, they are crying. You know I am 6’2” and at that time I weighed about 400 pounds. I was going to show him what it was like when somebody four times your size commences to shaking you. It took my partner, the other crew, a police officer and nurse who ended up sitting on my chest to pin me down saying ‘you worked way too long and way too hard to be a paramedic to lose it over some dirtbag scum... and I said ‘oh no I didn’t, I said ya’ll let me loose and I am gonna come out of here and whoop his ass.

Ironically, when asked ‘are there patient situations in which you feel no empathy?’ Edwin replies, “none, because if I ever lose my empathy, I don’t deserve this job. I have to be empathetic toward every patient.” As I probe further, “the abusive patient?” Edwin replies:

The abusive patient, the abuser. You have to demonstrate professionalism and empathy to every person. You cannot let the person affect your care. Your care has to be the same whether it’s the sweetest little old grandmother or Adolf Hitler. Your

care has to be the same. Ethics demand that you treat a patient exactly the same no matter what.

In summary of the findings associate with Iserson Model Test 1, there is a lack of consistency in the approach to ethical decision-making. Empathy appears to be the most frequent of all Iserson Model tests as participants considered ethical decisions, particularly, “what if this was me, or my parent?” While empathetic understandings were the most frequently found approach, disparities in perceptions of empathy were noted, most notably among certain demographics. When taught, the concept of empathy should draw upon rich resources in that practitioners do come to patient care with feelings of empathy toward some populations, and a similar struggle for empathy toward others. Perhaps bridging the gap in such understandings and linking the concept of personal empathy is a necessary step toward preparing paramedics to make ethical decisions.

Test 2: Universalizability - would you feel comfortable having this action applied in similar circumstances. Far less questioned by participants in critical decision-making, is the concept the universalizability test asks, “Are you willing to have this action performed in all relevant similar circumstances?” Iserson et al. (1995) reflect the application of Kantian categorical imperatives to determine if the intended decision is reasonable. Iserson et al. (1995) further suggests that this test may “help eliminate not only bias and partiality, but short sightedness” (p. 46). Paramedics using this test might note “justifying one particular instance that falls under a rule is not sufficient for justifying the practice of acting on that rule” (Iserson et al., 1995, p. 46). When asked if similarities in calls helped make subsequent

decisions easier, participants stories suggest repeated ethical decisions of similar nature rarely helped during the decision-making process.

John states:

It's not a conscious thought, you don't picture that face or that person and event as a dream or close your eyes and place it, you just have an experience where I remember I gave this one time, or I did this... I made the decision off of experience, but at this time I could not remember what the experience was.

Michelle further describes the moment after she arrives on the scene of the cardiac arrest:

I am running all this through my head, contemplating not doing the one thing I was told to do always, if you are called to code you are told to do everything to save that life, but... dispatch feels the need to call me and say "she does not want this worked." I knew the dispatcher and she said "Michelle, you should hear the panic in her voice." She says to the first responders as they arrive on scene to assist, "please just give me thirty seconds if nothing else" deciding to enter the residence alone and assess the patient situation.

Amanda says:

It is a matter of listing the priorities, which I have done for so long now it is just automatic. Sometimes you are going to have one where you are left scratching your head trying to figure out what was that all about. I try to keep an open mind about stuff like that... if I do this, then this could happen and I if I do that, then this could happen... I think really fast. Usually you have to make a quick a decision, whether good bad or indifferent, and go with it if it is critical.

Meagan states:

I have had multiple calls where it is the same type of sickness, but even when it is the same type of sickness... even the same person that I was going to over and over, but even with them it is always different. Something is always different, some things are still the same, but somethings are always different and I just have to look around and see what is was and find out what is different this time.

Describing the use of past experiences, Meagan states:

If I stood there and dwelled on it, it would be a hindrance... but I try to think about things, or a time when I had the same situation and then I am like, "this might not work the same, but let me try it anyway."

Calls are unique and rarely warrant similar decision-making patterns. Brian recalls two similar situations and which he handled each differently. In reference to a critical patient in respiratory distress who denies his care because he is a black man, he opts to cross the line and treat her, believing that failing to treat her would have been a failure on his part. The patient in this situation is white. He replies, "Ma'am I know your situation but I really don't give a damn right now whether I am black or not, I am going to treat you." She shook her head no and a family member offered, "She is from the old era." Brian replies, "That's fine, but she is going to die without treatment and I can't stand here and watch her die." On a second call, Brian is called to the home of a black female who also refuses his care because he is a black man. In this case, the patient is stable and he became frustrated.

I was more angry with her because I couldn't believe that someone of the same color would be such a rude person to a person of the same color because he is in that profession. So I called my supervisor to help take care of that call.

Paramedics do not routinely use the recall of prior similar experiences with ethical decisions during an incident. While similarities in decisions were not noted to help prepare paramedics for subsequent decisions, it is noted that critical reflection plays an active role in how paramedics approach future dilemmas. Data shows that participants frequently critically reflect on challenging calls and as they reflect, many discuss the experience with others for feedback. This process of critical reflection and in some situations, peer consultation, makes memories that may inform future practice as well as confidence levels for future encounters.

Critical reflection. In times of emergent decision-making, reflection is not possible. Iserson et al. (1995) suggest, "once the crisis has subsided, however, the practitioner should review the decision with the aid of colleagues and bioethicists to refine his emergency medical ethical decision-making abilities." (p. 46). While Iserson et al. (1995) agree that critical reflection is important following an ethical incident, findings show there is a far stronger link to the informal act of reflection and the consideration of experiences both observed and heard through the stories of others. Iserson et al. (1995) propose "careful ethical analyses in advance of emergency situation, as well as self-critical reviews after the crises have passed, are vital to developing skills to quickly identify and work through ethical problems as they arise" (p. 4). Participants revealed that they routinely critically reflect on calls, whether it be subconsciously to critique or question themselves, or consciously to seek the counsel of others. Storytelling is even reflected in training as "war-stories". While the

skill is not formally taught, it appears to occur and with great impact to future learning and decisions. Iserson et al. (1995) suggest a complex set of ethical decision-making steps, “useful only when there is time in which to ponder deeply and weigh alternative courses of action” (p. 44). The steps include: identify the ethical problem, list the options, list the ethical values and important interests at stake, allow for the greatest opportunity for deliberation, and formation of an ethical rule useful in future deliberations. “The emergency practitioner will find this method extremely useful when working out possible courses of action for common ethical dilemmas ahead of time. It is a useful tool for dissecting and reflecting on past dilemmas” (Iserson et al., 1995, p. 44). Perhaps useful as a formally taught tool for critical reflection, future research may consider the role of critical reflection to ethical decision-making competence.

Laura states, “every call you run you will reflect back to, but in some situations there is no time for reflection and you just have to make a decisions and stick with it.” Laura states, my medical director told me:

We are with the patients you bring in for hours and we miss things and you are with them even less so mistakes are going to happen, you are expected to make those decisions in such a quick amount of time.

Brian remembers a call for a patient that was critically ill but did not want to be transported to the hospital. He describes the patient:

Real sick and I spent way above the time that an average EMS person would’ve spent on scene... and hour is a long time, trying to convince the patient why she needed to go to the hospital. Still no luck. Just by leaving the patient I feel very bad. Think

about it night and day... what if I went back to that house and something else has happened? I went back and forth. I walked away feeling like ‘Brian, you didn’t do something right.’ And it bother me going on the next call. I try to do it over and over. Yeah, makes me feel kind of bad, like I should have done something more, just didn’t know what.

John states, “you critique your last call and say ‘if I ever had to do this again, would I do it this way?’ ... and you have a thought, ‘oh, I need to do this’ because of an experience in the past.”

Kevin recalls caring for a critical trauma patient.

It was a young lady that had a van on top of her hips, she was pinned under it in the mud... it was a bad call. We gave her morphine to help keep the pain under control... I just knew that once we took the car off of her she was going to die from compartment syndrome. Luckily she didn’t and we transported to a trauma center. I was asked by the chief, ‘why didn’t you fly her?’ and I told him I thought she was going to die... helicopters do not fly cardiac arrest patients, so why would I tie up that resource?

I ask “would you do that same thing again?” and Kevin relies... “most definitely.”

Describing his process for justifying actions, “I am just very professional and explain my thought process.”

Of note, in all cases where paramedics broke a rule, did not follow physician’s orders, or opted not to follow protocol, infractions were done for the benefit of the patient. When asked, would you do the same thing again? The overwhelming response by all who had

committed an ethical decision error, was “yes.” These findings are discussed in the final theme presentation.

In summary, while participants did not disclose learning the process of critical reflection, they did routinely and actively engage in the practice following challenging incidents. Critical reflection should be encouraged and capitalized upon through formal training in clinical preparation and continuing education, as well as informally among peers. To further prepare paramedics for practice, critical reflection can be encouraged through scenario based teaching. Such reflection is linked to the third and final Iserson Model test, justifiability. This will be presented in the subsequent subtheme.

Test 3: Interpersonal justifiability - are you able to find good reasons or justify your actions. Finally, the third test is the interpersonal justifiability test. The test asks the practitioner to consider the decision as one with a good reason, which can be justified to others. Iserson et al. (1995) suggest that this “test uses David Gauthier’s basic theory of consensus values as a final screen for a proposed action” (p. 46). Iserson et al. (1995) further state, “when ethical situations arise when no time exists for further deliberation, it is probably best to go ahead and act on the rule or perform the action that allows all three tests to be answered in the affirmative with some degree of confidence” (p. 46). Not practical for EMS, paramedics on occasion noted consideration of one of the tests prior to decision-making, not the progression through three tests. While colleagues are often consulted and discussion of difficult cases is noted to aid in the learning and preparation of providers, EMS, unto itself, is limited in resources for ethical questions. There are four themes presented in justifiability, the third ethical test: community, medical direction, patient’s best interest, and gray areas.

John says that he does not think of justifying his action at the time of decision;

If you think about the justifiable things more after the fact when you have gone and made your decision off of the training and knowledge that you have... sometimes you don't know why you make decisions that you do.

Brian remembers the decision he made not to resuscitate the cardiac arrest patient without a DNR and offers this about justifying actions:

For a brief period I thought about it, afterwards... writing it up back at the office, I say to myself 'Oh Lord Jesus, how can I explain this to my boss and medical director?... just for a few minutes, and then I just go with the flow.

Ben says:

I'm not saying I don't make bad decisions, I just try to justify or cover my tracks before it comes to someone else. Cover my bases and not get caught off guard. I know how to cover my tracks... I can say he was already intoxicated and that I did not want to enhance those effects. I am less likely to give pain medications to a drunk.

James says:

You always think 'am I going to have to justify this to anyone?' I think a lot of paramedics think about how they will justify this to anyone and that plays a role in the final decisions they make... and most of the time they are not willing to make that call.

Michael remembers a time that he opposed protocol to treat a patient dying of an allergic reaction. The call came into a school and upon his arrival, Michael noted the child was

critical. Although eight years old, the boy weighed 145 pounds. Michael treated using an adult dose of Epinephrine.

My partner said ‘you’re getting ready to go out of protocol’ and said ‘yes I am... if I don’t, I don’t think it’s going to work’. In this situation, I don’t have time to call medical control... you can call, but I am going to go ahead and treat. I did consider when I made the decisions how I would justify it. It was a split second of going through my mind, ‘oh crap, I am going to get in trouble for this’ ... I did know I was going to get in trouble for it, but I’m good doing it anyway because it’s what’s best for the patient. I didn’t have the time to consult and I had never had another call like this. I did get a slap on the hand... but later they said they would take it out of my file because it was in the best interest of the patient.

While paramedics do not consider justification as they make decisions, a noted correlation exists in that participants do consider justifying actions and decisions as they engage in critical reflection after the incident.

Community. Community as a theme refers to the sense of accountability and allegiance noted in the stories of many participants. Several noted the differences in EMS between small and larger towns, suggesting that paramedics that were a part of small town EMS had a greater sense of ethical accountability to the citizens they served. Also noted in this theme are changes with years of service to a particular town or community. James describes the changes in himself over the years by saying, “I am more independent. It used to be mother may I, now its mother, I did it and that is how it is.” He also notes a shift in accountability.

When I started we were ultimately accountable to the hospital and if you pissed off a nurse, you were done. Now it's the opposite, the nurses have no clue what we are doing and you don't care if they are pleased or not. The situation has changed a lot- it used to be nurses that taught our paramedic class... nurses were heavily involved with the paramedic profession and even rode along with them in the trucks. Now they have no idea... that integration has disappeared.

James believes that preceptors and instructors such as himself need to work at teaching people skills. "I can bring that, I can teach street smarts." James describes the new generation of paramedics:

Needing people skills... one of the biggest things to me is they have no vested interest in the community, they are not from here and they have never lived here they are just assigned some station, it's not their family, school teachers or their moms and dads friends. If you have a vested interest in the community and you feel like this is my town and these are my people and I will see this person again when I go to breakfast next week or at the doctor's office etc... that is when you make quality care decisions, but when you say 'I'm not ever going to see them again, I do not know them, this is just some place I ended up' then you make bad patient care decisions. Its ethics, bottom line, and they don't have a vested interest in the community. We have to start treating patients as customers because they are our business and so we need to drive that mentality into the paramedics that are out there- that each person is a customer. I think people in a community oriented organization will provide better service and make better decisions. Large city EMS deal with numbers and it's all

about numbers, but if you know you aren't going to have to see that person again.

We need to work on teaching people how to talk to somebody... and to make good decisions.

Michael agrees,

It's the mentality of the people... you get somebody that works in a big system to where everyone is reduced down to a number, versus someone that works in a smaller system where people are still people, there is a big difference in the care you give. One falls back on the fact that 'hey, this is someone's grandmother, I'd treat them the way I want my grandmother treated'... versus the bigger systems, 'I'm just getting you to the hospital and I don't care about you'. In some areas empathy is more an expectation and that affects your decision-making. The amount of time even making decisions has an impact on how you make decisions.

John remembers making a decision at an accident scene and then "the next morning at church I heard that my best friend was killed in a car accident... and that was him, I was the one that pretty much declared him dead." John states:

If I had known it was him would I have put a different effort to it? It bothered me in the beginning but as I look back at it through the years I have been able to live with that decisions because it was the one decision that was best for the whole situation and not one individual and that is what we are all about is just to make it as right as we can and of course do no harm in the short period of time that we have to make those critical decisions... save as many as we can.

Rick recalls being called to a farm accident involving the five year old son of a firefighter he had served with for many years:

The firemen were there and trying to comfort the kid, but the kid was so far gone he was beyond comfort. I finally had to tell the firemen that they had to back up and let me do what I was trained to do and I had to help him. I felt like I treated some of them harsh, but if I did not get him out of there he was going to die. I feel like there were firemen that did not like what I did that day, but I had to do what I had to do to save the life of a patient that had a chance at living if given the help.

Data demonstrates that the sense of allegiance to a community is a significant motivator in ethical practice. This finding was also noted in the concept of accountability as presented in the open-coding findings. The combined findings suggest that while paramedics may not consider community approval while they make decisions, the desire for respect and hero identity affect that gravity of such decisions and the need to for confirmation as part of the critical reflection process.

Medical director. The theme medical direction has been used previously suggesting that many aspects of paramedic care and ethical decisions relate to the medical director's oversight. In this theme, the term is used to describe findings associated with justifiability for actions. Rick remembers responding to a cardiac arrest for an elderly man diagnosed with terminal cancer. When he arrived, the family presented him with a prescription written by a doctor stating "Do Not Resuscitate, this patient has terminal cancer." All of the patient's family members had signed the prescription paper. Rick honored the family wishes

and did not begin CPR. Later, the one family member that had not signed the form turned Rick into the medical director and asked that his privileges be suspended. Rick states:

I had to go before the medical director and explain my actions. If it had been my father, I would not have wanted all that done to him. I would have wanted to hold his hand and feel like I did the right thing.

Rick describes his decision not to resuscitate a man dying of cancer, “I felt like I did the right thing.”

Michelle remembers a call involving the decisions not to resuscitate a terminally ill cancer patient without a DNR order. “You have to do your job if you don’t have that yellow piece of paper.” When I spoke to the supervisor he questioned that if I knew that if I had called medical control... I have worked with the medical director long enough, I know what he would have told me, and ‘you need to do your job, until they can prove that they have a DNR’ I couldn’t have done it... I could not have.” She further describes her partner’s response to the situation:

He said, ‘Michelle are you kidding me? We are going to work a code.’ And I said, ‘I don’t we are going to work this.’ He said ‘we have to, it’s our job.’ I said ‘the family is frantically searching for the DNR and the mother has terminal cancer’. He said ‘it doesn’t matter if you don’t have the yellow piece of paper then you have to do your job.’ But something just said, take another look, you know we are told from the moment we start class that time is everything. So we are in a job where is driven and I have to stop and it’s amazing how things run through your head in just mutes,

everything I have, I think I played every scenario in my head in that five mile drive.

Five miles.

Laura remembers making a judgment call against her protocol and having to answer to the medical director. She was called to a gas station where a five year old boy had gasoline splashed in his eyes. She states he was crying so hard that his eyes were “self-flushing.” The mother did not want to ride to the hospital with the child and he was scared. Protocol states that his eyes should have been flushed with fluid continuously enroute to the hospital. Alone in the back of truck, Laura elects to transport without holding the boy down to flush his eyes, believing this would be painful and traumatizing. “The ER doctors complained... if I had for one minute thought the boy would go blind because of that little bit of gas, I would have called for help and would have flushed his eyes, kicking and screaming.” Kevin also recalls a time when he offered treatment outside of protocol for a critical patient. When he discussed the call with his medical director, this was his concern:

I explained what I had done and said ‘I hope I am not in trouble’ and the medical director replied, ‘wow, that’s awesome’. I just told him my thought process and explained what I had done and he said it was right and thanked me.... It’s a mutual respect thing when you deal with the medical director.

Amanda remembers a difficult ethical decision involving patient care. “It was a lady from a nursing home and I met the squad enroute to the hospital.” The crew had called for Amanda to assist. When Amanda met the ambulance, the crew told her that the patient had experienced a “run of ventricular tachycardia and a seizure.” Ventricular tachycardia can be a lethal cardiac dysrhythmia. “The patient was sitting up and talking to us, but she looked

like crap and she had a DNR (Do Not Resuscitate) order.” The patient had experienced a recent heart attack and was staying at the nursing home for rehab, not as a resident. The crew resumes transport to the hospital with Amanda in attendance and the patient experiences another episode, “back into ventricular tachycardia and she is unconscious, she has a DNR.” Amanda recalls feeling that she was “damned if I do and damned if I don’t” when trying to decide how to treat the patient. Typically patients with Do Not Resuscitate orders receive only palliative care for comfort measures. In this case, the patient was not in cardiac arrest, but was unstable. Her complaint was not related to the DNR order and she had asked for 9-1-1. Amanda elected to call the ED physician for guidance. He offered suggestions for medications that worked effectively. Amanda remembers the dilemma, “you have to do something, but how much?”

Data from the open coding process suggested that participants feel a sense of accountability to the medical director under whose license they function. Findings associated with Iserson Model coding further demonstrate that participants consistently relate a need to please the medical director and often reference having a trusted relationship that they seek to maintain. This relationship and the need to make appropriate and justifiable decisions remains critical to employment and credential.

Patient well-being. Kevin remembers a time that he went against protocol requiring two paramedics to attend a patient for rapid sequence induction (RSI), a procedure where drugs are administered to anesthetize and paralyze a patient in order to get an advanced airway in place to ventilate the patient. This is an emergent procedure with a high likelihood of critical complications should the attempt fail. Kevin was alone in the back of the

ambulance with a patient who was not breathing and could not be ventilated with the placement of an advanced airway. With no time to wait for additional resources, he elected to perform the procedure against protocol. The procedure was effective and the patient had a favorable outcome, but Kevin was questioned not only by his own county medical director, but by the North Carolina State Medical Director, overseeing all EMS care.

You have to make a decision and can justify it and stand behind it... not just to the medical director, but I teach it to others. At least twice a year I get up and say 'Hi my name is Kevin and I have a problem... so you know many people have learned from it. It's not a good feeling when the state medical director calls you on your cell phone and wakes you up.

Rick reflects on his decision to go against orders and give a life-saving drug to a patient in shock.

I did what I thought was ethically right for the patient. It felt good because I had kept the patient alive though I took a chance on losing my certification and possibly losing the right to work in that county, but I felt like something needed to be for the patient.

Michelle remembers a time when she was required to call for orders to perform an advanced procedure called Rapid Sequence Induction (RSI). In the situation a patient needs an advanced airway to survive, but still has enough consciousness that they fight the airway placement or have an intact gag reflex. RSI is used to anesthetize and paralyze the patient so that an airway called the endotracheal tube can be placed. "I need to call to RSI that patient and I didn't have time. I had to do something about his airway or he was going to die. I never picked up the phone and called, never."

John states, “ethical decisions came from me thinking what is in the best interest of the patient at that time.” John also states:

When I look back at my pathway I have made decisions that I felt were in the best interest of the patient, I have made decisions that I would want to be made on my family members and that I can lay my head down at night and feel comfortable that I made the right decisions for my patient.

The strongest and most consistent finding amongst the paramedics that had “crossed the line” ethically, stated that they did so for the well-being of the patient. Participants readily expressed that if they had committed a breach of accepted ethical practice, it was to save the patient, or act in the patient’s best interest. Paramedics that expressed ethical decisions made for patient benefit, outside of accepted standard of care and protocol, expressed no ill effect or punishment and confirmed they did not regret the decision.

Summary of Iserson model findings. In Chapter Five, the data from the interviews of the thirteen paramedics were presented from document review structured around three general themes and numerous subthemes that emerged through analysis. Analysis was accomplished using framework coding generated from Iserson’s Model for ethical decision-making, which also served as the conceptual framework for this study. Iserson’s Model exists as the only proposed model for ethical decisions in emergency medicine in literature. Significant findings from the data analysis using both open coding as presented in Chapter Four, and the preceding conceptual framework findings presentation Chapter Five will be summarized and serve to suggest future implications for research and theory.

Chapter Summary

The purpose of this qualitative collective case study was to explore paramedics' perceptions of ethics, specifically ethical decision-making, as they describe their own experiences navigating such situations. Understanding the stories of practicing paramedics as they discuss experiences in emergent and autonomous patient care situations where ethical decision-making was implemented contributes to the knowledge of how paramedics experience ethical decision-making. This understanding also suggests the relationship between ethical decision-making and the instructional process for training paramedics to make such decisions. The chapter first presented individual profiles of thirteen practicing paramedics, educated in the state of North Carolina, and with at least five years of emergency medical services (9-1-1) experience in patient care. These thirteen participants from various geographical locations in North Carolina volunteered to be interviewed on the topic of ethical decision-making in patient care for inclusion in this research. Study findings were presented in two parts, the first presented the data from the interviews of the thirteen paramedics document review structured around four general themes and numerous subthemes that emerged through analysis of the data using open coding data analysis. The four themes that shaped the presentation of data are: paramedic's ethical values, accountability, professional identity, and decision stress. Participant quotes were incorporated throughout the presentation of findings to support and provide illustration of themes. The second part of the study findings was derived from data analysis using the conceptual framework, Iserson's Model for ethical decision-making. In summation, a discussion of findings was presented from the analysis of both open coding and framework coding of the data.

As I wrote Chapter Four, I was amazed at the powerful emotions that I experienced. As a paramedic, I experienced many of the emotions that my colleagues, these participants, revealed through interviews. As an educator of paramedics, I became passionate about the need for ethical decision-making training and preparation. As I conceived of the need for this research and began to plan my methodology and research question I felt very committed to discovering the stories of other paramedics as they revealed their own experiences with ethical decision-making. The excitement of contributing to literature and the possibility of informing the EMS community empowered my data collection. Most powerful to my writing of these findings was the realization that I had heard what I believed I would hear through the words of thirteen participants. As expressed by Michelle:

I appreciate you doing this and I am a little irritated with some of the things that I had to tell you because you are not supposed to break the outer shell, but what if those of us that know can help the ones that are coming in, or even give people that tiniest understanding of what we do, then it was worth sitting here and feeling this. The funny thing is when we first started, I was thinking that I wasn't going to have anything to tell you. I am amazed at what came out.

Well-designed qualitative research gets to the inner story, often a guarded or emotional story, and the significance of qualitative data is to gain access and reveal the story. I learned that it is also significant to the researcher when this occurs.

While it is the responsibility of a researcher to accurately convey the results of a study, this researcher also feels the burden to tell the story of paramedics, specifically thirteen brave men and women. This is the story of heroes who would rarely proclaim

themselves as such. The discoveries presented in this chapter reflect the stories of those who chose to put themselves in harm's way in order that they may save and impact lives. Theirs is an untold story that reflects years of the emotions, regrets, and rewards for making difficult ethical decisions with no time to consult other experts and with life often hanging in the balance. To the credit of those who shared such stressful events from their own paramedic careers, they wanted "someone" to know what it was truly like to be thrust into such an event, the worst event for many patients' lives, and to make life altering decisions with no formal training. They wanted someone to know what it was like to want so badly to help, and face such difficult decisions, often alone. Brian pleads, "I just wish there could be a real study on what we do, day-to-day, what it's like to be a paramedic to make those decisions. I've never heard of such research on EMS folks."

The goal of this research was not only to discover the stories of paramedics as they made such ethical decisions, but also to inform the research community and suggest a trajectory for future research, so that the decision-making process of paramedics in emergent situations will be reflected in literature and future paramedic education is informed. To accurately report findings is an expectation of quality research. To give credence and illumination to the stories of these brave men and women is both a privilege and a burden. They offered the right to interview them, often emotional and painful interviews, so that others may know. My hope is that the participant responses expressed here reflect that confidence and better the profession that we share.

I feel the tremendous burden associated with sharing the true stories of the profession... outside of the profession. As a practicing paramedic with twenty-six years of

experience, I feel a great deal of pride for my profession. I echo the words of John, “I wouldn’t change the experience I have had. Twenty seven years of fire and rescue experience, I started when I was seventeen years old... I wouldn’t have wanted to be anything different.” Having read this chapter, will “we” remain heroes in the eyes of reader? Will the magnitude of ethical decision-making in emergent situations where it is truly “all on me” be reflected in my words so that future research can further illumine such practice? As Laura states, “it is important for people to understand what we do and I do not think that they do.”

In Chapter Five, significant findings from the data analysis, using both open coding as and the framework coding presentation from this chapter will be presented and serve as the basis for suggestions of future implications for practice, theory and research.

CHAPTER 5: IMPLICATIONS FOR THE FUTURE

Study Findings

Through a purposeful selection process, study participants were comprised of thirteen practicing paramedics, trained in North Carolina and with at least five years of EMS experience. These voluntary participants represented a wide geographic area across North Carolina, with varied years of service and education. The data was coded two ways: open coding and through pre-selected framework coding. In an initial open-coding analysis of the data, four primary interconnecting themes were revealed from across the data, with a group of subthemes established for further definition. The first theme relates to *paramedic ethical values*. This theme identified three significant sub-themes: *morals, religious beliefs, and prayer in practice*. The second theme relates to the concept of *accountability* as perceived by each participant. The findings of this theme revealed great disparity in perceptions across the participant pool. From this theme, four sub-themes were established: *differences in concept, professional accountability, personal accountability, and autonomy*. The third theme focuses on paramedic *professional identity*. For this theme, there were four significant sub-themes noted in the findings: *more pay and respect for the profession, embarrassment, hero and hand-holder, and bad outcomes*. The final theme, *decision stress*, relates to how paramedics describe their own feelings associated with ethical decisions. Participants frequently used the word “heaviness” to describe such emotions. There are five subthemes within this data theme: *cumulative stress, community, regrets, resuscitation, and tunnel vision*. The data which supports these themes and sub-themes was presented in Chapter Four.

The second part of the interview protocol and coding process used the Iserson Model: A Rapid Approach to Ethical Problems, as a guide. Dr. Iserson suggests the value of this approach, “to ethical problems is vindicated if it improves decision-making on average” (Iserson et al., 1995, p. 44). The model is described as “oversimplified” and is intended for “those who are under severe time pressures and who wish to make ethically appropriate decisions.” Three important themes emerged from the Iserson Model coding structure, with a group of sub-themes established for each to further define the data. The first theme is *reliance on previous experience in decision-making* and is derived from the Iserson Model suggesting the practitioner consider whether this ethical dilemma has already been successfully addressed. There are three subthemes with this finding: *influence of experience, influence of education and training, and learning from mentors*. The second theme was derived from Iserson’s Model, suggesting that if time permits, consult someone regarding the decision at hand: *consult*. There are three subthemes that include: *consult medical direction, consult peers, and consult patient’s family*. Finally, the third theme: *emergent ethical decision-making and the Model; Rapid Approach to Ethical Problems*, represent Iserson’s three proposed tests of ethical decision-making. These tests or questions are subthemes as follows: *Test 1; Impartiality, Test 2; Universalizability, and Test 3; Interpersonal Justifiability*.

Discussion of Study Findings

Iserson et al. (1995) use the term normative ethics to describe “ethics for a rational practical activity” (p. 32). When considering the activity of EMS, how then do we understand or shape ethical paramedic practice? Findings suggest that the most difficult

ethical decisions exist outside of the framework of law, protocol and empathy. Perhaps the greatest challenge to the concept of ethical decision-making is that in many situations faced by paramedics, right or wrong, black or white, is not obvious. Iserson et al. (1995) state:

It does not follow that ethical relativism is true even if there is widespread disagreement on what is the ethical thing to do, even if ethical absolutism is false, even if there is no uniquely right answer to some ethical problems, or even if everyone's opinion is equally valid in the sense that everyone has the right to have an express and opinion (p. 35).

These statements suggest that not only do ethical situations exist without a true right or wrong answer, their navigation differs among individuals. Veatch (2012) suggests that “historically, ethics for the health professions has been dominated by the maxim of the Hippocratic Oath: Benefit the patient and protect the patient from harm” (p. 47). Veatch (2012) goes on to challenge that “if the health professional is to be Hippocratic and work only for the welfare of the patient, he or she must face a problem of whether to rely on subjective or objective assessments of benefit” (p. 47). The responses of participants clearly outline the differences between perceptions of quality of life issues, empathy and sense community to name a few. These differences in value align with Veatch (2012) to demonstrate “the judgment of benefit is subjective if it is based on the perspective of the one who is making the assessment” (p. 47). While objective judgments can be considered true regardless of who is making them, the findings of this study suggest that ethical decisions are often subjective and the interpretation of the “good” of the patient differs between not only paramedics, but patients and their family members as well. Yet ethical decision-making is a

part of paramedic practice with enormous consequences for the lives of both patient and paramedic. Iserson et al. (1995) suggest an approach to consensus:

An important task of normative ethics is to uncover this shared basis for determining how we ought to act and then to attempt to extend it through rational discourse into areas in which agreement has hitherto been lacking. I can still reason about my own ethical beliefs, and you can still reason about yours. Each of us can strive to make his or her own set of beliefs consistent (p. 35).

This study sought to explore paramedic perceptions as they navigate ethical situations. While a qualitative study limited to thirteen participants is inappropriate for a universal understanding of decision-making in paramedic practice, it can serve as a valuable first step in informing the research for the adult education and professional practice communities. This first step to understanding can be used to further inform a process for decision-making that approaches a normative ethics for EMS. Ethical dilemmas were presented through the stories of participants in this study as they described emergent situations that demanded a decision, even if imperfect. In addition to the demands of emergent ethical navigation, “situationalism holds that moral rules are merely guidelines of rules of thumb that must be evaluated in each situation,” whereas, “the rules of practice view holds that rules specify practices that are morally obligatory” and binding on conduct (Veatch, 2012, p. 4). While some ethical decisions exist as an interpretation of what is right and good, others are clearly against moral conduct. As an example, Amanda told us a story common to EMS, about a paramedic that had falsified documentation. In this case, the paramedic had been called to the residence of a patient with a badly broken leg who had lost a lot of blood. Called in to

assist on the scene, Amanda found the paramedic offering inadequate treatment. She attempted to suggest a course of treatment and was dismissed. Later, she found out that the paramedic wrote his report to suggest that patient findings were less severe than the true assessment that Amanda witnessed. Why? Did the paramedic sense disdain in Amanda's approach and feel embarrassment at his own poor judgment? Did he arrive at the hospital with the patient and face questions from a disappointed ED staff? Whatever the reason, he chose to falsify the call documentation. Scott takes the opposite approach when he realizes he has accidentally given the wrong dose of medication, stating, and "I can be the first one to say 'I am wrong.'" Having forgotten that a new packaging for the drug had been added to the ambulance, he didn't meticulously check dosing and gave the familiar syringe full of medication. "I went straight to the doctor at the ER and said 'here is what I did.'" The patient had no ill effects from the overdose of medication. Scott states, "I have seen some people try to sweep it under the carpet or let's just say they will forget it in their paperwork." Scott proudly suggests that his ethical behavior is consistent, "that is just me, if I screw something up, I will be the first one to tell you that I screwed up." The concept of value is again reflected in ethical considerations. While value theory suggests 'since beneficence (or producing good consequences) is one possible principle of right action and nonmaleficence (or avoiding producing a bad consequence) is another, a second question that has to be addressed in a full normative theory is 'what kind of consequences are good and valuable?'" (Veatch, 2012, p. 6). Beyond the determination of what is good for the patient, values play a role in the individual determination of good ethical judgment. Findings suggest that many participants attach these values to family, faith in a higher power, and accountability.

Noddings (2007) suggests that to learn or teach values consistent with ethical behavior, “not only must there be continuity in the educative experience, but the experience itself must have meaning for the students here and now. Education has something to do with the construction of personal meaning” (p. 32). What if the patient had experienced an ill effect, or death? What factors have contributed to Scott’s concept of ethical practice? These are two cases that represent a constant occurrence in health care, errors of omission or commission. Of particular concern, paramedics work with a high degree of autonomy, in critical situations, with uniquely challenging patient situations and extreme stress. Does this predispose that paramedic to errors of ethical judgment? Findings suggest this is the case, however further research is needed. Can improved capacity to navigate ethical situations be addressed through training? Lindemann et al. (2009) suggest that “we are situated observers whose observations are shaped not only by moral assumptions but by much of what we take for granted experientially, socially, institutionally, and culturally, and tacit presuppositions affect what we take moral assumptions to mean” (p. 10). While faith and accountability notably influence the decision-making of participants, learning through the experience of others in a community of paramedics also had noted influence. While none of the participants noted learning ethical navigation in critical events from the classroom, many participants discussed learning from observation and story-telling. Lave and Wenger (2009) describe “newcomers legitimate peripherally provide them with more than an observational lookout post: it crucially involves participation in a way of learning- of both absorbing and being absorbed in- the culture of practice” (p. 95). While learning in practice is notably experiential, “ethical precepts are not self-applying; we have learned precepts and what they mean in particular

communities of judgment from the typical application within those communities to particular situations” (Lave & Wenger, 2009, p. 10). Lave and Wenger (2009) state that community of practice continues throughout the work experience and “does imply participation in an activity system about which participants share understandings concerning what they are doing and what that means to their lives and for their communities” (p. 98) making this culture of practice their own. Again, findings suggest that there are commonalities to ethical decision-making among paramedics perhaps related to the community of practice and the uniqueness of situations in EMS.

While findings suggest there are many commonalities among paramedics as they approach difficult decisions, such as cardiac arrest resuscitation, why do inherent differences occur among paramedics with similar training and experience? For example, Kevin discussed his experiences and the difficulty of terminating resuscitation efforts in the field:

Our effort to resuscitate the patient cannot be done for the family’s state of being or half-way, ethically you cannot do it that way. You have to give the patient 110%, do we sometimes get a patient back that should not have come back, yes, but in the end I can tell the patient/family that we have done a, b, and c and they are not responding and it was exactly what they would have done in an emergency room and we can do nothing more. Once I have met the ethical burden in my mind, and in some cases it is much quicker to get there than others... once I have done everything in my power and they are not responding and exhausted all means possible, I still go a few more minutes just to see... then with everyone’s permission and my own best judgment, we discontinue efforts.

When asked to clarify the term “ethical burden”, Kevin explains:

It goes back to the 100% rule, me knowing I have to do this because it is right for the patient and right for me to do as a coping mechanism... when I come back I will not be “what-if-ing” myself and beat myself up after the fact... I know there is nothing else that could have been brought them back.

Kevin describes the difficult transition from transporting cardiac arrest victims to the ER for the physician to terminate efforts to field termination by the paramedic:

I was prepared through the protocol process, but I was not prepared for the emotional part of it. The emotional response of telling someone that their loved one was gone, i.e. telling a wife of fifty years that her husband was dead, I was not prepared for. I have gotten better with it, it is still there and if you don't give 100% it will eat you up emotionally.

While several of the participants interviewed have described the decision to resuscitate or terminate efforts in field as difficult, Edwin, uniquely states that for him, they are some of the easiest decisions:

Ethical decisions to resuscitate somebody is so much easier because there is so much criteria out there to help you to make a good resuscitation decision. You know if you can establish down time (the number of minutes the patient has been in cardiac arrest), and if you can start capnography on somebody, capnography is a good tool because it gives you a picture of the reverse side... you know, activity inside the cell. If I have an advanced airway on somebody and I start chest compressions on the chest and their entire CO₂ is less than 20, they are not making ATP, now... why aren't they

making ATP? Either they are too cold or they have been down too long to make ATP. Those are the only two options. If you reach down and feel them and they are not cold as an ice cube, it's pretty much they are outta there (dead).

In this discussion, Edwin refers the use of equipment that measures the amount of carbon dioxide exhaled by the patient through an advanced airway. Although the purpose of this document is not to discuss the science surrounding paramedic skills and knowledge base, of interest to the reader, carbon dioxide is only produced in tissues that are perfused with oxygenated blood, essentially, living tissue. Therefore carbon dioxide levels below 20 mmHg, as indicated by Edwin, suggest tissue death (not making ATP, the energy created by living cells). The American Heart Association 2010 Guidelines suggests using such low levels of carbon dioxide in the consideration of terminating resuscitation efforts. For Edwin, it seems the use of this diagnostic tool allows him complete confidence in resuscitation issues. Life or death, in his summation, is represented by a numeric equation on the cardiac monitor and he is simply confirming the reality of the current approach to cardiac arrest care. His approach to resuscitation decisions as described below seems to align with the Iserson Test of Impartiality, asking the practitioner “to switch their point of view, to take the other’s perspective” (Iserson et al., 1995, p. 46).

I put myself in the position of patient and family members when it comes to resuscitation because one of the things we try to do is provide total care. You know when you walk out of there and you start resuscitating somebody and you know the literature now says the best thing to do is resuscitate somebody on the scene. You don't want to transport unless you get ROSC (Return of Spontaneous Circulation or

return of pulse), so as you start resuscitating somebody and this is the hardest thing for people to grasp... one of the biggest holdouts we are finally getting people to realize, treat the patient on scene. If you treat the patient on scene your chance of getting a return of spontaneous circulation goes up. People are always resistant to new ideas. You always get the family members that walk up and say 'momma didn't want to be kept alive by no machine like that'.

Empathy, as conceptualized by the participants, demonstrates yet another area of disparity among paramedics. Hoffman (2000) suggests that "empathy is defined as an affective response more appropriate to another's situation than one's own" (p. 4). Empathy with another's circumstances arises from two cognitive modes, according to Hoffman (2000): mediated association, that is the association of expressive cues from the victim or the victim's situation with one's own painful past experience" and the "role of perspective taking, in which one imagines how the victim feels of how one would feel in the victims situation" (p. 5). The ability to feel empathy then is rooted to our own "semantic processing of information" and our perceptions of their cues. Hoffman (2000) further states that empathy and caring "are interdependent, mutually supportive, hence congruent dispositions to help others" (p. 225). While personal concepts and memories of pain may suggest why disparities exist among paramedic perceptions of empathy, bestowing empathetic care may differ among situations in relationship to the practitioner's concept of justice. Kant followers believe that "moral rightness of a person's due, a person's treatment of others," is related to the principle of justice (Hoffman, 2000, p. 223). Hoffman (2000) further states that in the instance that caring is subject to personal flings of justice, "caring is logically subordinate to

justice obligations in the two conflict” (p. 223). While obvious disparity exists among participants as to what constitutes an ethical dilemma in decision-making, all agree that many “gray” areas exist. If the findings of this research were used to develop a definition for “gray” areas in EMS, it might read: “an area that is not clearly defined by law, with no easy right or wrong answer, where the consideration of patient well-being conflicts with the accepted protocol standard, or the norm for paramedic behavior differs dependent on beliefs, experience, community of practice and mentoring.” Edwin describes:

Probably the gray area that I have experienced is the 15 and 8 year olds... I have called (terminated efforts or denied resuscitative efforts) a couple of them and went to the hospital and got the signature afterwards and it's like ‘I know they are supposed to be technically 18, I am sorry... if they have lividity or injuries incompatible with life you know at 15 they are doing something stupid’. The fact that is they are 15 and have their gray matter scattered all over the pavement, don't change the fact that they are not three years older, they are still going to be dead.

In this case, Edwin describes a gray area created by the limitations of the law as it applies to EMS. Consent for treatment in an “emergency requiring immediate action to save a life or to prevent permanent injury” (Iserson et al., 1995, p. 20) is implied. It is implied that a reasonable adult would want emergency care to save their lives. Children are defined by law as less than age 18. Implied consent considers the parent or guardian would want the child to be treated in the emergency setting, however, without such consent on scene, the paramedic must treat. Many protocols insist that even in cases of obvious death, the paramedic cannot

withhold resuscitation efforts, or they must have the approval of medical direction. Iserson et al. (1995) describe the same limitations:

Law may have little to contribute - beyond its pervasive emphasis on the importance of appropriate decision-making - to the resolution of the very dilemmas that emergency personnel find most ethically troubling. When right legal course is in doubt, health care providers should usually follow that course they believe is most defensible in medical and ethical terms until advice can be obtained from someone with legal expertise (p. 11).

For others, the gray area exists between what is right for the patient, and what are the accepted rules. Michelle states, "It's not that easy. Nothing is cut and dry... it would be nice, but nothing is cut and dry." Kevin agrees and describes the evolution of the decision-making process through over a decade of experience:

Going from the mentality that everything is black and white and cut and dry to saying there is a whole lot of gray. It takes more of a coping/decision mechanism because the gray is always going to be there... I wish going in that I knew that we work in black and white about 10% of the time, and 90% is gray.

For some participants, the challenge of opposing protocols equates to operating in a gray area. Several paramedics took comfort in their decision to oppose protocol if it represented the best interest of the patient. All described the stress endured in making a decision that could jeopardize career and certification. Scott discusses opposing protocol:

If it is going to make it right for the patient, then I will. You know if it is right for the patient and I have to step out of protocol, yeah, then it becomes extremely situational with what I call “mother may I,” or just do it!

Several factors seem to contribute to a paramedic’s willingness to operate in the often gray area of EMS decisions: a feeling that they are called to practice, service and allegiance to community, and accountability to family, patient, God, Medical Director and self.

Methods for learning to cope with such challenges were also comparable: mentoring, experiential learning and critical reflection. Findings suggest that there is a need for a method by which ethical decisions can be made in critical moments with autonomy and confidence.

This may lessen the stress associated with such gray areas and inform competent ethical decision-making. Merriam and Brocket (1997) describe workplace training as a combination of two concepts. The first, “performance based or competency based model of learning has been predominant because it stresses the attainment of measureable outcomes tied to established objectives” (p. 151). While this approach is favored in initial and continuing education program for paramedics because of its obvious strength in demonstrating results that can be verified, “it is possible to deduce that this approach is not an effective way to address learning related to values or critical thinking skills” (Merriam & Brockett, 1997, p. 151). The second concept suggested by Merriam and Brocket (1997) describes:

Learning organization as a place where people continually expand their capacity to create the results they truly desire, where and new and expansive patterns of thinking are nurtured, where new and collective aspiration is set free, and where people are learning how to learn together (p. 151).

For paramedics, the competency based approach is favored in initial and continuing education programs. Skills and cognitive competencies are verified by educational and employing organizations. Competency based ethical decision making education will be discussed as an implication for the future.

The following section presents a summation of findings. These six findings will be used to suggest and support implications for practice, theory, and research at the conclusion of this chapter.

Finding #1. Participants do not use a systematic approach, such as the Iserson Model, to navigating ethical decision-making situations. Data from this study demonstrates that participants do not routinely apply a specific methodical approach to ethical decision-making or to navigating ethical situations. Furthermore, none of the participants voiced awareness through previous training or professional exposure that such an approach exists. Rather, all stated that they had learned through lived experiences, through observations of mentors, and through the shared stories of other paramedics. Roberts (2012) suggests:

These basic tenets of the pragmatic ethos should be recognizable to students and practitioners of experiential education- the importance of consequences, the interactive nature of knowledge, the social qualities of learning, the notion of context and contingency, and the significance of trial and error (p. 52).

A key difference in participant experience and the approach suggested by Iserson et al. (1995), was that none of the participants perceived the opportunity for “buying time” to deliberate. As such, if an ethical consideration in the decision process was used, it was

limited to one “test” or question per incident. Findings suggest that if the use of an ethical decision-making model were encouraged and taught, it should be brief with few steps and easily committed to so that it can be practiced and relied upon in extremely stressful and fast-paced circumstances. Participants described an informal process of debriefing, however as a learning tool, debriefing has been used successfully in both simulation training and clinical internships. Fey, M., Scrandis, D., Daniels, A. and Haut, C. (2014) describe findings of a study on student perspectives of the debriefing process, “students found the conversational format allowed for learning synthesis. Self-discovery and self-reflection as conversations helped them evaluate themselves, identify their strengths and weaknesses, and motivated them to address their knowledge gaps” (p. 253). It also suggests that a post-incident or continuing education opportunity to debrief and learn with peers who are not in the immediate practice region may be valuable. While experiential learning is categorized by Merriam and Brockett (1997) as learning that takes place outside of the classroom, “cognition is not merely something that goes on in the individual, but rather is tied to the surroundings and life experiences of the person” (p. 156). More specific to practice, “situated cognition is based on the idea that what we know and the meanings we attach to what we know are socially constructed” (Merriam & Brockett, 1997, p. 156). Ostensibly, participants note learning to navigate ethical decisions through experiences, and without situational reference to a progressive model, such as the Iserson Model.

Finding #2. Participants do not routinely consider previous experiences or seek immediate consultation for help with ethical situations. Data from this study indicates that paramedics do not actively consider past experience with similar situations when making

critical decisions. This appears to be at least partially due to the perception that all calls are unique and it is dangerous to have “tunnel-vision” when considering an approach to a dilemma. In other words, over-reliance on past experience as a guide to practice may actually be intentionally avoided. The research shows that memories of former calls are solidified into experience and the development of professional judgment occurs during the critical reflection phase after a call. “Reflective practice is a deliberate pause to assume as open perspective, to allow for higher level thinking processes” (Merriam et al., 2007, p. 172). These memories help to guide decisions, but are not actively considered during a call.

Participants do not consider consultation to be a consistent source of assistance in difficult dilemmas. While consultation does occur, it is limited to peer and medical direction. Consultation is not routine and responses are varied between positive and negative so as to suggest this is not always perceived as a viable option for a paramedic in the field when faced with navigating an ethical situation. Merriam et al. (2007) state “learning requires a resolution of dialectally opposed modes of adaptation to the world; that is learners must move between opposing modes of reflection and action and feeling and thinking” (p. 163). The limitation of time, mistrust in doctor’s orders, or the perception that the paramedic should be able to operate with complete autonomy were all noted barriers to participant willingness to access medical direction. Given current trends in EMS and the findings of this study, reliance on medical directors that are well versed in paramedic treatment and protocol is unlikely to yield consistent application throughout the profession. However, the concept of medical direction is synonymous with paramedic practice and understanding. Training and protocol perhaps could offer a suggested guide to accessing medical direction. It is noted

that paramedics most often used medical direction to share the liability for decisions and experienced mixed results. While a physician as a resource should be utilized, structure and intent on the part of the requesting paramedic are important. Findings suggest the accountability and respect for the medical director is typically a coveted trust that motivates ethical care. Findings suggest that participants either believe or have experienced peer perceptions that routine access of on-line medical direction by a paramedic is a weakness. Findings suggest that participants favor a reduction in the reliance on medical direction through direct communication on calls. Statements in limited discussion time should be kept to problem and request. For example, “I have a patient in cardiac arrest, I have no DNR order. My dilemma is that protocol states to work the patient, death is confirmed and the family does not wish to have the patient resuscitated. I need orders to terminate efforts and call the code.” It should be noted that the findings of thirteen participants in one state do not in any way represent a standard of acceptable use of medical direction in the profession. These findings suggest a new understanding of trends and perceptions in medical direction and a call for further research. The implication for practice is the need to update materials used to prepare paramedics through initial training programs that reflect the current trends in medical direction. Specifically, there is noted movement away from reliance on medical direction. In addition, when medical direction is consulted, there is an enhanced need for a clear and structured communication reflective of precise requests or questions.

Finding #3. While no consistent approach to ethical decision-making was discovered, strong findings support the sense of community, empathy, and patient beneficence to be the motivating factors. The sense of community was strongly noted by

participants as a concept in accountability. The Iserson Model framework coded findings, it appear to be an effective motivator for ethical practice. Community identity is not actively considered during the decision-making phase of an emergent call. Rather, it appears a consideration of accountability after the call, and informs behaviors of professionalism and empathy on future calls. While the concept of community identity and accountability do not appear in findings as a consideration during a decision, the inclusion of this concept could be valuable in initial training and continuing education programs. This would encourage paramedics to reflect on ethics and engage in accountability to a community beyond self, patient, and medical director. Some participants voiced a disparity between rural and urban community identity, however most identified with the desire to be a “hero” within the community.

The most frequently applied of the Iserson Model tests or questions of ethical rightness, was impartiality. “Would I want this one for me or a loved one?” All participants noted this consideration at one time or another in an approach to a call. While the consideration of impartiality was acknowledged among all participants, no participant stated consistent application in each ethical decision dilemma they encountered. The implication through findings is that the use of this test was triggered by individual patient experiences. For some participants, a patient experience suggested a resemblance to a loved one, most frequently a parent. Less likely, but still noted in the responses of most participants, a patient interaction at times created a likeness to self. Based on findings, inclusion of this consideration in decision-making, “What if it were myself or loved one?” does allow

paramedics to experience a universal empathy approach that could be applied and practiced in patient dilemmas.

Participants clearly articulated the concept of patient at the highest level of accountability when they manage difficult ethical decisions. Most participants expressed dilemmas they had faced in which they had committed or omitted a standard of practice, protocol, or physician order for the benefit of the patient. These findings suggest that paramedics have frequently risked, at minimum, punishment or the loss of privileges in order to err on what they believe to be the side of the patient. Participants were willing to cross an ethical line when making decisions, even to the possibility of losing their job and certification. They did so if they believed it to be in the best interest of the patient. Of further importance, most participants had experienced the decision to “error” ethically in favor of the patient.

Finding #4. Participants do not actively reflect on prior experience during decision-making incidents however, they do form strong impressions from critical reflection following the call, mentoring and/or the experience (both personal and as told through stories of other paramedics). Data demonstrates that rather than reflect during the process of decision-making to consider whether a previous “rule” or solution exists, participants expressed that they reflection occurs after the call. This reflection may be individual or in discussion with peers, mentors, partners, or medical direction. “The affective domain can be seen to provide the underlying foundation of all learning” (Merriam et al., p. 164, 2007). The authors go on to suggest that the affective domain is important “in order for people to interpret experiences positively and to learn effectively they need to have

confidence in their abilities, good self-esteem, support from others, and trust in others” (p. 164). Perhaps most congruent with findings, participants suggest a level of trust and respect for the mentors or experienced providers as they consider their stories and opinions. This reflection appears to address the concern of “did I do the right thing?” Teekman (2000) states:

Reflective thinking was extensively manifest, especially in moments of doubt and perplexity, and consisted of such cognitive activities as comparing and contrasting phenomena, recognizing patterns, categorizing perceptions, framing, and self-questioning in order to create meaning and understanding. Self-questioning was identified as a significant process within reflective thinking (p. 1125)

Participants acknowledge that the practice of storytelling among paramedics is a long standing tradition. During this time of reflection, learning occurs. “The outcome of reflection is to gain deeper insights that lead to action” (Merriam et al., 2007, p. 172). When asked, “Do you reflect on prior experiences when making a decision?” the over whelming response was “no.” However, participants did acknowledge having grown and learned from their own past experiences and that of others in reflection. Osterman and Kottkamp (1993) describe reflective practice by stating:

Reflective practice, while often confused with reflection, is neither a solitary nor a relaxed meditative process. To the contrary, reflective practice is a challenging, demanding, and often trying process that is most successful as a collaborative effort. Although the term reflective practice is interpreted and understood in different ways, within our discussion, reflective practice is viewed as a means by which practitioners

can develop a greater level of self-awareness about the nature and impact of their performance, an awareness that creates opportunities for professional growth and development (p. 2)

Findings support these statements in that reflective practice by participants following difficult calls was a collaborative effort leading to a greater level of self-awareness with an impact on practice. Merriam et al. (2007) suggest that “the purpose of reflective practice in a group is not to be right or winning, but openness to a variety of perspectives, for it is not only in openness that new understandings can occur” (p. 172). The participants further acknowledged that this learning indirectly informed their decisions as they made them. While participants did not actively reflect on prior experience, experience and reflection did affect the decision process. Jarvis, as quoted by Merriam et al. (2007) “include both experimental learning (the result of a person experimenting on the environment) and reflective practice (thinking about and monitoring ones’ practice as it is happening) with what he conceives of as the highest forms of learning” (p. 164). The use of reflective practice appears to have significantly impacted participants learning through their own experiences, and from those of others as they reflect.

Finding #5. Participants learned the navigation of ethical practice through experience and mentoring, not from classroom or textbook learning. Data demonstrates that navigating ethical situations is a skill learned from experiences and from the experiences of others through storytelling and informal discussion. Perhaps the most familiar of experiential learning theory is Kolb’s Model:

Presented as a four stage cycle consisting of 1) gaining new kinds of concrete experience; 2) engaging in reflective observation that allows one to interpret experience from different viewpoints; 3) forming an abstract conceptualization that leads to the development of theories about the experience and reflection; and 4) active experimentation with these theories in order to solve practical problems (Kolb, 1984, p. 21)

As noted in previous discussion, situational learning and the community of practice are important considerations to the experience, Fenwick as cited in Merriam et al. (2007) offers a critique of Kolb, stating “the learner’s context is not taken into consideration” (p. 163). Most participants voiced the respect of an experienced paramedic or mentor. “Although the issue of power and knowledge is fundamental to the theory of situated cognition, it is often downplayed or overlooked in favor of how to apply the concept” (Fenwick, 2003, p. 180). Power of influence is strongly noted amongst all participants. They agreed that they have learned ethical practice in situations of mentoring and the immediate community of peers. As participants select ethical behavior to model or opinions to solicit, power is perhaps an aspect of mentor or peer selection. Some experiences were gathered during clinical or precepting experiences, while others were attributed to working with peers. In all cases, participants confirmed that their own skills with ethical decision-making were gained from experience and discussion among peers. This is an important distinction. An Australian study, French and Casali (2008) found a “gap between individual ethical decision-making approaches and organizational decision-making in EMS” (p. 44). Using a Managerial Value Profile, participants were categorized by three ethical principles: utility, morality, and justice

with regard to both organization and individual. “The overriding principle was rights (morality) with almost 60 % of respondents demonstrating a preference for right based ethical decision-making” (French & Casali, 2008, p. 47). This finding is consistent with findings of this study where participants were willing to make decisions that included personal risk for the patient well-being. French and Casali (2008) state that “evidence indicates that ambulance professionals perceived their own individual ethical reasoning differently from that of their organization” (p. 47). This further delineates the differences between peer and mentor learning and learning through organizational structure. No participant in this study voiced a link between learning to navigate ethical situations and organizational objectives.

Of similar note, all participants stated that they did not remember or attribute any ethical decision-making to classroom learning or textbooks. However, the basis for field practice is grounded in the cognitive domain occurring in classroom settings. Arguably, the answer to informing paramedic training with enhanced ethical decision tools is to present educators with proven teaching methods and content introduced in ways that lends itself to the objectives and informs actual practice with a proven approach. Wlodkowski (2008) suggests that the starting place for educational delivery is in motivation. He proposes a motivation framework for culturally responsive teaching: 1) establishing inclusion by creating a learning atmosphere in which learners and instructors felt respected by and connected to one another, 2) developing attitude by creating favorable disposition toward the learning experience through personal relevance and choice, 3) enhancing meaning by creating challenging thoughtful learning experiences that include learner’s perspectives and

values, and 4) engendering competence by creating an understanding that learners are effective in learning something they value. “These four factors are essential for developing intrinsic motivation for learning” (Wlodkowski, 2008, p. 113). Students motivated to learn ethical decision-making concepts must also embrace empathy. Galbraith (2004) states “adults can develop functional skills and attitudes necessary for an effective adult life” (p. 361). Of note, Galbraith (2004) concurs that “experiential learning may be used to develop an ethical stance, to develop moral reasoning, or judgment in complex situations” (p. 361). The researcher notes a dominant theme in that all participants voiced learning of ethical practice through mentorship and peer interaction, often in the form of story-telling within the practice community. Further self-reflection formed future implications for ethical navigation in emergent situations through the same interaction with peers and mentors after a difficult dilemma.

Finding #6. There is a great deal of disparity among participants with regard to the concepts of accountability and empathy. While disparity exists in these concepts, the impact of difficult ethical decisions appears consistent. Participants noted the effects of cumulative stress as a result of such decisions and most described it as “heaviness”. Data demonstrates that although the term accountability as taught in paramedic training programs is universal, participants have their own concept of accountability. Whether patient, medical director, self, or God are the first chosen in accountability, it is evident that it is a powerful motivator in ethical behavior.

Likewise, the concept of empathy as taught is a universal concept. Data demonstrates that feelings of empathy toward patients or the lack of empathy toward patients has strong

ties to particular age groups, patient complaint, or social identity. Not surprising, empathy toward young children appeared strongest among participants. Yet, while several patient populations evoked a sense of empathy among participants, others by contrast, generated indifference in others. One paramedic noted feelings of empathy for the homeless, while another found the demands of care for the homeless population using EMS for basic needs, like transportation, rather than emergent needs, to be frustrating. Perhaps the approach to such learning activities should consider that “all learning involves socially organized activity, the question is not whether to give instruction in a complex social environment, but what kind of complex social activities to arrange for which aspects of participation and in what sequence to use them” (Merriam et al, 2007, p. 180). For some, alcohol and drug use in patients evoked painful associations with parents or other family members that abused substances. The commonality is that all participants experienced feelings of empathy based on their own life history. All participants voiced feelings of frustration with a particular patient population, also based on personal experiences.

Conclusions

The purpose of this chapter is to present and offer a discussion of the findings of this study based on an analysis of data of how practicing paramedics perceive ethical practice and make ethical decisions in practice. This chapter began with the findings associated with a conceptual framework analysis and a brief discussion of the structure of the study to include methodology and selection of participants. Iserons’s Model for a Rapid Approach to Ethical Problems was presented with reference as to how it was used as the conceptual framework, subsequent development of the interview protocol, and structure for data analysis. Following

this discussion an integrated presentation of student findings and discussion was presented. Six primary findings resulted from the culmination of two strategies for data analysis (open and framework). From this discussion of study findings, specific implications and recommendations have been determined as related to theory, research, and practice in paramedic ethical decision-making. These implications and recommendations will be presented in the following section.

Implications for Future: Practice, Theory, and Research

An increasing demand on paramedics to operate with autonomy and offer ever advancing emergency medical care is placing an enormous demand on paramedics to make ethical decisions. Yet, preparation for such decisions has not increased to reflect this exponential demand. While ethical decision-making undisputedly occurs, it is poorly understood, identified, or addressed in literature. The paramedic, thrust into critical circumstances, is called to make rapid decisions with tremendous impact. Such decisions can have long-reaching and devastating outcomes for both practitioner and patient. Understanding the ethical decision-making process is as important as the decisions surrounding assessment and treatment of critically ill patients. The findings of this study offer meaningful insights into how paramedics perceive, encounter and experience ethical dilemmas and the decisions that accompany such situations in practice. The subsequent section, implications, is organized around an integrated discussion of the implications for practice, implications for theory, and implications for future research, as supported by the study findings.

Implications for Practice

The findings from this study of ethical decision-making in paramedic practice gave participants an opportunity to share their experiences. In addition to experience in making difficult ethical decisions, participants offered key understandings of their own learning processes. Some offered key insights that support the findings and implications of this research. These findings generated specific implications for practice that relate to teaching ethical decision-making, informing theory, and substantiating the need for further research.

Educators and curriculum developers should consider scenario based training with discussion, case study presentations, and simulation for use with relevant ethical dilemmas. The need to practice patient care and the psychomotor skills that accompany each treatment modality is a given in paramedic training and education programs.

Curriculum reflects not only methods for practical teaching and testing, but mandated minimum competencies prior to successful completion of programs and certification exams (NHTSA, 1998, 1:5). Scenario based training offers a golden standard of incorporating a cognitive theory base with psychomotor skill and the necessary affective domain behaviors to communicate effectively with both patients and EMS teams. As common place as this approach is to EMS education and training, it is not a current widespread approach to ethical decision-making training. While ethics theory is a required component of didactic curriculum content at a minimal two seated hours, no active scenarios or discussion methods offer students that opportunity to experience ethical decision-making in initial programs (NCOEMS, 2005, p. 3). The consideration of such teaching methods may result in increased requirements for didactic programs. Of similar note, no ethical component is required of

continuing education or recertification processes for practicing paramedics. When new techniques, equipment, or science have been introduced into EMS, typically initial training programs and continuing education programs address the changes so as to ensure a consistent level of care among all providers. Findings of this study suggest that ethical decision-making is a skill requiring an initial level of competence, exposure through clinical training and a continued consideration in training to maintain competency. The “case method refers to a method of instruction based on real life examples. Cases typically include three interrelated components: a case study or report, case analysis and case discussion” (Galbraith, 2004, 383). Cases are well suited to mimic the reality of gray areas where no single right answer seems plausible. Galbraith (2004) further suggests that case studies in group discussion can “broaden the learner by encouraging a wide range of viewpoints from others” (p. 383).

Kevin recalls having a continuing education course regarding cardiac arrest termination that was taught by a spiritual leader, and remembered that “there are things you don’t learn unless you find a niche or in a specialty class.” Kevin believes that one of the best ways for paramedics to learn such ethical decision-making practices is through case scenarios:

Case scenario... this is your patient, what would you do? With only the pivotal information that you would have and not the treatment revealed, you would have to decide what to do for the patient with caveats thrown in your way in an effort to teach you how to prepare for such a situation. You learn from doing and by others experiences, like some of the after-the-fact decisions from 9/11, learning from others. That’s the worst situation anyone can be in and knowing that you can see them making decisions and knowing you could be put in the position... so learning from

someone else. I learned from watching the providers I was working with... sitting back after someone has had a challenging call and talking about the situations after the fact... saying ‘tell me what you did?’ I would have them talk to me about it so that I was helping them deal with. It helped me learn.

Kevin believes that:

Repeated experiences make it easier, but you are still always trying to do what is right and what is best... so it’s not always easy. I’ve seen people come and go at EMS and it’s because of the difficult calls. They get tired of it, they can’t get over it, or they make a terrible mistake and are no longer allowed to be a pre-hospital provider for some reason.

Modeling initial training in certification and degree programs after cardiac arrest scenarios, or traumatic injury scenarios offers students exposures to examples of ethical decisions, discussion opportunity, and the practice with effectively working through such challenges. Galbraith (2004) suggests “demonstration and simulation methods are based on experiential learning” (p. 361). Ethical decision possibilities are as endless as patient illness and injuries; however, common ethical problems can be used to form scenarios and discussion questions. Suited to ethical decision-making, “one of the values of simulation is its potency and its ability to get learners involved cognitively as well as emotionally” (Galbraith, 2004, p. 372). Students can be instructor-led through such training and practice, as a team leader, how to consider and make difficult decisions, often, where there is no true right or wrong response. Such scenario practice allows students to gain a basic

understanding and minimum competence prior to patient and family interaction, and may help to prepare students for clinical opportunities.

The adult learning theory foundation suggested for further development of this implication is Experiential Learning Theory. Theorists such as John Dewey, Kurt Lewin, David Kolb, Carl Jung, Carl Rogers, and others, have placed experience at the center of the learning process. Of note, experiential learning theory further considers the experience and resultant learning to be cyclic in nature in that learners continue to consider and reconsider ideas that relate to an experience and they make meaning. Experiential learning theory incorporates action/reflection and experience/abstraction, suggesting that learning through experience continually informs future experiences, and in the case of this study, ethical decision-making.

Ethical decision-making should be incorporated into preceptor and mentor preparation training. Students with a basic understanding through initial training, such as discussion and scenarios, are better prepared to understand the challenges associated with ethical decision-making as they observe preceptors. The role of preceptors in preparing paramedics for such experiences was strongly supported in the findings of this research. All participants noted that learning had occurred through experience, precepting, and mentoring, not through formal classroom teaching. Fenwick (2003) suggests the “knowledge is not received and later transferred to another situation, but part of the very process of participation in the immediate situation,” she goes to suggest that “the physical and social experiences in which learners find themselves and the tools they use in the experience are integral to the entire learning process” (p. 25). It should be noted that with no formal classroom ethical

decision-making practice, it is difficult to determine whether such training would have impacted participants. Lave and Wenger (1991) suggest that “groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly” (p. 29), and indeed, findings support the idea that hearing the stories of paramedics, or watching paramedics make such decisions is directly contributed to learning such behavior. The learning that occurs is not necessarily intentional. Lave and Wenger (1991) contend that three components are required in order to be a Community of Practice: 1) the domain, 2) the community, and 3) the practice (p. 98). This fact should be capitalized upon in preceptor preparation and/or formal mentoring programs. “In situated cognition, one cannot separate the learning process from the situation in which the learning was presented” (Merriam et al, 2007, p. 178). Walker (2009) suggests that we are “situated observers whose observations are shaped not only by moral assumptions, but by much of what we take for granted experientially, socially, institutionally, and culturally” (p. 10). Ethics is learned “in the particular communities of judgment from their typical application within those communities to particular situations” (Walker, 2009, p. 10). Preceptors should understand the responsibility and effectiveness associated with demonstrating ethical care and decision-making.

Mentoring is a concept noted in adult learning literature and used across a variety of professional contexts such as health care. Mentoring is a concept noted by study participants used in formal training programs, such as the assignment of a student to a paramedic preceptor, or more informally as beginner paramedic practitioners learn from experienced paramedics. Indeed, Fenwick, as cited in Merriam et al, (2007), states “scholars that study

organizational learning indicate that knowledge transfer of tacit knowledge (knowledge evident in our actions but that may not be explicitly articulated) occurs through socialization with others” (p. 179). As an extension of experiential learning, mentoring is a powerful learning tool. Most participants voiced learning roles and responsibilities associated with ethical decision-making through the process of watching and listening to mentors. Further, participants voiced reaching out to mentors in times of dilemma. Burke, Christensen, and Fessler (1984) suggest that “mentors are usually at the competency building or enthusiast and growing stages of careers” (p. 34). Daloz (1996) suggests that “mentors support our best aspirations, challenge us to reach beyond ourselves, and perhaps most important, inspire us by giving us important work to do in the world” (p. 15). Students in training and in the early stages of a career that are confronted with stressful situations demanding ethical decision-making and unable to rely on formal training, are openly interested in an “answer” from those they identify as trusted members of the profession. Learning in this setting was described as powerful influence by most participants. Zachary (2000) states:

Three assumptions can be made about the nature of mentoring: 1) mentoring can be powerful growth experience for the mentor and the mentee, 2) mentoring is a process of engagement that is most successful when done collaboratively, 3) mentoring a reflective process that requires preparation and dedication (p. 201)

The implication for practice, given the findings of this study, is that mentoring as a noted method for learning ethical decision-making should be taught and encouraged so that learning occurs for the enhancement of empathetic patient care in a way that minimizes cumulative stress noted by participants.

Ethical practice situations should be incorporated into clinical paperwork for students to include a review of calls involving ethical decisions and post-dilemma discussion or debriefing. The inclusion of reporting ethical decision-making into clinical paperwork increases the likelihood that students and preceptors will reflect and recognize where ethical decisions have been made. As Michelle reflects on her interview experience, she states:

You know a doctor makes a bad decision and they that's why it's called practicing medicine, a paramedic makes a bad decision and you carry it the rest of your life. I'm not saying the doctors don't carry their patients, but there is a big difference between us and them and I don't think sometimes we see it until we sit like this... really, I did not realize some of the things that I have made decisions about, until now.

Other participants voiced the same realization through the interview process, that they did not realize how many ethical decisions they made in practice. Calling attention to such practice by incorporating exposures to ethical decision-making in patient care, into precepting, and clinical paperwork allows for realization, critical reflection, and structured learning. This inclusion further allows for the debriefing of such exposures. All participants voiced the "heaviness" or stress associated with such decisions. Using precepting and mentoring opportunities to discuss these emotions promotes learned ethical management as well as stress management. Findings suggest paramedics deal with such incidents of stress through reflection n discussion post-event.

Yinger and Clark (1981) believe that reflection results written down are more powerful than reporting them orally, and suggests that "Journal writing is a powerful learning

tool, uniquely suited for professional thought and reflection” (p. 1). Students in clinical internship programs are frequently required to use forms of journaling to document experiences. These experiences may include the number and type of patient assessment or treatment they administered in a given shift. Use of this technique to document ethical decision-making opportunity allows for recognition of the ethical decision-making process and opens a dialog for discussion with instructors or preceptors. In addition, Yinger and Clark (1981) state, “feedback and opportunity for reflection are also cited as powerful writing features the support learning” (p. 1). The concept of verified and documented clinical decision-making skills is required to substantiate learner readiness for autonomous field practice. The inclusion of learning outcomes related to ethical decision-making should also be documented. This verification with confirm that students in field internships, or new paramedics being mentored as they enter practice, have experienced the opportunity to observe and discuss ethical decision-making.

Individual values, community based ideals and empathy should be incorporated into ethics training. Findings suggest that participants most frequently considered the first test of Iserson et al. (1995) in approaching ethical decisions: impartiality. Participants of this study did acknowledge, though not consistently, the consideration of “would I want this done to me or to a loved one?” as they made decision. Findings further suggest the allegiance to community and community memberships strongly motivates paramedics as they make ethical decisions. Finally, empathy varies vastly among paramedics and most likely relates to past experiences. Instructors that use these findings to approach teaching concepts of ethical patient management will likely find enhanced understanding in students. Specifically,

instructors that allow students to understand the concept of impartiality by discussing and envisioning what it would be like to have themselves or a loved one in their care will likely experience increased competence in ethical decision-making among students. Of similar note, instructors that promote a feeling of heroism in the community and the identity of EMS as a position of accountability among citizens may encounter enhanced understanding of the concepts, but with an inherent challenge demonstrated by this study, the viewing of large cities versus smaller towns. Students who are unable to imagine life in a small town due to a lack of experience from which to draw upon, may have a hard time imagining what emotions are associated with decisions regarding such community practice. Discussions may be instrumental in allowing them to feel a small town accountability and identity, while working and living in a large city. Finally, all participants voiced populations that evoke feelings of empathy, and those populations with which they struggle to feel compassion or in fact become frustrated with. Instructors that introduce the concept of concerned and impartial care to all patients may incorporate teaching methods that allow students to anonymously identify their own feelings of empathy and ambiguity. Such teaching and learning prepares the paramedic to make decisions regarding both populations with awareness.

Petrova, Dale and Fulford (2006) suggest that “value-based practice is one of a number of new approaches to supporting clinical decision-making where complex and sometimes conflicting values are in play” (p. 703). Differing from the broader bioethics theory base, value-based practice is “interested not only in moral values, but also in differences in perspective, preference, priority, point of view- a respect for differences in individual, social and cultural values” (Petrova, Dale and Fulford, 2006, p. 706). The

approach considers the values of both patient and practitioner as important to the decision-making process. Several participants voiced concern that paramedics they had witnessed making poor ethical decisions lacked personal values. While values-based practice theory does not imply that values can be taught, it does suggest the “enhancing awareness of one’s own values and the development of analytic and communication skills to elicit the values of individual patients and other stakeholders are primary ways to achieve this” (p. 707).

General practice differs significantly from emergency medicine in that patients can choose their physician, develop a relationship, and are generally afforded the luxury of time. The concept of understanding one’s own value set and the differences that might be inherent among the patients they serve can be facilitated through classroom and mentoring learning opportunities. Petrova, Dale and Fulford (2006) suggest, “Education and professional development are seen as the primary focus of change that will facilitate practicing in a more values-based way” (p. 707).

The National Association of EMT’s (NAEMT) recently developed a continuing education course for EMS providers, which is titled “Principles of ethics and personal leadership.” The course uses video clips from movies for group discussion and includes excerpts as reading to include EMS conference speakers and Florence Nightingale. The course text suggests that students will learn concepts to include: awareness of leadership challenges facing today’s EMS, personal responsibility and accountability for ethical decision-making, core values, strategies for conflict resolution, and ambassadorship for the profession (NAEMT, 2015, p. 1). The course text places an emphasis on an ethical culture with an organization “communicates an acceptable limits, how employees learn ought to treat

others, whether it is acceptable to question authority figures, if it is safe to report observed misconduct, and the importance of compliance controls and safeguards” (NAEMT, 2015, p. 16). The authors further suppose that “employees form collective perceptions depend on ethical criteria used for organizational decision-making and the loci of analysis used in that decision-making process” (NAEMT, 2015, p. 16). Individual ethical decision-making is not addressed, however, the authors state that “we learn what is valued and show what we value by our words and our actions” (NAEMT, 2015, p. 16) suggesting that moral organizational culture informs moral ethical behavior among its employees. To the converse, the text suggests that “normalization of deviance is a long term phenomenon in which individuals or teams repeatedly accept a lower standard of performance until that lower standard becomes the norm” (p. 21). Ethical behavior is expressed in relationship to groups. The authors state, “ethics poses questions about how we ought to act in relationship and how we should live with one another” (NAEMT, 2015, p. 35). While the focus of this study explored individual perceptions of ethics in patient care and individual ethical decision-making perceptions, findings did support that the culture of EMS through peer and mentor discussion, had a significant implication for paramedics learning to navigate ethical dilemmas. The uniqueness of the Iserson Model for ethical decision-making, and this study remains the pursuit of findings surrounding the individual paramedics as a position of autonomy in emergent situations.

The relevancy of the Iserson model in current paramedic practice is needed.

While the model is taught in current textbooks, no practice or scenario based training supports field use. The first print of the Iserson text, “Ethics in emergency medicine”

occurred in 1986, the second edition in 1995. Iserson suggests that the updated version included “new cases, and sections, updated materials, and in some cases new slants on old ethical dilemmas” (p. v). Since the 1986 print, Iserson’s work had been focused on disaster settings or mass casualty incident stress and ethics. No data exists to determine if paramedics use the model in practice on a consistent basis and if it has been tested in paramedic practice. This study indicates that the model needs modification for field use. More research with a larger numbers of participants is needed to confirm these findings, however, the modified model that is suggested includes the aspects of Iserson et al. (1995) work that are confirmed among participants and are reasonable to ethical decision-making. The inference is that the modified model is safe for application, and simplified for enhanced teaching and retention.

The modifications that are suggested consider the findings as aligned with the Iserson Model that were strongly supported among participants: impartiality, limited to self or loved ones, and justifiability to medical director. While peer and community are strong motivators, they inform the future practice after the fact, and not during critical calls. Universalizability is not pertinent in these findings, nor as an implication for future practice because paramedics consider each incident unique. Paramedics do not routinely question past experience for the same reasons. Consult, buying time, and previous experiences are not routinely considered during incidents. These findings are used to suggest a modified and simplistic approach to ethical decisions making in the subsequent theory section.

Implications for Theory

While a model for practice is suggested as an implication for the future, it is presented in the *theory* section of this chapter as the model is based on this research with limited

participants and has no other literature support. The need for further research to determine efficacy of the model is addressed in the subsequent section, *research*.

Research addressing the consideration of an EMS specific ethical decision-making model is needed. Supporting the need to prepare paramedics for difficult ethical decisions using an easily taught and remembered model is suggested in the implications for theory section as it in no way reflects readiness for practice. Further development and research are necessary before curriculum can be effectively created to ensure understanding and application in scenario based methods. Rick states:

EMS has changed and we can do more and that is why it is important that our medics are very well trained because we make a lot of decision on our own and they are responsible for life and death and so if you do not get the orders you have to make the call what to do about it.

In errors of ethical judgment, paramedics frequently error in the best interest of the patient. The patient is most important and consistently the first consideration among participants.

The conceptual framework used in this research supports that participants rely on #1: Error on the side of saving the patient, Is it in the best interest of the patient? Accountability findings also suggest that participants feel most accountable to the patient and are likely to adopt such a first step in an ethical decision-making algorithm. This test reflects the justifiability test in the Iserson Model, which is #2; Would I want this for myself or a loved one? This was a powerful finding among participants and is easily captured in instruction and practice as one can infer all paramedics can identify with the concept of protecting self or a loved one. This test reflects Iserson's first test, impartiality. #3; Would my medical

director support me? While this test of justifiability is reflected in Iserson's Model, it is considered a tertiary consideration in this revised model as it is not routinely considered during incidents; however accountability and justifiability to the medical director have a strong presence in the findings such to suggest that a step in ethical decision-making is to consider the relationship of medical direction either by protocol, or on-line contact, is a practical step.

The new model might be simplified and altered to include significant findings of this research as follows:

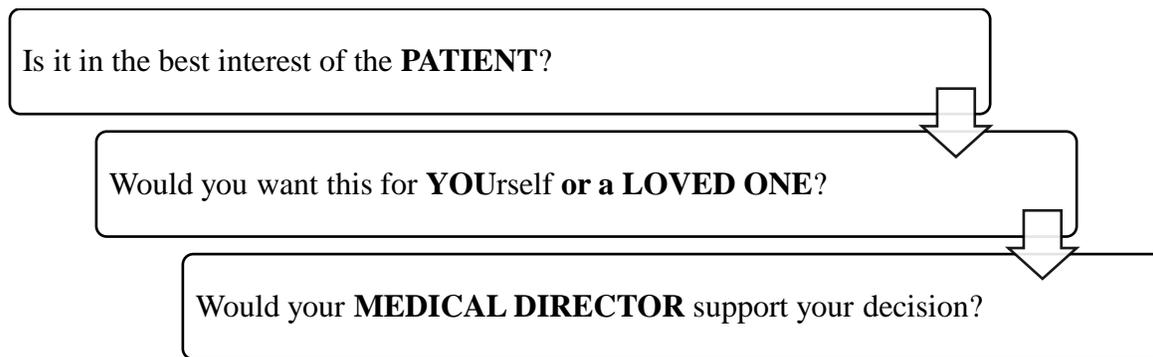


Figure 2 - The Revised Model

This revised Model is based solely upon the findings of this research study, not literature. The suggested application for this revised model would combine didactic learning through case study, discussion, clinical precepting experience, or simulation training with the practiced approach of the aforementioned questions. As practitioners learn to navigate ethical dilemmas, the use and repeated consideration to such a progressive, yet simple series of three questions may allow for a rapid, yet comprehensive consideration of empathetic care

and medical direction. To ease the “heaviness” associated with such ethical decisions would further add to the positive outcome of an effective model specific to EMS practice.

The employment of this simplified model may further be used in critical reflection subsequent to such ethical decision navigation.

Critical reflection is a powerful tool found to inform future decision and should be taught through both initial training programs and continuing education to practicing paramedics so that the impact on practice is positive.

Data demonstrates that participants actively reflect on critical decisions made in practice. While this practice is noted as both individual and among peers, it is consistently noted in the stories of all participants. Participants voiced a connection between reflection post call, to an overall knowledge base that they attribute to experiences. What is unclear, is the learning associated with such reflection positive or negative? The practice of critical reflection appears to have a strong influence on practice in ethical decision-making.

Participants do not acknowledge a systematic practice of reflection nor do they acknowledge the learning that is a result. For this reason, it is suggested that the theories surrounding critical reflection in practice be applied to the teaching setting so that paramedics understand and acquire the ability to reflect. In addition to offering a powerful and useful tool for processing decision-making, it is hopeful that a more actively engaged reflective process might yield more easily expressed and understood outcomes. A more consistently applied reflective approach and the tangible learning associated might enhance future research opportunities to determine the efficacy of reflective practice in decision-making.

Critical reflection theory is situated in adult learning theory with a strong connection to experiential learning theory. The concept that learners make meaning of experiences through reflection aligns with the constructivist epistemology. Findings of this research suggested that participants frequently engaged in critical reflection. Some, relived and reconsidered decisions individually for years, while at other times they engaged in conversations to tell stories of ethical dilemmas and hear the stories of others. Hatton and Smith (1995) indicate that engaging with another person in a way that encourages talking with, questioning, or confronting, helped the reflective process by taking the learner in a safe environment in which self-revelation can take place.

The ability to reflect as a learned behavior is a concept promoted among many professional education settings. While the degree of reflective behavior may vary among individuals, addressing critical reflection as a core concept in paramedic training helps to ensure its use as a skill among practicing paramedics. Indeed, findings indicate that in varying degrees, reflection is common. Reflective skill building helps to promote such activity. Critical reflection requires the practitioner to expose an experience thus making the process very personal, and perhaps even vulnerable to interpretation that decisions or actions were made in error. Brookfield (1995) states:

A precondition of critical conversation is a willingness to make public one's private dilemmas, uncertainties, and frustrations. Too often, however, the institutional rhetoric that emphasized the importance of 'learning from our mistakes' is contradicted by the penalties that accompany admissions of failures (p. 250)

Critical reflection in paramedic practice is described as informal conversations sought by the practitioner, perhaps allowing the open reflection process to occur in a situation of trust.

Interaction that occurs informally through social interaction in which the practitioner feels safe in the environment, promotes greater reflection. Bandura (2001) suggests that:

Verification of the soundness of one's thinking also relies heavily on self-reflective means. In this metacognitive activity, people judge the correctness of their predictive and operative thinking against the outcomes of their actions, the effects that other people's actions produce, what others believe, deductions from established knowledge and what necessarily follows from it (p. 10)

In addition to deeper critical reflection, social interaction among paramedics through stories of critical decision-making situations promotes learning among all participants as ideas are shared. Participants shared stories of learning through social interaction among experienced paramedics. This interaction encourages the formation of new ideas and deeper thinking. Such opportunities for discussion are noted among participants in preceptor, mentoring, and informal discussions in the workplace. The concept of discussion can be used in curriculum design for ethical decision-making concepts. As part of critical reflection teaching, the introduction of continued social interaction can be encouraged. Surbeck, Han, and Moyer (1991) state, "the nature of the stimulus to reflect will impact the quality of the reflection" (p. 25). Suggesting that reflection occurs to varying degrees, three levels of reflection are identified: reacting (commenting on feelings towards an experience), elaborating (comparing the reactions of others), and contemplating (constructive personal

insights). Contemplative reflection, as a process in ethical situations, may continue for months or years, as noted among study in participants. Merriam and Brocket (1997) suggest:

Reflection on action involves thinking through a situation after it has happened. In reflection on action, we consciously return to the experiences we have had, reevaluate these experiences, decide what we could do differently, and the try whatever we decide to do differently (p. 174)

The reflective experience that leads evaluation and revision is echoed in the needs for further research. While the findings in this study are presented with intent to inform, future research is indicated to develop implications, revise current methods, and inform the future of EMS ethics in practice.

Implications for Future Research

The importance of research in any profession cannot be underestimated. Literature presented in Chapter Two suggests that informed health care practice through current research benefits patient as well as practitioner. EMS, as a profession, is young by comparison to other areas of health care and as such, there is a limited amount of research conducted by graduate prepared, paramedic trained, EMS profession-specific researchers. While the number of studies specific to EMS has escalated, indeed just since the inception of this study, the focus most notably has been on areas of emphasis for current clinical practice. As more paramedics achieve graduate degrees and begin to contribute to other areas of the profession - education, management, EMS research, and indeed ethical care principles, the underpinnings of this profession will enjoy the informed standings of others in literature. The need for research specific to this profession and practice cannot be overstated.

There is a need for EMS research to further develop understanding of ethics specific to practice. Data from the study demonstrates the desire and commitment of paramedics to improve the profession through participation in research. Literature further notes in numerous studies the relative dearth of studies in many areas of EMS, education and ethics to name two. As Kevin relates his interest in participating in this study:

Anything that can help improve going forward in our career, we need all the help we can get. We are always on the back side of everything. We always have to learn from our mistakes and move forward... instead of our foresight. So anything that can help fix that going forward for someone else.

Ostensibly, the paramedic profession has likeness to other areas of health care, and yet notes a uniqueness that demands research specific to its context. The very use of terms to describe paramedics noted through the literature used for this study denotes a need for enhanced understanding of the practice worldwide. Paramedics have been termed as ambulancemen, EMT's, prehospital providers, prehospital care providers, out of hospital professionals, and emergency workers to name a few. Just as a disparity of terms can limit understanding of the practice, a lack of research further contributes to a lack of understanding, and limits a forward progression toward best care practices in this essential field.

There is a need for EMS research to further develop understanding of ethics specific to practice. While literature reflects the stress encountered by paramedics as they navigate ethical situations, and data supports the same through the findings of this study, there is no literature to suggest the reduction of stress and effectiveness of a simplistic model

for such decisions. It can be surmised from the participant interviews that some participants have continued to debate ethical decisions they have made for years. Such findings imply that the use of a model to determine best action, with autonomy, and in an emergent setting would not only limit the stress of such a decision, but further limit the anxiety felt and expressed as a “heaviness” over years of practice. As well, it can be reasoned that such a model for application would bring a consistency in an approach to ethical matters that could, with learned application, transverse the disparities of varying EMS organizational cultures across fifty states and beyond. Would the consideration of such a model as the practitioner navigates ethical situations offer acceptance to patients, bystanders and family members? Further research is necessary to determine this fact.

Research addressing the proposed and revised model for ethical decision-making is needed to determine efficacy. A model for decision-making was proposed in this study. This model was based solely on the limited perceptions of thirteen paramedics. While the findings compare to the Iserson Model, they further simplify the approach. Much work would need to be done to offer the model suggested herein as a process to navigate ethical decisions. Having said this, the implications of a well-defined, easily taught, and demonstrated effective model for ethics are far reaching both for patient benefit and paramedics. Literature does demonstrate the stress felt by significant others and paramedics in situations of an emergent ethical nature. The data presented in this research further confirms this need for support in the navigation of ethical situations.

Research that illuminates the patient perspective is needed. In a qualitative study that addressed the experiences of significant others to out-of-hospital cardiac arrest, Bremer,

Dahlberg and Sandman (2009) acknowledge “when it is unclear how the care and the event itself will affect significant others well-being, prehospital emergency personnel face ethical decisions” (p. 1407). Bremer et al. (2009) note that significant others described the arrival of EMS with “a sense of hope and relief” (p. 1408). Participants further described the feelings of stress when the resuscitation failed, some even “wished for the patient’s death” and others stated they “did not expect the dramatic response and resuscitative efforts that were performed, and even thought more was done than was needed” (Bremer et al., 2009, p. 1408). While most agreed that the care and notification offered by paramedics following the termination of efforts was appropriate, several were left with unanswered questions. One particular participant of this study noted her own emotions having been asked by a cardiac arrest patient’s family member “please do not torture my mother”. Noting the common concepts surrounding the traumatic effects of resuscitation and the gap between family/bystander understandings of the treatment and the paramedic desire to offer effective care, more work should be done to inform the EMS community of such bystander’s feelings and certainly to offer better support to those who will face the resuscitation of a family member.

There is a need for further research specific to EMS practice on Iserson model.

No data could be found to show an expanded use of the Iserson Model in EMS beyond textbook. While Iserson et al. (1995) suggest the use of the model in ethical dilemmas, no studies suggest that it has been used in practice or the efficacy of such an application. The results of such a study would be beneficial to future work on ethics training. This legitimization of such a unique instrument would further illumine the fields of adult education,

ethics in practice, and EMS. Furthermore, such information could be instrumental in further use and adaptation of the model.

Chapter Summary

The paramedic serves as the highest certification level in Emergency Medical Services. Since the inception of EMS in the 1960's, the role of the paramedic and the training required to accomplish this profession have grown exponentially. Paralleling this growth is the increase in demand for paramedics who now practice in a setting of autonomy with a clear need to practice rapid and critical decisions for ethical patient care. While the need is obvious, an understanding of how such decisions are made is not. The findings from this study provide meaningful insights into how paramedics make ethical decisions, and the factors that contribute to ethical practice. This study further informs the community through a qualitative methodology and in-depth descriptions of such decision-making practice. This chapter was organized around an integrated discussion of the six primary findings of the research that support specific implications for practice, theory, and future research. The discussions developed around the implications provide direction to both paramedic educators in developing and structuring programs to teach effective ethical decision-making, and to researchers for the development of effective ethical decision-making models for consistent delivery in EMS.

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APPENDICES

Appendix A - IRB Exemption Request

IRB#

**North Carolina State University
Institutional Review Board for the Use of Human Subjects in Research
REQUEST FOR EXEMPTION (Administrative Review)**

GENERAL INFORMATION

1. Date Submitted: <u>April 2013</u>
2. Title of Project: Ethics in paramedic Practice: A qualitative study of paramedic perspectives on learning ethical decision making
3. Principal Investigator: Susan Crisp
4. Department: <u>Adult and Community College Education</u>
5. Campus Box Number: _____
6. Email: FanofthePack@gmail.com
7. Phone Number (919) <u>628-6212</u>
8. Fax Number: _____
9. Faculty Sponsor Name and Email Address if Student Submission: <u>Dr. Susan Bracken.</u> <u>susan_bracken@ncsu.edu</u>
10. Source of Funding? (required information): <u>None</u>
11. Is this research receiving federal funding? <u>No</u>
12. If Externally funded, include sponsor name and university account number: _____
13. RANK: Faculty: <input type="checkbox"/> Student: <input type="checkbox"/> Undergraduate; <input type="checkbox"/> Masters; or <input type="checkbox"/> PhD Other (specify): <input checked="" type="checkbox"/> <u>EdD</u>

As the principal investigator, my signature testifies that I have read and understood the University Policy and Procedures for the Use of Human Subjects in Research. I assure the Committee that all procedures performed under this project will be conducted exactly as outlined in the Proposal Narrative and that any modification to this protocol will be submitted to the Committee in the form of an amendment for its approval prior to implementation.

Principal Investigator:

<u>Susan S Crisp</u>	_____*	<u>04/2013</u>
(typed/printed name)	(signature)	(date)

*As the faculty sponsor, my signature testifies that I have reviewed this application thoroughly and will oversee the research in its entirety. I hereby acknowledge my role as the **principal investigator of record**.*

Faculty Sponsor:

<u>Dr. Susan Bracken</u>	_____*	_____
(typed/printed name)	(signature)	(date)

***Electronic submissions to the IRB are considered signed via an electronic signature**

PLEASE COMPLETE AND DELIVER TO:

(carol_mickelson@ncsu.edu) or Institutional Review Board, Box 7514, NCSU Campus (Administrative Services III, Room 245)

For SPARCS office use only

Regulatory Compliance Office Disposition

Exemption Granted Not Exempt, Submit a full protocol
Exempt Under: b.1 b.2 b.3 b.4 b.6

IRB Office Representative

Date

Project Description: *Describe your project by providing a summary and answering the requests for information below.*

1. Project Summary. Please make sure to include the purpose and rationale for your study as well as a brief overview of your study.

This study seeks to explore the phenomenon of how paramedics experience and learn ethical decision making in patient care settings. The paramedic exists as a highly trained pre-hospital provider with a newly acquired, high degree of autonomy in practice. Paramedics function in stressful a environment where quick decision making skills have life altering implication for both career and patient outcome. Ethics is a small part of paramedic curriculum as required through the North Carolina Office of EMS, yet undeniably, has a major role in paramedic decision making practice. The purpose of this qualitative case study is to understand the perceptions of experienced paramedics as they make ethical decisions in the patient care setting. An understanding of ethical decision making would inform the scholarly community about the nature of practice and fill a void in the literature relating to ethics in both paramedic practice and adult education

This study will be conducted in the context of emergency medical services (EMS) when possible. To accomplish this, interviews will be conducted in EMS stations.

The research data for this study will come from semi-structured open-ended interviews with each research participant. The narratives from the interviews will provide data that will address the research questions previously identified in this study.

2. Description of participant population, including age range, inclusion/exclusion criteria, and any vulnerable populations that will be targeted for enrollment.

Participants will represent active, experienced paramedic in the practice setting. The participants will be selected by referral from county director with regard to specific criteria and willingness to participate. The county director designation will be acquired through the North Carolina Office of EMS as the individual responsible for paramedic level care provision.

3. Description of how potential participants will be approached about the research and how informed consent will be obtained. Alternatively, provide an explanation of why informed consent will not be obtained. Include a copy of recruitment materials, such as, scripts, letters of introduction, emails, etc. with your submission.

This study will utilize purposeful sampling with selection beginning with the director of North Carolina counties identified through the Office of EMS as “Paramedic Level” providers. Each director will be asked to identify up to five participants that have at least five years of experience and senior administrative officer at each community college. Additional participants will be identified by the senior administrative officer as being in positions of leadership or having emerged as leaders in the globalization movement. Initial contact will be conducted via telephone or email to determine if potential participant would be interested in being a part of the study. Follow-up confirmation will be sent by email or postal letter providing the date, time, and location of the interview. At this time, participants will also be provided with a summary of interview questions and a copy of the informed consent document for review. At the time of the interview, the official copy of the informed consent will be presented to the participants for final review and to address any questions addressed by the participants. The document will be signed by both the participant and the researcher. The participant will receive a signed copy of the document.

4. Description of how identifying information will be recorded and associated with data (e.g. code numbers used that are linked via a master list to subjects’ names). Alternatively, provide details on how study data will be collected and stored anonymously (“anonymously” means that there is no link whatsoever between participant identities and data). Describe management of data: security, storage, access, and final disposition.

Interviews will be digitally recorded using a Sony digital recorder and saved to a USB jump drive. Back up of interviews will be saved to an external hard drive. The interviews will be transcribed verbatim and a copy will be sent to each participant via email for review. The USB jump drive, hard copies of transcriptions, and the external hard drive will be stored in a locked file cabinet located in the researcher’s home.

To provide security and to maintain confidentiality of study participants, no real names will be used in the analysis or reporting of data. The community colleges and participants will be identified by using assigned names.

5. Provide a detailed (step-by-step) description of all study procedures, including descriptions of what the participants will experience. Include topics, materials, procedures, for use of assessments (interviews, surveys, questionnaires, testing methods, observations, etc.).

The data will be collected through semi-structured, open-ended participant interviews. The interview is structured so that participants will be able to describe their personal experiences in leading to ethical decision making in patient care settings. The interview process will focus on these experiences of ethical decision making in patient care context. I anticipate that I will hear stories of personal and professional challenges that relate to emergencies, end of life issues, and insights that regard patient care. These personal stories may include accounts of the patient care setting, but will not violate patient confidentiality. Participants will be urged to discuss experiences without fear of judgment based upon performance and patient outcome. This research is in no way an attempt to review the care rendered, rather to understand the decision making process. Participants may divulge personal struggles in patient care settings and the associated stress. The interview will focus on how these experiences have effected decision making by the participants and on what they believe they may possibly have learned from participation in the process.

The initial interview with participants will last for approximately 90 minutes, with a follow up interview lasting approximately 60 minutes.

Participants will receive a copy of their own transcribed interviews for review, clarification, and/or correction.

Observations of EMS station events and interactions will be included in the field notes.

6. Will minors (participants under the age of 18) be recruited for this study:

No

7. Is this study funded? No If yes, please provide the grant proposal or any other supporting documents.

8. Is this study receiving federal funding? No

9. Do you have a significant financial interest or other conflict of interest in the sponsor of this project?
No

10. Does your current conflicts of interest management plan include this relationship and is it being properly followed? NA

11. HUMAN SUBJECT ETHICS TRAINING

*Please consider taking the [Collaborative Institutional Training Initiative](#) (CITI), a free, comprehensive ethics training program for researchers conducting research with human subjects. Just click on the underlined link.

12. ADDITIONAL INFORMATION:

a) If a questionnaire, survey or interview instrument is to be used, attach a copy to this proposal.

b) Attach a copy of the informed consent form to this proposal. See the IRB website for a Sample Consent Form and Informed Consent Checklist <http://www.ncsu.edu/sparcs/irb/forms.html>

c) Please provide any additional materials (i.e., recruitment materials, such as “flyers”, recruitment scripts, etc.) that may aid the IRB in making its decision.

**If a survey instrument or other documents such as a consent form that will be used in the study are available, attach them to this request. If informed consent is not necessary, an information or fact sheet should be considered in order to provide subjects with information about the study. The informed consent form template on the IRB website could be modified into an information or fact sheet.*

The Following are categories the IRB office uses to determine if your project qualifies for exemption (a review of the categories below may provide guidance about what sort of information is necessary for the IRB office to verify that your research is exempt):

Exemption Category: (Choose only one of the following that specifically matches the characteristics of your study that make this project exempt)

1. Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as (i) research on regular and special education instructional strategies, or (ii) research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

2. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless: (i) information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects; and (ii) any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability, or be damaging to the subjects' financial standing, employability, or reputation.
***Please Note- this exemption for research involving survey or interview procedures or observations of public behavior does not apply to research conducted with minors, except for research that involves observation of public behavior when the investigator(s) do not participate in the activities being observed.**
3. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under paragraph (b)(2) of this section, if: (i) the human subjects are elected or appointed public officials or candidates for public office; or (ii) federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.
4. Research, involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available, or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.
5. Not applicable
6. Taste and food quality evaluation and consumer acceptance studies, (i) if wholesome foods without additives are consumed, or (ii) if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration, or approved by the Environmental Protection Agency, or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

Appendix B - Initial Contact and Confirmation Letter

Letter for initial email contact or as a script for telephone contact

Susan Smith-Crisp, M.Ed., NREMT-P
49 Wallace Street
Angier, North Carolina
27501

(Perspective Participant's Name)

(Address)

Dear (Proposed Participant):

My name is Susan Crisp and I am a doctoral student at North Carolina State University conducting research for my dissertation. My study will seek to explore the phenomenon of how paramedics understand, and perceive ethical practices and related decision making in their work. . The purpose of this study is to understand the perceptions of paramedics as it relates to ethical decision making practice. (You have been identified as a currently practicing North Carolina paramedic with at least 5 years of experience and having attained North Carolina certification through education in an accredited North Carolina Advanced Education institution as identified by North Carolina Office of EMS.

I will be traveling to (Your Area) during 2013 and would like to include you as a participant in this research. If you would consider this opportunity, your involvement would primarily include one interview of approximately 90 minutes to gain an understanding of your experiences in ethical decision making related to your practice as a paramedic in North Carolina. The interview could be scheduled on a date and time that will be convenient to you; and please note that your contributions to this study would remain confidential.

As a 25-year paramedic and currently credentialed North Carolina Paramedic, I understand the value of your experience and practice in patient care. I would greatly appreciate an opportunity to further discuss this proposal with you and answer any questions that you may have about the process and your possible participation. If you are willing to participate or have any questions, please contact me by calling (919) 628-6212 or via email at FanofthePack@gmail.com

I appreciate your consideration of this project and willingness to participate in my doctoral dissertation. I will confirm the interview per our telephone conversation; your interview has been scheduled for:

Location: (building/room)

Date: Time:

Sincerely,

Susan Crisp

Appendix C - Informed Consent Form

Revised 04/2009

North Carolina State University Institutional Review Board For The Use of Human Subjects in Research

GUIDELINES FOR PREPARATION OF INFORMED CONSENT FORM

PLEASE READ ALL OF THIS INFORMATION CAREFULLY PRIOR TO COMPLETING THE CONSENT FORM

An **Informed Consent Statement** has two purposes: (1) to provide adequate information to potential research subjects to make an informed choice as to their participation in a study, and (2) to document their decision to participate. In order to make an informed choice, potential subjects must understand the study, how they are involved in the study, what sort of risks it poses to them and who they can contact if a problem arises (see informed consent checklist for a full listing of required elements of consent). Please note that **the language used to describe these factors must be understandable to all potential subjects, which typically means an eighth grade reading level.** The informed consent form is to be read and signed by each subject who participates in the study **before** they begin participation in the study. A duplicate copy is to be provided to each subject.

If subjects are **minors (i.e. any subject under the age of 18)** use the following guidelines for obtaining consent:

- 0-5 years old** – requires signature of parent(s)/guardian/legal representative
- 6 – 10 years old** - requires signature of parent(s)/guardian/legal representative and verbal assent from the minor. In this case a minor assent script should be prepared and submitted along with a parental consent form.
- 11 - 17 years old** - requires signature of both minor and parent/guardian/legal representative

If the subject or legal representative is *unable to read and/or understand the written consent form*, it must be verbally presented in an understandable manner and witnessed (with signature of witness). If there is a good chance that your intended subjects will not be able to read and/or understand a written consent form, please contact the IRB office 919-515-4514 for further instructions.

*For your convenience, attached find a sample consent form template that contains necessary information. In generating a form for a specific project, the principal investigator should

complete the underlined areas of the form and replicate all of the text that is not underlined, except for the compensation section where you should select the appropriate text to be used out of several different scenarios.

*This consent form template can also be adapted and used as an information sheet for subjects when signed informed consent is waived by the IRB. An information sheet is usually required even when signed informed consent is waived. The information sheet should typically include all of the elements included below minus the subject signature line; however it may be modified in consultation with the IRB.

**North Carolina State University
INFORMED CONSENT FORM for RESEARCH**

Title of Study: Ethics in paramedic Practice: A Qualitative study of paramedic perceptions on ethical decision making

**Principal Investigator: Susan S. Crisp
Bracken**

Faculty Sponsor (if applicable): Dr. Susan

What are some general things you should know about research studies?

You are being asked to take part in a research study. Your participation in this study is voluntary. You have the right to be a part of this study, to choose not to participate or to stop participating at any time without penalty. The purpose of research studies is to gain a better understanding of a certain topic or issue. You are not guaranteed any personal benefits from being in a study. Research studies also may pose risks to those that participate. In this consent form you will find specific details about the research in which you are being asked to participate. If you do not understand something in this form it is your right to ask the researcher for clarification or more information. A copy of this consent form will be provided to you. If at any time you have questions about your participation, do not hesitate to contact the researcher(s) named above.

What is the purpose of this study?

This qualitative case study seeks to explore the phenomenon of how practicing paramedic understand the process of ethical decision making.. The purpose of this study is to understand the perceptions of paramedics in patient care settings as they relate use of ethics in decision making.

What will happen if you take part in the study?

If you agree to participate in this study, you will be asked to participate in a semi-structured open-ended interview that will focus on your experiences in ethical decision making related to your practice and North Carolina Paramedic.

Your interview will take approximately 90 minutes and will be digitally recorded. The interview will take place at a mutually agreed upon location and time. The interview will be transcribed verbatim primarily by the researcher, with the assistance of an outside transcriptionist who will be required to sign a confidentiality statement to insure privacy. Your name and the name of your community college will be changed to insure confidentiality. Printed transcripts of the interview and all digital records will be securely stored in the home of the researcher. Following the interview, you will receive a copy of interview transcript for review so that you may make any corrections and/or changes that will make the document more reflective of your experiences. This review should take about one hour. Your total time commitment will be approximately three hours. The data from the interview will be used in a doctoral dissertation and may be considered for future publication.

Risks

Participation in this study and the telling your experiences may bring about emotional reactions associated with process challenges and personal frustrations. At any point in the interview, you are free to ask that we stop the interview or that the digital recorder be turned off. Your wishes will be honored.

Benefits

Sharing your experiences as a leader in the globalization process at the local community college may not provide any direct benefit to you; however, it is anticipated that the knowledge and understanding gained from this study will contribute to the body of knowledge on community college globalization, as well as provide insight to local institutions and their leaders pursuing similar globalization initiatives.

Confidentiality

The information in the study records will be kept confidential. Data (hard copies and digital devices) will be stored securely in a locked cabinet in the researcher's home and will only be used by the researcher. No reference will be made in oral or written reports that could link you to the study. You will NOT be asked to write your name on any study materials. Your identity will not be matched to the answers that you provide.

Compensation

You will not receive any form of compensation for your participation in this study.

What if you have questions about this study?

If you have questions at any time about the study or the procedures, you may contact the researcher, Susan Crisp at 49 Wallace Street, Angier, NC 27501, or by telephone at (919) 628-6212, anytime.

What if you have questions about your rights as a research participant?

If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Deb Paxton, Regulatory Compliance Administrator, Box 7514, NCSU Campus (919/515-4514).

Consent To Participate

“I have read and understand the above information. I have received a copy of this form. I agree to participate in this study with the understanding that I may choose not to participate or to stop participating at any time.”

Participant: _____ **Date** _____
Print Name

Signature

Investigator: _____ **Date** _____
Print Name

Signature

Appendix D - Interview Protocol

Interview Protocol

Ethics In Paramedic Practice: A qualitative case study of paramedic perceptions on ethics in professional practice

Time of Interview – Start:	End:
Date:	
Place:	
Participant Pseudonym:	
IRB Informed Consent Signed: ()	
Participant Profile complete:	

Project Description:

The purpose of this qualitative case study is to understand how practicing paramedics perceive ethics in patient care. Currently, the curriculum requirement for initial paramedic training programs represents a two hour block of didactic education on ethics, with no scenario based practice or clinical internship preparation for the paramedic to make ethical decisions. Arguably, practicing paramedics make ethical decisions with varying degrees of life threat and a high degree of autonomy. The Iserson Model for ethical decision making in emergency medicine will be used as the conceptual framework. This exploratory case study will utilize semi-structured interviews as the primary data collection. Theoretical coding will be adapted from the conceptual framework, specifically adapted to look at three concepts: impartiality, universalizability, and interpersonal justifiability.

Research Question:

This study seeks to investigate the following research question: What are paramedic perceptions of ethical practice?

Interview Questions:

Introductory Questions:

- 1) Tell me about your experience as a paramedic
- 2) Tell me about your educational background
- 3) Tell me why you were interested in participating in this study
- 4) Tell me about your decision to be a paramedic.
- 5) Tell me about the things that you enjoy most about your practice and the things you least like. Tell me about the qualities you feel most important to being a good paramedic.

Questions of Similar Decision:

- 1) Tell me about a time that you faced a difficult dilemma with a patient.
- 2) Do you feel that you have faced some dilemmas more than once?
- 3) Did repeating the experience help you determine what to do? Tell me how you handled the situation.

Questions of Consult:

- 1) Have you ever had to consult with someone that wasn't on the call for help with a patient situation (excluding treatment)?
- 2) Tell me about that. Was it helpful?
- 3) Has there been a time when you felt that you wished you could consult with someone about a patient care dilemma while you were still in the situation?

Questions of Impartiality:

- 1) Have you experienced feelings of empathy for patients?
- 2) How has it affected your care or feelings about the call?

- 3) Has there been a time that you experienced situation where you had to put yourself in the place of the patient and ask; “Would I want this done to me?”. How did that impact your care?

Questions of Universalizability:

- 1) Have you used experiences in one patient situation to make sense of another?
- 2) Have you used experiences on one call to explain your actions in a similar situation?
- 3) Do you feel that calls that are similar can be treated the same? How do you approach this?

Questions of Interpersonal Justifiability:

- 1) Have you ever been asked to explain or defend decisions that you made regarding a patient’s care? (not related to treatment)
- 2) How did you approach that?
- 3) Tell me about your accountability as a paramedic.

Closing Questions:

- 1) Can you tell me about a difficult call you have had?
- 2) Why do you remember it?
- 3) Have you had a call that still bothers you? Why?
- 4) Have you ever felt that you would change a decision that you made? What made you feel that way?
- 5) Is there anything you would like to add

Appendix E – The Hippocratic Oath

I swear by Apollo Physician and Asclepius and Hygieia and Panacea and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant:

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art — if they desire to learn it — without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

Appendix F – Code of Ethics and EMT Oath

CODE OF ETHICS FOR EMS PRACTITIONERS

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

- to conserve life, alleviate suffering, promote health, do no harm, and encourage the quality and equal availability of emergency medical care.
- to provide services based on human need, with compassion and respect for human dignity, unrestricted by consideration of nationality, race, creed, color, or status; to not judge the merits of the patient's request for service, nor allow the patient's socioeconomic status to influence our demeanor or the care that we provide.
- to not use professional knowledge and skills in any enterprise detrimental to the public well being.
- to respect and hold in confidence all information of a confidential nature obtained in the course of professional service unless required by law to divulge such information.
- to use social media in a responsible and professional manner that does not discredit, dishonor, or embarrass an EMS organization, co-workers, other health care practitioners, patients, individuals or the community at large.
- as a citizen, to understand and uphold the law and perform the duties of citizenship; as a professional, to work with concerned citizens and other health care professionals in promoting a high standard of emergency medical care to all people.
- to maintain professional competence, striving always for clinical excellence in the delivery of patient care.
- to assume responsibility in upholding standards of professional practice and education.
- to assume responsibility for individual professional actions and judgment, both in dependent and independent emergency functions, and to know and uphold the laws which affect the practice of EMS.
- to be aware of and participate in matters of legislation and regulation affecting EMS.

- to work cooperatively with EMS associates and other allied healthcare professionals in the best interest of our patients.
- to refuse participation in unethical procedures, and assume the responsibility to expose incompetence or unethical conduct of others to the appropriate authority in a proper and professional manner.

Originally written by: Charles B. Gillespie, M.D., and adopted by the National Association of Emergency Medical Technicians, 1978.

Revised and adopted by the National Association of Emergency Medical Technicians, June 14, 2013.

EMT OATH

Be it pledged as an Emergency Medical Technician, I will honor the physical and judicial laws of God and man. I will follow that regimen which, according to my ability and judgment, I consider for the benefit of patients and abstain from whatever is deleterious and mischievous, nor shall I suggest any such counsel. Into whatever homes I enter, I will go into them for the benefit of only the sick and injured, never revealing what I see or hear in the lives of men unless required by law.

I shall also share my medical knowledge with those who may benefit from what I have learned. I will serve unselfishly and continuously in order to help make a better world for all mankind.

While I continue to keep this oath unviolated, may it be granted to me to enjoy life, and the practice of the art, respected by all men, in all times. Should I trespass or violate this oath, may the reverse be my lot.

So help me God.

Written by: Charles B. Gillespie, M.D.

Adopted by the National Association of Emergency Medical Technicians, 1978