

# I

# Ethics and law for the paramedic

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## Introduction

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The role of the ambulance clinician has undergone enormous development since the early 1990s, with the term 'paramedic' now being synonymous with front-line pre-hospital health care. As a protected title, anyone wishing to call themselves a 'paramedic' must first be registered with the Health Professions Council (HPC) and must adhere to the professional and ethical standards they prescribe.

## Why is this relevant?

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In addition to adhering to the expectations of the HPC, paramedics are also required to work within the legal parameters dictated by legislation. All areas of paramedic practice, notably

the gaining of consent, drug administration and issues of confidentiality, must be undertaken within the legal framework of the territory in which the paramedic practices.

Paramedics often meet people in extremely difficult and distressing personal circumstances and at critical times in their lives. Patients and families can be vulnerable during these moments, so it is crucial that ambulance clinicians have an understanding of the key legal and ethical issues that may impact on their decision making. Without an understanding of the ethical principles, legislation or legal precedents that apply to their practice, paramedics may potentially be at risk of incurring fitness to practise investigations, civil litigation, or, in extreme cases, criminal charges.

No text can prepare the reader for all eventualities, but a discussion of the key legal and ethical issues is vital for safe, competent and professional practice.

### Definitions

Practice is a noun, a thing.

Practise is a verb, a doing word.

For example: 'The only thing George did not like about skills practice was practising his cannulation.'

## Ethics

Ethics can be considered a 'moral code', and as such can be very subjective. There are many textbooks devoted to ethical principles and theories, including an array of those that focus on medical ethics. Such texts often contain ethical scenarios for the reader to dissect, discuss and consider. Examples of subject matter for this type of scenario could include termination of pregnancy, resource allocation, assisted suicide, end of life issues, organ donation or 'saviour siblings' to name but a few. The difficulty with such ethical dilemmas from the perspective of the paramedic is that they tend to be focused on situations that occur in non-emergency environments within health care and can, therefore, be viewed as not relevant to the paramedic. However, with the expansion of the role of the paramedic to include alternative treatment pathways, and an increasing tendency to refer patients to areas other than emergency departments, a deeper understanding of ethical decision making should be considered *a must* for paramedics who are now at the front line of *out-of-hospital* rather than *pre-hospital* care.

The role of the paramedic often demands rapid decision-making capability where it could be argued that ethical considerations are put aside for clinical decisions to be made. There are generally very clear clinical guidelines for paramedics to follow, but there are rarely considered ethical decision-making processes that accompany them.

The principles of ethics proposed by Beauchamp and Childress (2001) are a good starting point for the paramedic. Their *four principles* approach provides paramedics with the basic tools to enable them to consider ethics in their practice (see Box 1.1). By giving some consideration to each of the four principles, paramedics can weigh up their decisions and ensure that they are in the best interests of the patient while being ethically sound.

**Box 1.1 The four principles approach to ethics**

**Respect for autonomy – ‘self rule’**

**Autonomy is the principle that allows an individual to have control over their being.**

This means that any decision that they make about their treatment must be respected.

**Nonmaleficence – ‘do no harm’**

**This principle advocates not causing undue harm to the patient.**

Such harm may be considered direct physical harm, such as the insertion of an intravenous cannula, or harm brought about by failing to consider foreseeable outcomes of a proposed course of action, such as leaving a vulnerable patient at home when their presentation requires hospitalization. The negative impact of any harm must be balanced against the potential benefit achieved.

**Beneficence – ‘do good’**

**This principle advocates maximizing benefits and minimizing harm to patients.**

Beneficence underlies all of the actions of the healthcare professional and can be allied with the term ‘best interests’. It is important to note that a patient’s perspective of what is in their best interests may not always be the same as that of the health professional caring for them. In these cases, there may appear to the paramedic to be a conflict between beneficence, nonmaleficence and autonomy.

**Justice – ‘what is right?’**

**This principle looks at what is right or fair in any given situation.**

For example, patients who have mental health problems have the same right to appropriate treatment as those who do not. In the paramedic world, situations such as availability of resources and time spent on scene with patients could be considered when looking at justice.

The principles proposed by Beauchamp and Childress (2001) are just one approach to ethics and even these cannot be covered in great depth in an introductory text of this type. To give the paramedic an introduction to how these principles may be considered in practice, each of the principles will be discussed alongside the case studies presented later in this chapter.

**Law**

Law in the United Kingdom (UK) comes from several sources: the European Community (EC), legislation from Parliament, case law, books of authority, custom and law reform. For aspects of law, the UK is generally divided into three territories: Scotland, Northern Ireland, and England and Wales. The majority of legislation and case law is consistent between the territories, but there may be specific legislative requirements within each area, so the paramedic must be familiar with the peculiarities of the territory in which they practise.

**Table 1.1** Criminal law versus civil law

	<b>Criminal law</b>	<b>Civil law</b>
Purpose	To protect society by maintaining law and order	To uphold the rights of individuals and to settle disputes
Participants	The case is brought by the Crown Prosecution Service on behalf of the State, and is represented as the crown versus the defendant, e.g. R vs. Shipman	The case is brought by one individual or organization against another individual or organization, e.g. Kent vs. London Ambulance Service NHS Trust
Standard of proof	To be found <i>guilty</i> , it has to be shown <i>beyond reasonable doubt</i> that the <i>defendant</i> committed the alleged crime	To be found <i>liable</i> , it has to be shown that, <i>on the balance of probabilities</i> , it is more likely than not that the <i>respondent</i> is responsible for the alleged act
Findings	The defendant can be found guilty or not guilty (or in Scotland a third possibility of 'not proven')	The respondent can be found liable or not liable
Outcomes	A guilty verdict will result in some sort of punishment, such as prison, a fine, or a community service order being imposed	A liable verdict should result in the situation being 'put right'. This may mean an apology, a change to policy or the awarding of compensation to the claimant

The legal system in place within the UK can be broadly divided into two main branches: criminal law and civil law. Table 1.1 details the differences and similarities between these two areas.

Paramedics are subject to the same legislation as any other individual in the UK, and are specifically named in practice notes for particular legislation such as the Mental Capacity Act 2005.

In practice, the majority of legislation that impacts on the day-to-day work of the paramedic is dealt with by the paramedic's employing authority. Health and safety, data protection, drugs regulation, medical equipment safety, and human rights are all areas that are legislated and put in place by employers.

Paramedics as individuals are more likely to fall foul of the civil side of the law if they either lack competence or engage in behaviour which could be considered as misconduct. This will be discussed under the heading of professional regulation.

A third branch of the legal system is that of the coroner's inquest. Threats of 'explain it to the coroner' have historically been used to encourage student paramedics to do the right thing when treating patients and when completing records, often portraying the coroner as someone to be feared. This is simply not the case. The role of the coroner in relation to deceased individuals is to establish facts. There are four main facts that the coroner must establish:

- the identity of the deceased;
- the place of death;
- the time of death;
- how the deceased came by their death.

Coroners are usually lawyers with specialist training, with only about 25 per cent being medical doctors with a legal qualification. The coroner's inquest follows an inquisitorial process which aims only to establish the facts, as opposed to criminal and civil cases which follow

an adversarial process with one side trying to prove that their case is more just than their opponents.

Paramedics may be called upon to provide written witness statements of fact to the coroner and any patient report records that they have completed may also be subjected to scrutiny. In some cases where further clarification is needed, the paramedic may be required to give evidence at a coroner's inquest. Once the paramedic has answered any of the coroner's questions, the coroner may invite any interested parties to question the paramedic. This means that relatives of the deceased, or their representatives, may ask the paramedic questions. This can be a difficult and uncomfortable experience for the paramedic concerned, but it often goes a long way to giving bereaved relatives a greater understanding of what happened to their loved one. In order to make such experiences as pain free as possible, it is vital that the paramedic thoroughly documents all details for all the calls that they attend.

## Professional regulation

The paramedic profession, currently along with fourteen other allied health professions, is regulated by the Health Professions Council (HPC). The HPC was brought into existence by the Health Professions Order 2001 (the Order) which sets out the roles and responsibilities of the HPC.

The HPC's overarching objective is the protection of the public, which it achieves in four main ways:

- the maintaining of a register of health professionals, including paramedics;
- the approval of education programmes leading to eligibility to apply for registration;
- the assessment of continuing professional development (CPD);
- the hearing of Fitness to Practise complaints.

The term 'paramedic' is a protected title, meaning that it can only be used by those whose name appears on the register maintained by the Health Professions Council; there are over 15,000 registered paramedics in the United Kingdom. Use of the protected title by someone whose name does not appear on the HPC register is a criminal offence. In order to gain entry to the HPC register, an individual must demonstrate that they have achieved the threshold requirements of the profession – the HPC Standards of Proficiency for Paramedics (HPC 2007), generally by completing a programme of study approved by the Education Committee of the HPC. To remain on the register the paramedic must demonstrate CPD activities and adhere to the HPC Standards of Conduct, Performance and Ethics (HPC 2008). The implications of failing to do so will be addressed later in this chapter.

### Stop and think



Have you ever heard a paramedic say 'What does the HPC do for me?' before going on to complain that 'I pay out each year and I don't get anything in return'? Comparisons may then be made between the HPC, trade unions and the College of Paramedics. This is a relatively common viewpoint of paramedics who do not fully understand the role of the HPC. The HPC is a regulatory body in place to protect the public and give the public confidence in all of the professions it regulates. The paramedic's registration fee allows this to happen. Trade Unions represent the interests of their members and offer assistance and representation to individuals as well as groups, and the College of Paramedics is a professional body which furthers the interests of the profession as a whole, for example by producing curriculum guidance.

## Accountability and clinical negligence

The Health Professions Order (DH 2001: Part V, 21. 1a) requires the Health Professions Council to establish and keep under review the standards of conduct, performance and ethics expected of registrants and prospective registrants. The HPC produced a document, *Guidance on Conduct and Ethics for Students* (2009), which outlines to students on pre-registration courses the expectations of the HPC. Every paramedic applying to go on the register has to confirm that they have read and agree to adhere to the fourteen standards explained in the *Standards of Conduct, Performance and Ethics* (HPC 2008).

The areas covered within this document are outlined in Box 1.2.

### Box 1.2 Summary of the standards expected of registered paramedics

Paramedics must:

- 1 act in the best interests of service users;
- 2 respect the confidentiality of service users;
- 3 keep high standards of personal conduct;
- 4 provide (to the HPC and any other relevant regulators) any important information about their conduct and competence;
- 5 keep their professional knowledge and skills up to date;
- 6 act within the limits of their knowledge, skills and experience and, if necessary, refer the matter to another practitioner;
- 7 communicate properly and effectively with service users and other practitioners;
- 8 effectively supervise tasks that they have asked other people to carry out;
- 9 get informed consent to give treatment (except in an emergency);
- 10 keep accurate records;
- 11 deal fairly and safely with the risks of infection;
- 12 limit their work or stop practising if their performance or judgement is affected by their health;
- 13 behave with honesty and integrity and make sure that their behaviour does not damage the public's confidence in them or their profession;
- 14 make sure that any advertising they do is accurate.

(adapted from HPC 2008)

The areas detailed in Box 1.2 form the basis on which registered paramedics will be held accountable, should a complaint be made against them. The HPC has practise committees who look into allegations made against registered paramedics. There are three practise committees:

- First, the **investigating committee** normally looks at every allegation to decide whether there is a case to answer. If a case to answer is apparent, this committee deals with the case or decides to pass it onto one of the other two committees. It is expected that the investigating committee will always deal with cases of fraudulent or incorrect registration.
- Second, the **conduct and competence committee** normally deals with cases of misconduct and/or competence. They will also deal with matters arising from police cautions or criminal convictions.
- The third committee is known as **the health committee** and deals with cases of ill health.

Any HPC fitness to practise hearing is based on current impairment to practise at the time of the hearing. The council, after dealing with each case, has the power to take action against a

health professional if a case is established and current impairment is found. Such action may involve removing the paramedic from the HPC register. Other action may include suspension from the register or restricting the individual's work or publicly cautioning him or her.

Those prospective paramedics who are trying to join the register will not incur any penalties from the HPC during education, but will be unable to register if they do not reach the requirements of the HPC relating to the standards of conduct, performance and ethics that they have to reach in order to apply to be registered with the HPC. The standards will form part of their educational programme and may be assessed in theory and in the practice environment, depending on the structure and content of the programme approved by the HPC.

Clinical negligence is an area that is often associated with fitness to practise. As employees of NHS ambulance trusts, paramedics are covered by vicarious liability for their actions. An employer can also be held vicariously liable for an employee's breach of a statutory duty. If the statute imposes a duty on the employee personally, as in the case of the Mental Capacity Act 2005, and makes no reference to the employer, vicarious liability still applies (*Majrowski v Guy's and St Thomas' NHS Trust* [2006] UKHL 34). If vicarious liability is imposed on an employer, both the employer and employee are held jointly liable, technically enabling the employer to claim a contribution from the employee in respect of any financial loss incurred (Civil Liability (Contribution) Act 1978), however, in practice this does not happen. The NHS Litigation Authority generally deals with claims of negligence relating to NHS staff or organizations.

Those paramedics who work privately would be well advised to ensure that they are fully covered with regard to negligence claims. For a claim in clinical negligence to be successful, three key elements need to be established;

- duty of care;
- breach of duty;
- negative consequences as a direct result of the breach (causation).

The ambulance service itself has a duty of care from the point that it has established the location and identity of a patient, a duty which begins before the paramedic has even got to the scene (*Kent v Griffiths* [2000] 2 All ER 474). A paramedic's duty of care is often straightforward to establish and would begin when the paramedic enters into a patient-carer relationship with the patient by engaging in direct contact with them.

A breach of this duty is when a paramedic has failed to carry out their duties to an expected level of care. In negligence claims this is an area where expert witnesses may be employed to determine if the paramedic had breached their duty by comparing their actions to those that a *reasonable* paramedic should have undertaken in the same circumstances.

The final element, that of causation, is generally the most difficult to establish and it is on the basis of this that a case may or may not proceed to court. Establishing causation relies on proving a link between the breach and the resultant harm using the '*but for*' test (*Barnett v Chelsea and Kensington Hospital Management Committee* [1968] 1 All ER 1068); *but for* the breach, the harm would not have occurred (*Wilshire v Essex AHA* [1988] 1 All ER 871, [1988] AC 1074 (HL))

## Case Study 1.1

### What happened?

A patient complains to the HPC about the treatment of their relative who died following an acute asthma attack. The attending paramedic failed to identify that the patient was asthmatic, treating instead for a drugs overdose. No bronchodilating drugs were administered and the

patient suffered a cardiac arrest. The paramedic failed to maintain the patient's airway and did not attempt intubation.

### **The employer's perspective**

An employer's investigation found that the paramedic had failed to correctly diagnose the patient's condition – a competency issue. The paramedic was given a period of update training and supervision in practice until his employer was satisfied that he was competent. He continued to work as a paramedic pending an HPC hearing.

### **The HPC perspective**

When the case was heard by the HPC Conduct and Competence Panel it was found that there had, indeed, been a lack of competence at the time of the call. The paramedic had breached standards by not keeping their professional knowledge and skills up to date.

However, when considering the issue of current impairment, it was found that the remedial plan put in place by the employer, and seen through by the paramedic, meant that the paramedic was currently able to practise without any impairment. No further action was taken.

The lesson to be learnt from this case study is that professionals need to demonstrate that they have reflected on their mishaps and developed themselves appropriately. It is not uncommon for competency cases brought before the HPC to result in a finding of no current impairment to practise even though the facts of the case have been established against the registrant.

## **Capacity and consent**

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All individuals have fundamental legal and ethical rights in determining what happens to their own bodies – the principle of autonomy. To respect a patient's autonomy the paramedic has to obtain valid consent in the majority of healthcare encounters. Failure to do so may result in an accusation of assault or battery.

### **Adult consent**

For consent to be valid, a patient has to have the appropriate information and must be able to comprehend the procedure, treatment, intervention and so forth, being proposed by the paramedic. This means that the patient must be able to understand not only the procedure or treatment to be carried out, but also the consequences of such actions. This will allow the individual to consider the pros and cons of such situations and provide what is termed 'informed consent'. The depth to which the paramedic must discuss these details will be determined by several factors. One may be the severity of the presenting condition and the timescale in which the proposed intervention must take place. The vast majority of invasive pre-hospital interventions are undertaken in circumstances where they are necessary to prevent rapid deterioration of a patient's condition. In such circumstances it would not be realistic, or expected, for the paramedic to discuss all possible issues surrounding a procedure.

The Department of Health (2001a) advises that consent must be given voluntarily without duress or undue influence from health professionals, relatives or friends. In order for the patient



to give consent it does not have to be written, as this does not exclusively prove the consent is valid. Written evidence is used to record the patient's decision and the events which may have taken place. Consent can only be valid if the patient has capacity.

## Capacity

The comprehension required for informed consent is based around the patient's *capacity* to understand the procedure being explained to him or her. The paramedic must have an understanding of the Mental Capacity Act 2005 (MCA), indeed, paramedics are among the professional groups named in the MCA Code of Practice (Lord Chancellor 2007) who are required to have regard to the Act when carrying out their duties.

The Mental Capacity Act (2005) confirms in legislation that it should be assumed that adults (aged 16 or over) have full legal capacity to make decisions for themselves (the right to autonomy) unless it can be shown that they lack capacity to make a decision for themselves at the time it needs to be made. The Code of Practice to the Act (Lord Chancellor 2007: 36) states that assessing capacity occurs in two stages:

**Stage 1** Does the person have an impairment of, or a disturbance in the functioning of their brain or mind? e.g. concussion following head injury.

**Stage 2** Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?

In answer to the question in Stage 2, the Act states that a person is unable to make a decision if they cannot:

- understand information about the decision made (the Act calls this 'relevant' information);
- retain that information in their mind;
- use or weigh that information as part of the decision-making process; or
- communicate their decision (by talking, using sign language or other means).

In circumstances described above, the Act provides a legal framework for how to act and make decisions on behalf of people who lack capacity to make specific decisions for themselves. In order to assess whether the patient understands the information given, the paramedic should explore the individual's ability to decipher what information is relevant in relation to the nature of the decision, to understand why the information is needed and the likely effects of deciding one way or another or making no decision at all. The Code of Practice to the Act (Lord Chancellor 2007) advises the practitioner to take time to enable the person to take in the information given to them. It also states that the practitioner must give an appropriate amount of information to the patient and must provide information relating to the risks of any treatment or non-treatment. With respect to *taking time* with the patient, the Code does provide guidance on emergency situations. Code of Practice to the Act (Lord Chancellor 2007: 36) states:

In emergency medical situations, urgent decisions will have to be made and immediate action taken in the person's best interests. In these situations, it may not be practical or appropriate to delay the treatment while trying to help the person make their own decisions. However, even in emergency situations, healthcare staff should try to communicate with the person and keep them informed of what is happening.

The Act also introduces several new roles, bodies and powers, all supporting the Act. These include:

- Attorneys appointed under Lasting Power of Attorney (LPA). Such an attorney only acts on behalf of an individual, the *donor*, once they have lost capacity, either temporarily or

permanently. The attorney will have been appointed by the donor at a time when they did have capacity and may, in some cases, share their powers with another. LPAs should be treated as the proxy of the donor, with all relevant information that would have been communicated to the donor now being communicated to the LPA. Any decisions made by an attorney who holds the appropriate documentation **must** be treated as the wishes of the donor concerned.

- The Court of Protection and court-appointed deputies. The paramedic may need to know when and how to make an application to the Court and certainly should have an understanding of the powers of the Court of Protection.
- Independent Mental Capacity Advocates (IMCA). This service is independent and is for people who lack capacity to make certain important decisions and, at the time such decisions need to be made, have no one else (other than paid staff) to support or represent them or to be consulted.

The paramedic, in the course of a lifetime career, is likely to come across many difficult and complex situations. Therefore, it is essential the paramedic has an understanding of the above powers or bodies. It is strongly recommended that any ambulance clinician in difficult circumstances and having problems with the issue of capacity should ask for advice from their ambulance NHS Trust or employer through the normal emergency channels within their service.

In the time-critical situation the paramedic should always take the *best interests* approach to patient care. As long as the paramedic can justify that their actions were, in their professional opinion, in the best interests of the patient, there can be little comeback.

### Link to Chapter 2



for the theory and value of communication in patient and colleague encounters.

Link to Chapter 7 where common conditions are explained and signs and symptoms are explored, which will be useful for the paramedic to establish competence. The Mental Health Acts of 1983 and 2007 are discussed in more detail and useful web addresses provided.

### Case Study 1.2

#### What happened?

A paramedic solo responder attends an elderly patient who is resident at a nursing home. The patient is presenting with mild abdominal pain that they have been experiencing for a number of weeks. The paramedic finds that the patient's observations are normal and suggests that an appointment be made for the patient's own GP to attend. The carers at the nursing home insist that the patient is taken to hospital and say that they have spoken to the patient's son who also wants the patient taken to hospital. The patient is able to understand and retain the information given to her and appears content to await a GP visit, but is anxious not to upset the staff at the home.

#### The ethical perspective

The patient has demonstrated capacity, and therefore is able to give or refuse consent to treatment. Undue influence from the nursing staff and her son may impact on the decision,

so that it is not entirely autonomous. Similarly, it is not the paramedic's job to *convince* the patient either way. The paramedic should ensure that sufficient information is given to the patient to allow her to come to her own decision-enabling autonomy. The principle of justice may be considered by the paramedic; would calling an ambulance to convey this patient remove the resource from others who may need it more or would leaving an unwell patient at the nursing home divert the attentions of the nursing staff away from their other patients? Nonmaleficence may also be considered; would conveying this patient to hospital expose them to potential risks from infection or bed sores which would not develop if she were to remain at the nursing home? What course of action would be the most beneficial for the patient? A consideration of beneficence may mean that the paramedic considers contacting an out of hours service rather than waiting for the patient's own GP.

### **The legal perspective**

As the patient has demonstrated capacity, the paramedic cannot remove her to hospital against her will, regardless of the wishes of the patient's family or the nursing staff; to do so would constitute an assault.

### **Child consent**

The Department of Health (2009) explains that before examining, treating or caring for a child the paramedic must seek consent. Young people aged 16 and 17 are presumed to have the competence to give consent for themselves. Younger children who understand fully what is involved in the proposed procedure can also give consent, although it is better if their parents are involved in the decision at the time it is being made. In other cases, someone with parental responsibility must give consent on the child's behalf, unless they cannot be reached in an emergency. If a 'competent child' consents to treatment, a parent cannot override that consent. Legally, a parent can consent if a competent child refuses, but it is likely that taking such a serious step will be rare.

Generally, the complexities surrounding child consent tend to be reserved for debate in the hospital or primary care environment around issues such as immunization or organ transplantation. It is highly unlikely that paramedics will ever have to deal with a child, or their parent, who refuses a proposed life-saving intervention. If in doubt, adopt the *best interests* approach.

### **Patient refusal**

In the paramedic's role, consent tends not to be so much of an issue as does *refusal* to consent. Competent adult patients may refuse treatment (DH 2009); however, any refusal of treatment must be an *informed* refusal. The only exception to this rule is where treatment is for a mental disorder/illness and the patient is detained under the Mental Health Acts (DH 1983, 2007). If a patient is not competent, then a paramedic may treat the patient if it is in their best interests. This may include the wishes of the patient when they were competent. People close to the patient may be able to give more information and help the paramedic make a balanced, well-informed decision in such circumstances. Patients may make decisions relating to their future care either verbally or in writing. In cases relating to life sustaining treatment any decisions must be in writing and independently witnessed. The MCA introduced 'advance decisions' which take the place of advanced directives or living wills which may have preceded them. Advance decisions can only refuse consent to certain treatments or interventions in given circumstances, they cannot demand interventions.

### Case Study I.3

#### What happened?

A paramedic ambulance crew are called to a 45-year-old male patient in cardiac arrest. On arrival, the patient's wife presents the crew with a Lasting Power of Attorney (LPA) document that identifies her as the holder of the LPA. The crew initiate basic life support while the document is checked. It is confirmed that the LPA gives the patient's wife decision-making capacity in aspects of healthcare and specifically gives decision-making rights in end of life situations.

The patient's wife indicates to the crew that she wants them to stop CPR as her husband was terminally ill and would not want to be revived.

#### The ethical perspective

By appointing a lasting power of attorney, the patient has delegated their autonomy to their representative. Although the crew may believe that, considering the principle of beneficence, the best course of action for the patient would be to commence resuscitation, the patient has expressed to his representative that this is not what he would want.

Even if the crew do not agree with the decision of the patient, expressed through their attorney, they must still respect it as an autonomous decision. Not carrying out resuscitation may be an uncomfortable decision, but it would be ethically justified.

#### The legal perspective

If the crew *reasonably believe* the information given to them is true then they would be legally obliged to respect the wishes of the patient's representative. If there was any doubt regarding the identity of the attorney or the validity of the documentation, then the crew could commence resuscitation and convey the patient while a definitive answer was sought from the Court of Protection.

There can be no legal claim for 'wrongful life', meaning that if the crew did successfully revive the patient and it was later discovered that this was against his wishes, the patient would not be able to sue the crew for taking life-saving action.

## Confidentiality and data protection

The NHS Code of Practice, *Confidentiality* (DH 2003a: 11), clearly defines a duty of confidence as:

"when one person discloses information to another e.g. patient to clinician in circumstances where it is reasonable to expect that the information will be held in confidence. It is:

- a A legal obligation that is derived from case law;
- b A requirement established within professional codes of conduct; and
- c Must be included within NHS employment contracts as specific requirement linked to disciplinary procedures."

The Health Professions Council (2008) states that 'You must treat information about service users as confidential and use it only for the purposes they have provided it for. You must not knowingly release any personal or confidential information to anyone who is not entitled to it,

and you should check that people who ask for information are entitled to it.' The UK Ambulance Service Clinical Practice Guidelines (JRCALC 2006) provide guidance concerning the ethical issue of confidentiality. Practitioners should ensure that information regarding their patient is recorded clearly and precisely so that the patient's care pathway is processed without error.

In order to protect patient information the guidelines provide five essential steps to ensure compliance with the relevant standards of confidentiality (see Box 1.3).

### **Box 1.3 Five essential steps to ensure compliance with standards of confidentiality (JRCALC 2006)**

- 1 record patient information concisely and accurately;
- 2 keep patient information physically secure;
- 3 follow guidance before disclosing any patient information;
- 4 conform to best practice;
- 5 anonymize information where possible.

The principles outlined in Box 1.3 need to be supported by ambulance service policies and procedures that incorporate the ethos of the Data Protection Act 1998, which describes the processes for obtaining, recording, holding, using and sharing information.

The issue of confidentiality is one that requires careful management by paramedics. When dealing with the public, healthcare professionals and other professional bodies, there is a potential for information to be leaked about patients and their treatment. It is easy at the scene of an emergency call to declare information about a patient that may be overheard by members of the public. Patient records present another risk to patient confidentiality. Forms completed by paramedics with respect to patient treatment and details must be recorded as accurately as possible and be protected from viewing by those not entitled to do so. Safe storage and disposal of these forms is also a requirement of the Data Protection Act 1998 and various ambulance service policies and procedures should reflect this requirement.

### **Case Study 1.4**

#### **What happened?**

You are in the ambulance station mess room with six colleagues when a paramedic arrives back from a call. They proceed to tell the staff in the mess room about the call that they have just attended. They say that they went to Kipling Rise where they treated a 14-year-old girl called Mary for severe abdominal pain. They diagnosed an ectopic pregnancy and took the girl straight to the emergency department of the hospital where she was transferred to theatre and underwent an emergency operation. The paramedic is very pleased that he correctly diagnosed the presentation.

You notice that one of your other colleagues is very quiet and looks angry. It transpires that this colleague is the uncle of Mary and this is the first he has heard of his niece either being unwell or being sexually active.

#### **Has confidentiality been breached?**

Patient confidentiality has definitely been breached in this case. From the information disclosed – name, age and address – the patient could be easily identified.

**How could this have been avoided?**

Mess room discussions and de-briefs are an important element of personal and professional development and should be encouraged, as long as confidentiality is respected. There is no breach if there is no disclosure of identifiable data. This case could just as easily been discussed as a purely clinical presentation with no reference to the patient's name or address. Identifiable data does not only include names and addresses; if the identity of a patient can be determined by the information disclosed, perhaps due to the unique nature of the presentation within a hospital, then confidentiality can be considered to have been breached.

**Stop and think**

Have you observed colleagues try to maintain patient confidentiality in public places during an emergency? Think about the strategies you can use to try and maintain confidentiality in emergency situations. Also think about the possible consequences of ignoring the importance of trying to maintain confidentiality.

The relationship between healthcare professionals and their patients has always been considered especially significant with regard to disclosure of information. Much of the information given to the paramedic is often of a sensitive nature and there is an expectation that this information will not be passed onto others without the consent of the individual concerned. The confidentiality model (see Figure 1.1) advocated by the Department of Health (2003a: 10) may help to remind paramedics of their main responsibilities regarding patient confidentiality. This model will naturally involve paramedics in other aspects of quality monitoring, such as clinical audit, in order to establish ways to improve their own and others' professional practice.

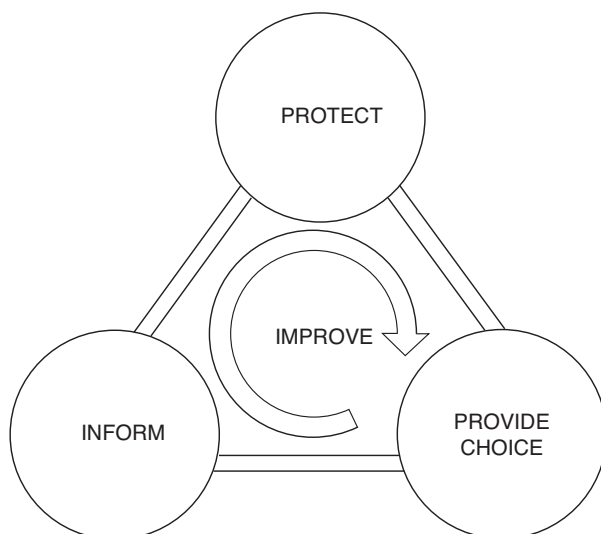
**Link to Chapter 3**

for a more in-depth discussion on clinical audit.

**Link to Chapter 4**

for ideas and strategies on how to reflect and subsequently improve professional practice and patient care.

It is rare that paramedics are the only healthcare professionals involved in the patient's care; an inter-professional approach is the usual practice. It is necessary to disclose information to health and social care professionals when paramedic practitioners, for example, convey patients



- a. PROTECT – look after the patient’s information;
- b. INFORM – ensure that patients are aware of how their information is used;
- c. PROVIDE CHOICE – allow patients to decide whether their information can be disclosed or used in particular ways. To support these three requirements, there is a fourth:
- d. IMPROVE – always look for better ways to protect, inform, and provide choice.

**Figure 1.1** The confidentiality model

Source: DH (2003a: 10)

to emergency departments (ED) to provide the uninterrupted ‘patient care pathway’. In such situations, a copy of the patient report form will be left in the department with the relevant ED staff. Patients’ consent in such situations should be sought, to enable disclosure of their information wherever possible. When patients are conveyed to hospital, their consent will have been obtained routinely in the vast majority of cases. It is accepted that by agreeing to be taken to hospital, disclosure of information relating to the patient will be shared by the ambulance clinician with those entitled to receive it.

There will be situations where the need for confidentiality has to be balanced against what is termed the ‘public interest’. Under common law, practitioners are permitted to disclose personal information in order to support detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to others where they judge, on a case-by-case basis, that disclosure outweighs the obligation of confidentiality. Practitioners should consider each case on its own merits. On occasions, due to the nature of the incident, it may be difficult to make a decision. In such situations it may be necessary to seek legal or specialist advice from professional, regulatory or employing authorities’ legal departments, who will seek further legal advice as required.

The NHS policy relating to confidentiality is grounded in guidance from Department of Health documents such as *Confidentiality: NHS Code of Practice* (DH 2003a), *Guidance for Access to Health Records Requests* (DH 2003b) and from the Information Commissioner: *Use and Disclosure of Health Data* (Information Commissions Office 2002).

**Stop and think**

Patients have a legal right to access their health records (Access to Health Records Act 1990). This must be considered when completing any patient report documentation and appropriate language and medical terminology should be used throughout.

**Conclusion**

It is accepted that the role of modern paramedics brings with it a number of important legal areas within their scope of practice. Paramedics need to be aware of the consequences of their actions and be able to maintain a professional, legal and ethical approach at all times. Understanding the law is particularly important as paramedic practice continues to develop and broaden in scope. The HPC seeks to provide a framework within which paramedics are able to practise to the highest standards and simultaneously maintain their accountability to patients, clients and other professionals. This chapter represents an overview of some of the most common legal and ethical issues facing the paramedic in the twenty-first century. Many of the areas require further investigation and wider reading in order to obtain a more comprehensive understanding of the issues covered in this chapter.

**Chapter key points**

- Ethical dilemmas are part of everyday practice within the NHS.
- There are differences between paramedic guidance and that of other healthcare professionals.
- Paramedic ethical dilemmas occur across the lifespan, due to the nature of the role.
- Paramedics require a good understanding of their ethical responsibilities in relation to the role, in order to practise in a safe, competent and professional manner.

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