Ethical Conflicts in Prehospital Emergency Care

Lars Sandman and Anders Nordmark

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This article analyses and presents a survey of ethical conflicts in prehospital emergency care. The results are based on six focus group interviews with 29 registered nurses and paramedics working in prehospital emergency care at three different locations: a small town, a part of a major city and a sparsely populated area. Ethical conflict was found to arise in 10 different nodes of conflict: the patient/carer relationship, the patient's self-determination, the patient's best interest, the carer's professional ideals, the carer's professional role and self-identity, significant others and bystanders, other care professionals, organizational structure and resource management, societal ideals, and other professionals. It is often argued that prehospital care is unique in comparison with other forms of care. However, in this article we do not find support for the idea that ethical conflicts occurring in prehospital care are unique, even if some may be more common in this context.

Introduction

All carers face ethical conflicts in providing care for people in need, regardless of the care context. Prehospital emergency care is no exception to this rule. It has even been argued that this care is unique and characterized by factors that are likely to give rise to a different set of ethical conflicts in comparison with other forms of care. Factors said to support this are: distance to resources such as personnel, medicotechnical aids and information; caring where people's normal living takes place; being on public ground; being called to scenes where someone has called for help; arriving at crime scenes; working tightly in a small team etc.[1–9] The assumption that these factors result in ethical situations with a unique character is largely discounted in this study. Nevertheless, these factors have the potential to result in ethical situations in which the prehospital emergency team will have to face difficult priorities between conflicting values and norms that may have far-ranging consequences, and where members of the emergency team sometimes make decisions more usually made by more qualified carers or medical professionals.[10,11]

In order to handle these ethical conflicts in the best possible way, tools for ethical decision making are needed. However, before providing the tools it is essential to

Address for correspondence: Lars Sandman, School of Health Sciences, University College of Borås, 510 90 Borås, Sweden. Tel: +46 732065818; E-mail: lars.sandman@hb.se

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know in relation to what ethical conflict situations these would be needed. This article provides a survey of different types of ethical conflict faced by prehospital emergency carers (PECs) in the Swedish care context as a background to the further development of normative tools. The term PEC will be used for both registered nurses and paramedics working in prehospital emergency care. Even though Swedish health authorities have required at least one registered nurse in every prehospital emergency team since October 2005, this was not the case when the study was performed. Even in teams involving a registered nurse, ethical decision making was performed jointly with the paramedics.

All carers in the Swedish health care system are required to have a 'reflected ethical attitude'[11] and assure that patients receive the best possible care, given a fair distribution of resources. Hence, PECs are required to handle the ethical situations arising in their field of work in a reflected and well-founded way. In line with the development of prehospital emergency care in Sweden from being more of a transport service to becoming prehospital emergency *care*, the need for well-founded and reflected ethical decisions has been emphasized. At the same time, there is a lack of in-depth discussion around ethical issues in the prehospital emergency field. Discussion focuses mainly on ethical problems with cardiopulmonary resuscitation CPR, do not resuscitate orders etc.[9] or 'triage' in disaster situations.[12,13] The lack of thorough and in-depth discussion on ethical issues is also shown in the educational literature in the prehospital field.[9,14] Discussion often results in the recommendation of protocols, which, as our study indicates, do not necessarily resolve ethical issues in a way that will result in the best possible care for the patient, given the different circumstances to take into account.[9,15–18]

To fulfil the ambition of having a prehospital emergency service in which staff members make reflected and well-founded ethical decisions, the types of ethical conflict faced have to be analysed and described and then normatively discussed. The values and norms that should guide prehospital emergency care are those of health care in general, in which ethical decisions are often made with limited time and space for reflection. This approach does not imply that ethical problems and conflicts can be solved before facing them in real life. Rather, to solve these problems in the best possible way, PECs should consider possible arguments for and against different options and should be able to weigh these arguments against each other in real situations.[9] This article gives an overview of the ethical conflicts faced by PECs. We will discuss different types of conflict elsewhere.

Even if all care could be characterized as ethical situations because it involves values and norms about issues such as health and a good life, not all care could be characterized as ethically problematic. At times, the values, norms and carers' actions coincide and there is no ethical problem, but at other times situations can be characterized as ethically problematic. To consider a situation to be an ethical conflict, there needs to be conflict between legitimate values or norms.

Aim

The aim of the study was to analyse and describe ethical conflicts faced by PECs in the prehospital emergency setting.

Method

Data collection

Six focus group interviews were conducted between May 2003 and December 2004 at three different sociogeographical locations: a small town with surrounding countryside, a part of a major city, and a sparsely populated area. Three interviews were conducted with registered nurses with different educational backgrounds and three with paramedics who had undergone complementary education in ambulance nursing. (In many countries, the term 'paramedic' now covers both registered nurses and others with complementary training.) Table 1 details the distribution of educational background, sex and years working in prehospital emergency care of 29 participants.

The groups were selected to reflect variation in sociogeographical location, educational background, sex and work experience. In order to avoid professional conflict and influences of authority structures on the material, registered nurses and paramedics were interviewed separately.[19,20] However, the ethical conflicts have not been analysed from the different perspectives of these two groups.

Contact was made with the supervisors of the prehospital emergency services in the chosen areas to gain overall approval and to identify ambulance stations whose personnel would participate in the interviews. The heads of the ambulance stations were then asked to recruit registered nurses and paramedics with a work experience of at least five years. In the sparsely populated area, the registered nurses shared their time between the prehospital emergency service, the intensive care unit (ICU) and primary care respectively.

Two interviewers were present during the focus group interviews. No pre-existing scheme was followed, but the informants received a short text about ethical conflicts together with information about the study. When necessary, the moderator told of an ethical conflict he had experienced in his own work, checking also that other fields of care situations were touched upon. Each interview lasted between 2.5 and 3 hours and was recorded on tape or minidisc. Both interviewers recorded their first-hand impressions of each interview straight after the event. The interviews were then transcribed verbatim.

Ethical considerations

On recruitment, the participants were given information about the research project concerning how the material would be handled and emphasizing their right to withdraw at any time. All signed a consent form. The research project was piloted and approved on three different occasions owing to the locations being situated in areas covered by different ethics committees.

Analysis

The data were analysed using content analysis, focusing on the explicit and implicit ethical conflicts found in the material.[21] No analysis, however, was aimed at detecting differences between the sociogeographical or educational perspectives, as this was not the aim of the study. Our aim was to gather details of a wide range of ethical conflicts

Table 1 Background characteristics of informants

Interview no.	Research site	No. registered nurses	No. paramedics	No. men	No. women	Individual prehospital work experience (years)	Group prehospital work experience (years)
1	Small town		6	6		15, 26, 16, 16, 25, 36	134
2	Small town	6		4	2	13 (RN = 3)[a], 11, 9, 15 (RN = 5)[a], 4, 7	59
3	Sparsely populated area		5	3	2	15, 16, 12, 12, 15	70
4	Sparsely populated area	3		2	1	5, 16 (RN = 11)[a], 10 (RN = 15)[a]	31
5	Major city	5		3	2	24, 1 (RN = 4.5)[a], 4, 24 (RN = 10)[a], 1.5 (RN = 4)[a]	54.5
6	Major city		4	4		9, 10, 6, 21	46
Total		14	15	22	7	394.5	394.5

[a]No. years worked as a registered nurse before working in prehospital emergency care.

without, however, detailing the circumstances under which they occurred or whether carers solved the dilemmas differently under these circumstances.

First, the transcripts were read through to obtain an overall picture of the content; then each interview was read carefully, noting each new conflict or version of a conflict and the handling of the conflicts. Codes were then used for grouping into a number of clusters. Finally, the items in each cluster were regrouped in order to identify a number of nodes between which conflict could be said to arise. Ten such nodes were found and grouped together in what might be called a conflict scheme (Figure 1).

Results

When PECs care for a patient, the relationship is the centre around which, and in relation to which, the conflict arises. In all (or almost all) of the conflicts presented some of the nodes were always involved, for example, the patient's best interest, the PEC's professional role, self-identity and ideals, the organizational structure and resource management, the societal ideals and, to the extent the patient is competent, the patient's self-determination. At other times, the prehospital emergency care of patients also involves significant others or bystanders, other care professionals, and other professionals (primarily police and firefighters). In many of these situations, there is no conflict between the different nodes involved. However, at other times, one or several of the nodes give rise to a conflict that can be characterized as ethical. The different types of ethical conflict found in the interviews will be presented according to

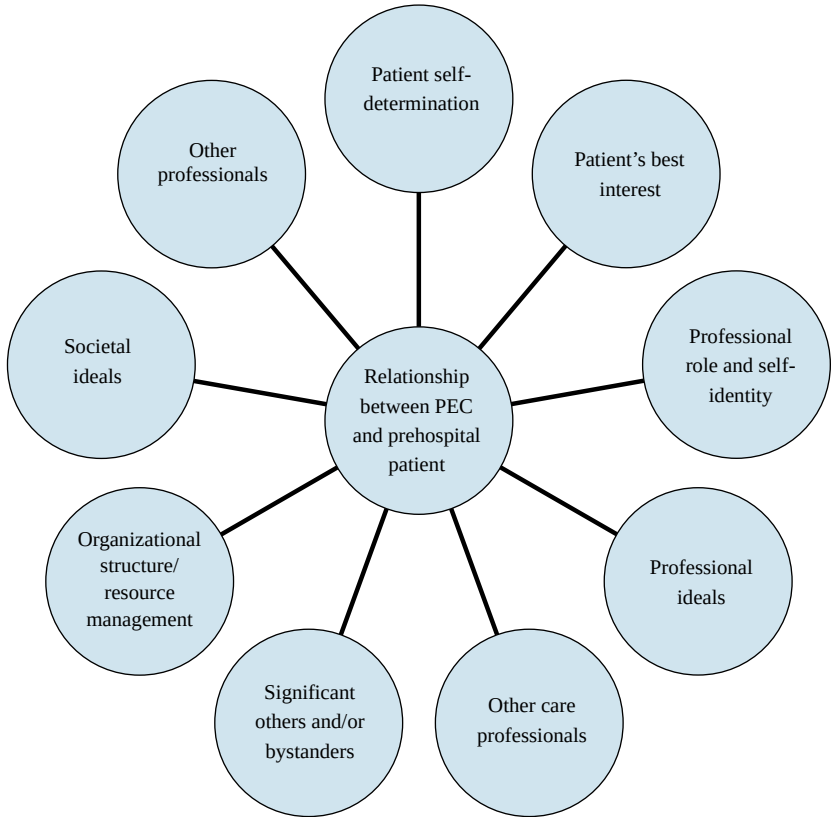

Figure 1 Ethical conflict nodes in prehospital emergency care

a structure where conflicts will be grouped together under the node that is interpreted as giving rise to or being the source of conflict.

Patient's best interest

- A central task for the PEC is to care for the patient according to the patient's best interest. At times, when there are different care options and it is not obvious which one is in the best interest of the patient, a care conflict can arise. For example, in situations where initiating CPR or not is the option.

Patient's self-determination

- The PEC may assess the patient to be in need of care and transport, but the patient refuses (at least initially) to co-operate with this (or parts of this). Here, a complicating factor in some situations was to assess whether the patient was competent or not.
- The PEC may assess the patient as not being in need of prehospital emergency care and transport, but the patient demands or wants care and transport.

- The PEC may characterize the patient's situation in a certain way, but the patient refuses to accept this characterization. For example, the PEC meets a patient living in social misery and reports this. However, the patient does not want to agree with the characterization that he or she lives in such miserable conditions.
- The patient demands/wants prehospital emergency care and transport without being assessed to have such a need; instead, the PEC assesses that this will risk the best interest of other patients. For example, a patient with influenza may demand transport to the emergency room, where he or she will not receive any help but is at risk of passing on the infection to other patients.
- The patient's requests for care and transport may conflict with the organizational structure and resource management of the prehospital emergency service. For example, a patient wants to be transported to the university hospital (which is actually closer), but resource management considerations and the organizational structure require that the patient is transported to the local hospital in the health care region where he or she has been taken ill.

Professional ideals

- According to the professional self-identity of PECs, they should care for patients with prehospital care needs. At the same time, they face patients with more general care needs that go beyond (or fall outside) the prehospital care responsibility (or what the PECs view as their care responsibility). The professional ideals of caring for patients regardless of their need may give rise to conflict. For example, a PEC faces a patient with psychological or social needs that cannot be met by the PEC.
- The professional ideal also includes the ambition of providing fair care for all patients. At times, different patient interests will imply a conflict for PECs (eg when facing a patient with a minor need that does not require prehospital emergency care). Other more needy patients may thus have to wait to receive prehospital care.
- The professional ideal of not taking age or social situation into consideration when providing care comes into conflict with the professional ideal of providing effective care and care in the patient's best interest. For example, when receiving a call about a cardiac arrest, the patient's age will influence decision making about initiating CPR or not. Similarly, the social situation of a drug user can be taken into account as a reason for not providing relevant care because of a lack of adherence on behalf of the drug user.
- The professional ideal of establishing a caring relationship at times conflicts with the PEC's actual ability, given the situation required to establish such a relationship (eg when the PEC and the patient start off on the wrong footing).
- The professional ideal of treating patients as unique beings at times conflicts with the actual care (eg when the PEC needs to interpret general signs of a situation in order to make a decision).

Professional role and self-identity

- In their professional role, PECs emphasize that working co-operatively with their colleagues will sometimes conflict with consideration of the patient's best interest

(eg when a PEC has a different view about a patient's best interest, but refrains from arguing about this with his or her colleagues).

- Professional self-identity implies being in a professional role as a PEC, which in turn involves not sacrificing one's own best interests to fulfil this role. At times, this conflicts with being able to attend to the patient's best interest, such as in a threatening situation when a badly hurt patient carries a gun.
- Being in a professional role as a PEC also implies a distinction between the professional and the private role. At times, this will put PECs in a situation of conflict when they are viewed as carers in a private situation and are expected to care for a patient's best interest.
- According to some PECs' views on their professional self-identity, they are expected to make quick decisions that fulfil their role. At times this will conflict with the long-term best interest of the patient or the overall resource management of the care system. For example, instead of arguing with a patient who is considered not in need of prehospital emergency care, PECs just bring the patient along and 'dump' him or her at the hospital.
- The professional ideals of equal treatment, of treating the patient with respect, of good care and the societal ideals of being true to one's own values and judgements conflict at times with the professional self-identity of being loyal to and not criticizing one's colleagues in public. This can be seen in situations when a colleague breaks these norms and the PEC does not intervene until afterwards.

Organizational structure and resource management

- The organization has certain guidelines or protocols to which PECs should adhere. In certain situations, the protocol requires PECs to provide treatment, even if the carer does not view this as in line with the patient's best interest or even if the protocol conflicts with the patient's self-determination (which the PEC should respect). Examples are situations when a decision about providing CPR must be made.
- The protocols may also conflict with significant others' best interests (eg in situations when a relative requires that the patient should be taken in an ambulance although the person is not considered a prehospital emergency patient according to the protocol).
- The organizational structure is set up according to a formal authority structure. At times, this conflicts with what a PEC judges as being in a patient's best interest, as in situations when a physician requires something that is not in line with the PEC's views about the patient's best interest.
- Organizational structures where different carers have different care responsibilities give rise to conflict when the patient's best interest falls between the responsibility of the PEC and other care professionals (eg when patients have a psychiatric diagnosis combined with a drug problem). These patients are often not accepted anywhere.
- The organizational protocols of an emergency medical dispatch centre may at times conflict with professional self-identity and the professional ideals of PECs (eg in requiring PECs to be ready for a new call after the death of a patient when the PEC finds it essential that he or she should stay with the relatives and friends).

- Lack of resources conflicts with the best interest of patients. Here, the PEC with his or her professional ideals and self-identity of caring for patients in need is caught between two needs. Sometimes the prehospital team will have to transport a patient from the hospital to his or her home, even if they judge the patient as still being in need of hospital care.
- The professional ideal of always informing the patient can conflict with the organizational demands of transporting a patient, without trouble, to a new care facility.

Societal ideals

- Society demands that we should be true to our own personal values, opinions and judgements. PECs' own personal values and judgements will at times conflict with organizational guidelines or protocols.
- Society demands equality between the sexes. This will at times conflict with the professional self-identity of some PECs of being able to transport a patient on a stretcher in all situations when it is required.
- The ideal of equality between the sexes will at other times conflict with the professional ideal of caring for patients according to their own perspective of their best interest as influenced by cultural and religious norms (eg when a woman wants to be cared for by a female PEC).
- The ideal of following the law will at times conflict with significant others' best interest, for example, when laws about the loading capacity of the ambulance do not allow them to accompany the patient.

Significant others and/or bystanders

- In most cases when there is someone else present at the care scene besides the patient it is someone close to the patient. However, at times there are other bystanders (not close to the patient) present, but these are grouped together in this article as we found that the conflicts arising with bystanders are a subgroup of conflicts arising with significant others.
- The views and needs of significant others and bystanders about the best interest of the patient come into conflict with the patient's self-determination, especially when a significant other wants the patient to be taken away while the patient refuses.
- Significant others' own best interests can come into conflict with the organizational demands and professional self-identity of PECs to care for patients with prehospital emergency care needs according to their best judgement. This can happen when significant others are so stressed by the situation that the PEC has no possibility of taking care of the patient.
- Significant others' and bystanders' views and wants about the best interest of the patient may come into conflict with the PEC's assessment (based on professional self-identity of being an experienced carer) of the patient's needs and best interest.
- Significant others' views and wants about the best interest of the patient may come into conflict with organizational structure and resource management, for example, when a significant other wants the patient to be cared for at a specific hospital because of geographical distance, but the organizational structure requires that he or she should be cared for within the administrative health care area.

- PECs can be caught between the different requests made by significant others concerning the patient's short-term and long-term interests, for example, when significant others make decisions about CPR and later reconsider these decisions.
- Significant others' wants may come into conflict with the PEC's assessment of a significant other's own best interest (based on professional self-identity of being an experienced carer). For example, significant others may claim that they can take care of the patient, but the PEC considers the significant other to be too stressed to manage this.
- Different significant others or bystanders may be in conflict over the patient's best interest. Here, the PEC is caught between these different wants around the patient.

Other care professionals

- Other care professionals' views about patients' needs and best interest can come into conflict with organizational demands and the PECs' self-identity to care for patients with prehospital needs (eg when other care professionals call for an ambulance and the patient does not need prehospital emergency care).
- Other care professionals' inability to care for a patient may give rise to a conflict between the PEC's self-identity to care for patients with prehospital emergency needs and the professional ideal to care for patients in need, irrespective of whether it is a prehospital emergency need or not, such as when a patient in need is not provided with care by the emergency room and later again becomes a problem for PECs because they are not able to care for the patient's needs.
- Other care professionals' views about their responsibility may come into conflict with a patient's rights. Here, professional PECs are caught in the middle. The patient has the right to be transported to a hospital of his or her own choice but the care professionals question having the patient transported to their care unit.
- Different care professionals can be in conflict over what is in the best interest of the patient. The PEC may be caught in the middle when registered nurses and health care assistants at a nursing home are in conflict over whether a patient should be allowed to die at their care facility or be transported to the emergency room or ICU.

Other professionals (mainly police and firefighters)

- The professional self-identity and ideal of caring for the best interest of the patient may come into conflict with the role and duty of other professionals, for example, when the police want to question a badly hurt patient before the PEC takes him or her away for care.

Discussion

Method

A problem with using focus group interviews is a certain lack of depth in the data material compared with individual interviews. In this study, the informants more often presented generalized examples of ethical conflicts rather than specific, contextually

situated examples. However, since the aim of the study was to find as wide a variety of ethical conflicts as possible, this was not considered a serious problem.

Another aspect of focus group interviews is the extent to which group dynamics influence the data material. Some of the groups showed a great degree of unanimity about how to deal with ethical conflicts, while others demonstrated some disagreement. There was also some disagreement about whether a conflict was indeed a conflict or not. Therefore it could be that group dynamics hindered some of the informants from talking about conflicts that they expected the rest of the group not to see as conflicts. Hence, group dynamics could to some extent have restricted some of the informants from being open about more problematic conflicts or ways of handling the conflicts. Compared with other studies in the field, we found a few examples of conflicts where group dynamics could have played a role in restricting the informants from talking about these types of conflict. However, the aim of the study was not to assess how PECs deal with ethical conflicts, but rather to identify these ethical conflicts. The dynamics of the focus groups gave us reason to believe that, given our aim, we found more types of ethical conflict than we would have done by using individual interviews.

Four of the informants did not meet the criterion of at least five years' work experience but, since the criterion was set to have focus groups with a long total experience of prehospital care, we judged two informants with 4 years' experience and two others with 1 and 1.5 years' experience respectively as having enough experience to be able to take part in the groups. In the sparsely populated area, the registered nurses shared their time between the prehospital service, the ICU and primary care respectively, which was to some extent shown in the material in terms of role conflict. However, this was considered too peripheral and is hence not included in the results.

Results

The ethical conflicts have been presented as arising between different nodes of conflict, where these different nodes represent values that could conflict in a specific situation. Some of the nodes represent more or less basic values in prehospital care, for example, that self-determination is best for the patient. Some nodes are representative of a cluster of values, such as professional and societal ideals. Others have a more instrumental relationship to relevant values: professional role and self-identity, other care professionals, significant others and bystanders, organizational structure and resource management, and other professionals. However, in the choice between analysing and presenting the conflict nodes exclusively in terms of more or less basic values and analysing and presenting the nodes in terms of factors that would be recognizable as conflict nodes by the prehospital carer, the latter approach was chosen.

Only one published study surveying the field of ethical conflict in a prehospital setting was found.[9] Other studies emphasized and discussed a limited number of conflicts at some length; the conflicts presented were not identified by empirical studies, only by the authors' experience. Below, these studies will be related to the results of the present study.

Patient's best interest

Prehospital carers are usually sensitive to a patient's own views about what is in his or her best interest, and, to the extent that the patient is not considered to be

incompetent, they allow the patient's opinions to be decisive in relation to the care they administer. However, if CPR is an option, how can this be left to the patient's own judgement? The fact that this situation constitutes a conflict for the carers is expressed in the material. Here, PECs try to balance the chance of further life against allowing the patient to die a dignified death. This is a central ethical conflict also discussed in some studies.[4,9,17,18,22–27] However, in our study the PECs emphasized the option of a dignified death as a reason for not initiating CPR while the published studies rather discuss the patient's self-determination in terms of advance directives or do not resuscitate orders. In one study,[26] continuing with CPR in order to enable organ donation was presented as a conflict, something we did not find in our study. Conflicts between being truthful to the patient and seeing to the patient's best interest were found in two studies.[9,22] In our study, the question of being truthful with the patient appeared rather as a conflict with the organizational demands of transporting a patient to a care facility to which the person did not want to go. Being faced with situations where initiating CPR is an option is clearly not unique to the prehospital care setting; nor are situations involving truthfulness. However, the former decisions are normally made by a physician, which is not the case in the prehospital setting, where a nurse or a paramedic will have to decide (even if supported by protocol and consultation with a physician).

Patient self-determination

This is central to PECs when deciding whether to give care to a patient. However, at times this results in ethical conflict, for example, when patients refuse to be cared for even if carers assess them to have a need for care.[9,22,23,25,26] The same thing happens when a patient demands care that PECs are reluctant to provide, either because the patient is not judged to need care or because the care required is beyond their responsibility.[9,23] Conflicts arise from problems of assessing whether a patient refusing care is competent or not.[9] We also found that a patient's demands may put other patients at risk, whereas in other studies it is rather the patient's refusal of care that has been emphasized as putting other persons at risk.[22,25] In a study by Adams *et al*.,[9] conflicts around self-determination and minors were found, which were not present in our study. These aspects are likely to be shown in other care contexts. However, a possible complicating factor in relation to self-determination in prehospital emergency care is that, in comparing with most other care situations where the patient is the one seeking care, in an emergency someone else might have called for an ambulance because they believed the patient to need care.[23,27]

Professional ideals

Conflicts found in relation to the professional ideals of prehospital carers are not found to a great degree in other studies, where only bias concerning age, type of illness, social status etc. is discussed.[23,27] In our data, these conflicts were not always explicitly expressed or experienced as conflicts, but rather as the researchers' interpretations when comparing what the carers claim they actually do related to what the professional ideals expressed in official documents claim they should do. Not being able to care for conditions outside their professional responsibility is experienced as a conflict dealt with by referring to the responsibility of the prehospital carer. All ethical conflicts found under the heading of professional ideals are also likely to be found in other care contexts because the

professional ideals at stake are not unique to prehospital emergency care. The carers in our study seemed often to have a well-defined picture of the meaning of being a prehospital carer and some situations were considered to fall clearly outside their responsibility.

Professional role and self-identity

The impression gained from our study is that the professional self-identity of PECs is strong. This is reported to be due to the fact that they work in teams at a distance from other resources and staff, thus creating a strong group identity.[28] The self-identity of having a united front against patients, significant others or other professionals gives rise to ethical conflicts that may be less marked in other contexts.[26] Working outside the hospital, they are likely to face threatening situations to a greater degree than carers generally in their professional role, without having the possibility of calling in extra resources (which may, for example, be the case in psychiatric care).[9,23] By working outside the hospital and facing a large number of patients and their significant others (and bystanders) PECs face a greater chance of being recognized as professional carers in their private life. We did not identify conflicts revealed in some studies, such as: jeopardizing patient care in order to keep one's job;[22] conflicts involving colleagues with problems;[25] conflicts arising from a colleague wanting to train for intubation and extubation on a deceased patient;[9] or prehospital carers explicitly referring to the reputation of the prehospital service as a reason for a particular action and possible conflict in relation to other (better) grounds for action.[27] The focus group situation might have restrained the informants from telling us about conflicts that could incriminate them or their colleagues and hence be a reason for not identifying these types of conflict.

Organizational structure and resource management

Most of the conflicts found under this heading may be found also in other contexts, even if the use of a protocol, which is relatively frequent in prehospital emergency care, differs between those contexts. This has to some extent been voiced in other studies in the field, where the use of protocols is frequently discussed.[17,18,23,24,26] In these studies, protocols are seen as problematic, as voiced in the present study, or more or better protocols are seen as a way of resolving ethical conflict. The formal authority structure of the care system was noted to give rise to conflict in our study, as well as in others. Examples are: a physician's order for CPR conflicting with the PEC's own assessment,[4] but also a physician's improper order about the administration of drugs (in relation to CPR).[22] Only in Adams *et al*.[9] were conflicts around resource management found, where the focus is on priorities between conflicting situations. This was not revealed in our data, since such priority decisions are made by an emergency medical dispatch centre. What we did find is that the demands of the emergency medical dispatch centre to answer a new call could conflict with the present assignment of the prehospital team.

There is no equivalent to the emergency medical dispatch centre in other care situations, where non-medical professionals or medical professionals with less formal education require the services of other carers. A discussion around these centres is to be found only in Naess *et al*.,[27] but not from the perspective of creating a conflict.

Societal ideals

The only conflict under this heading found in the other studies is that arising between following the law and other legitimate values; that is, referring to the legal duty to breach confidentiality in certain circumstances, for example, when it concerns child abuse.[22] The duty to report child abuse was also found in our data, but not in situations where it was considered to be a breach of confidentiality. Conflicts arising from societal ideals are likely to be found in other care contexts and are hence not unique to the prehospital emergency care setting.

Significant others (and/or other bystanders)

In other studies, conflicts with significant others are almost exclusively found in relation to the choice of whether or not to start CPR. Significant others' opinions may conflict with the patient's views,[26] with other significant others' views,[4] with other care professionals[4] or with the PEC's responsibility.[23] Similar conflicts are to be found in our data, but they were not related only to situations involving CPR. Something not explicitly revealed in our study is the problem of confidentiality in relation to bystanders when carers communicate with each other around a patient,[22] and the problem of whether a prehospital carer should 'lie' to the family about a patient's condition.[22] The focus group discussions might have inhibited the informants from reporting situations where they would breach confidentiality by being thoughtless or lie to the family. An interesting situation in relation to CPR found in Naess *et al*.[27] is the carers' attitude that, if a bystander had initiated CPR, the PEC would normally have continued with it regardless of whether this was considered likely to benefit the patient or not. This was not reported in our study. Initiating CPR for the sake of significant others or bystanders was however found in our study, which could result in a similar conflict between interests. The conflicts found under this heading are not unique to the prehospital setting, except for ethical conflicts involving non-close bystanders because prehospital emergency care is normally the only care taking place in the public arena. However, conflict arising from providing care in the public arena was not something the informants emphasized as specifically problematic. Rather, such conflicts were just another version of the more general conflict between significant others and bystanders and the patient or the PEC.

Other care professionals

For conflicts between other care professionals who are not formally in an authority position and the prehospital carer (see 'Organizational structure and resource management' above) none of the conflicts found in our study has been found in other studies in the field. Conflicts around having to carry out research with questionable ethical aspects on the demands of other care professionals was voiced in two studies,[9,22] something that was not found in our study. This could have several explanations: the informants not having taken part in research studies, the informants not having experienced anything unethical in relation to these studies, or simply that ethical conflicts in relation to research were found to be peripheral to the prehospital emergency care mentioned by the informants. In the Swedish health care context, clinical studies and clinical trials in the prehospital field are carried out mainly in the major cities. Four of the six focus group interviews took place at locations outside major cities, thus this would have affected to what extent ethical

conflict in relation to research was found in the data. Conflict over a PEC's assessment of a patient being ignored by another care professional making a new assessment[26] was not found in our study. This was discussed in our material as a source of potential conflict, but none of the informants had actually experienced such a situation. Rather, the informants had experienced the opposite situation when they took over in a trauma situation. When another care professional had initiated care and treatment, but not in a way that would measure up to the expected standard, the PEC assessed the need to start again.

All conflicts under this heading can be found in other care contexts when representatives from different care situations face each other. However, PECs will face representatives of the emergency room on a daily basis and, in transporting patients from other care facilities, they also face other care professionals regularly. This means there is a relatively high frequency of such contacts in contrast to those between many other care professionals.

Other professionals

The situations revealed in our data concerned police or firefighters delaying intervention or continued transportation by the PEC while fulfilling their own professional roles. However, in other studies, conflicts with other professionals (police) focus exclusively on confidentiality, that is, the police wanting the PEC to provide information about the patient, which would imply breaching their confidentiality,[9,22,23] or the media requesting such information.[9] This was not found in our study, where the police focused on questioning the patient rather than putting the PEC in an awkward position and we found no reports whatsoever of media intervention.

The type of conflict found under this heading could, under very special circumstances, also be found in relation to other care professionals. However, since PECs have the public arena as one of their fields of work, these conflicts will almost exclusively be found in relation to prehospital emergency care.

Conclusion

Few of the conflicts identified are unique to the prehospital emergency field, even if some are found with greater frequency within it. However, some of the conflicts that are normally handled by physicians in other care contexts, for example those around whether to provide treatment or not, are in this situation (despite protocols and consultation) handled by registered nurses and paramedics.

Further research

As there have been few surveys of the ethical conflicts faced by prehospital carers, further research is needed to substantiate and complement the results of this study. Further research is needed in order to analyse and describe other ethical problems (besides conflict) that need to be described and analysed in the prehospital care context. In addition, research is required around how different factors such as the sociogeographical context influence ethical decision making and how decision making

in the prehospital setting affects further decision making in the health care system and the ethical problems resulting from this.

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Lars Sandman, University College of Borås, Borås, Sweden.
Anders Nordmark, Ambulance Service, Falköping, Sweden.

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