Honors Senior Thesis:

Applied Ethics for Emergency Medical Services

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I. INTRODUCTION

Project Aim

In this project, I will characterize major ethical frameworks and apply them to a series of ethical dilemmas encountered in prehospital emergency medicine, giving EMTs and Paramedics a toolbox for making moral judgements in the field. For this project to serve as both a tool for EMS providers and an academic application of ethical theory, I have structured it in such a way that it should be accessible and beneficial to members of both disciplines. For this reason, I strive to paint a picture of the realities of prehospital emergency medicine as well as provide a thorough explanation of philosophical concepts.

To do this, I first provide an overview of EMS and address the need for such a project in both academia and the field. In the next section, I give a brief introduction to the study of ethics, and I explain how to evaluate and apply ethical theories. I also define some relevant philosophical concepts and terms. I then discuss two major ethical frameworks: teleological ethics, and deontological ethics. In the last section, I apply these ethical frameworks to discrete moral dilemmas that EMS providers are likely to be tasked at solving. In reading this paper, EMTs and Paramedics should become better equipped at making ethical decisions, and other readers should have a better understanding of the responsibilities and challenges EMTs and paramedics are faced with daily.

It is not my intention that this paper argue for or against any theory or discrete action. Further, it is important to note that EMS providers should not deviate from local protocol and standard operating procedures in your own practice; ethical concerns that present a conflict with protocol should be brought to the attention of management and your Medical Director.

Introduction to EMS

Before I delve into the specifics of ethics in EMS, I will provide a context for this discussion by broadly explaining the system of emergency medical services. In this project, I will use emergency medical services, EMS, and prehospital emergency medicine interchangeably as is customary in the discipline. In broad terms, the purpose of EMS is to provide medical assistance to patients at the scene of an incident – injury or medical complaint – and to subsequently transport patients, under continuous care and observation, to the appropriate facility for further evaluation and treatment.

The birth of prehospital emergency medicine can be traced back to World War I when injured soldiers were first transported by ambulances to medical aid stations. By World War II, the military had specially-trained medical providers to deliver initial care to injured soldiers on the battlefield and transport them to aid stations, and in the Korean and Vietnam conflicts, the military had field medics and medical evacuation helicopters. However, in the civilian world, emergency medical services had not progressed as quickly. Well into the 60s and 70s, emergency medical service was highly inconsistent across the United States, ranging from ambulances staffed by hospital personnel to hearses and station wagons staffed by funeral home workers, firefighters, and police officers with only basic first aid training and supplies. The early 1970s saw the beginning of national standardization and modernization of EMS, which still continues today (American Academy of Orthopedic Surgeons [AAOS], 2017, pp. 9-10). Even with the push to modernize and standardize EMS in the United States, the provision of emergency medical services still varies widely across the country. One aspect that varies greatly by location is the type of agency responsible for EMS; emergency medical services are provided by hospital-based ambulances, fire departments, government agencies, non-profit organizations, and even for-profit corporations (“What is EMS?” n.d.). It is safe to say that prehospital emergency medicine in the United States is still in its infancy.

Regardless of the type of agency responsible for the provision of emergency medical services, the roles, responsibilities, and scope of practice for rescue personnel remain relatively consistent nationwide. The four main certification levels for prehospital care providers, in order from least to most advanced, are (1) emergency medical responder, (2) emergency medical technician (EMT), (3) advanced emergency medical technician, and (4) paramedic. Most ambulances are staffed with a combination of EMTs and paramedics, so for this project, I will refer to these providers collectively as "EMTs and paramedics." Additionally, many agencies use nurses, respiratory therapists, and physicians for critical care transportation and air ambulances (AAOS, 2017, pp. 1-20).

Typically, an EMS incident or call occurs in the following progression: First, an injury occurs or an acute medical complaint arises that prompts a victim or third party to activate the EMS system by calling 911. Once the caller states that the incident is a medical emergency and provides a location, the 911 call taker will immediately have an EMS unit dispatched to that location and will continue to provide first aid instructions to the caller over the phone. Once an EMS unit arrives on scene and makes contact with the patient, the care providers will begin assessing and treating the patient on scene; shortly thereafter, they will transport the patient to an appropriate facility. Upon arrival at the hospital, the care provider will give a thorough account of their patient assessments and all medical interventions provided under their care. Once this report is given, the hospital will continue caring for the patient and the EMS unit will return to service.

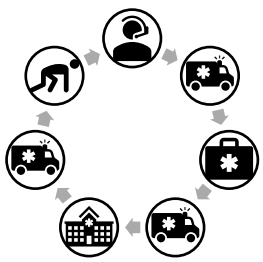


Figure 1. Flowchart of an EMS call. Ethical dilemmas may occur at any stage.

The Need for Applied Ethics in EMS

There does not appear to be much academic literature addressing ethics specific to prehospital emergency medicine, and the ethical dialogue for EMS is notably set apart from that of medical ethics in general. First, while EMS calls are medical in nature, the scene or environment of an incident is often just as important, and sometimes more important, than the patient's medical complaint. The role of EMTs and paramedics is part public safety professional and part medical professional. Additionally, when compared to the hospital setting, the field setting is considered a low-resource environment. EMTs and paramedics are expected to handle any imaginable medical complaint, psychological complaint, or traumatic injury with only the tools and supplies available in an ambulance. Another aspect of this resource-limited environment is that there are usually only two people on an ambulance. This means that, unlike in hospitals, there is not an entire team available to deliberate ethical dilemmas. Moreover, due to the emergent nature of the job, the evaluation of moral dilemmas must be quick; EMTs and paramedics are expected to demonstrate superior moral intuition as second nature.

The first source I would like to address is the ethics discussion found in the "preparatory" chapter of *Emergency Care and Transportation of the Sick and Injured,* which is the standard EMT textbook. This source is important in that it is usually an EMT or Paramedic's first encounter with ethics in EMS. This section begins by briefly defining ethics as "the philosophy of right and wrong, of moral duties, and ideal professional behavior," and morality as a societal, personal, or religious code of conduct. A few simplified examples of ethical dilemmas are then provided, such as noticing the smell of alcohol on a coworker, lying about attending mandatory training, the use of lights and sirens, and termination of resuscitative efforts. The text then calls on the provider to make ethical decisions based on a combination of professional standards and their own moral codes. If a provider has any

doubts about how to address an ethical dilemma, they can defer to medical direction, an on-call physician that field providers can consult over the phone or radio. Furthermore, this source states that most dilemmas faced by providers have already been addressed by laws and policies and that these laws and policies take precedence over any personal ideas of morality. Above all else, complete honesty is expected in reporting the details of every call. This source also provides a checklist consisting of 6 yes or no questions to evaluate ethical decisions; the checklist asks whether or not the decision (1) is in the patient's best interest, (2) is logical and not emotional, (3) respects patient rights, (4) is the decision you would make if you were the patient, (5) is a decision you would make every time if given similar circumstances, and (6) can be defended to others (AAOS, 2017, pp. 102-103). While the EMT textbook provides a thorough discussion of medical and legal expectations for EMTs, it only briefly discusses ethics and falls short at providing EMTs with the tools necessary to evaluate ethical dilemmas.

The other principal source of ethical guidance in EMS is the "EMT Oath and Code of Ethics". The National Association of Emergency Medical Technicians (NAEMT) provides the following list of ethical obligations for EMTs: (1) do no harm, foster health and relief of suffering, and conserve life; (2) be nonjudgmental, compassionate, and respectful, and provide care regardless of race, class, beliefs, or nationality; (3) only use professional knowledge for the good; (4) do not share confidential information unless required by law; (5) use social media responsibly and without harming the image of the profession; (6) maintain knowledge and high quality of care; (7) take responsibility for your actions; (8) research and participate in EMS legislation; (9) cooperate with other healthcare and public safety personnel; and (10) expose and do not participate in unethical behaviors. While these are clearly good rules to guide EMTs and Paramedics in their actions, they fall short on promoting critical thinking and effective moral reasoning.

II. ETHICS

Perhaps one of the most fundamental deliberations of human existence is on what moral people, moral actions, and a moral life all look like. It seems this initial question opens a pandora's box of questions on which the answer to the former rests. Why should we even try to live our lives ethically? Can we prescribe a universal code of ethics? Are there any unifying moral principles? Should we derive overarching rules by looking at discrete acts, or should we evaluate discrete acts by looking at established rules? Should we worry more about the consequences of an action or the intention behind it? To what extent, if any, should we consider the wellbeing of others? What sorts of things are morally valuable? Is morality an aspect of human nature? Is morality contrary to human nature? Does morality come from within us or somewhere else? Ethics as an academic field seeks to systematically answer these questions and many others, and I hope to shed some light on many of them in this section. I will endeavor – to the furthest extent possible – to give the best interpretation of each theory in order to provide the fairest application and critiques; this means that I will avoid formulations of deontological theories that rely in large part on consequentialist principles and vice-versa.

The study of ethics can be divided into three major levels: metaethics, normative ethics, and applied ethics. Metaethics looks at what constitutes our basis of morality and seeks underlying justification for our methods of moral reasoning. In other words, it is an exercise in thinking about how we think about ethics. Normative ethics, on the other hand, seeks to derive systems to evaluate right and wrong conduct. Normative ethics can be further subdivided into two major frameworks: consequentialist (teleological) theories and non-consequentialist (deontological) theories; I will discuss these in-depth later on in this paper. Finally, applied ethics seeks to evaluate and judge individual acts using normative ethical

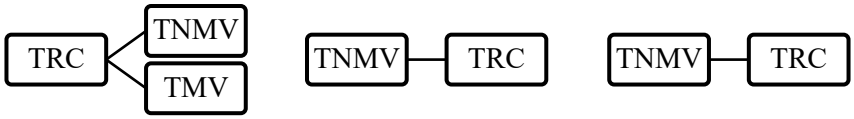
theories and metaethical principles. This paper serves as an exercise in applied ethics specific to the context of prehospital emergency medicine.

Structure of a Moral Theory

Before I can delve into any specific normative theories, I must first explain the overall structure of a moral theory and the system I will use to evaluate them; this will help me to consistently characterize and evaluate different theories. In this project, I will use the system outlined by Timmons (2003) to reconstruct and evaluate ethical theories. Moral theories are comprised of two main parts, or basic moral concepts: a theory of right conduct and a theory of value. A **theory of right conduct** is "…an account of the nature of right and wrong action (Timmons, 2003)" and is formulated as *some action* X *is right if and only if, of all available actions, that action* does Y. **Deontic concepts** evaluate actions in terms of right and wrong. Actions that one ought to perform are **obligatory (right) actions.** Actions that are impermissible or forbidden to perform are **wrong actions**, and those which are merely permissible – neither wrong, nor obligatory – are **optional actions.**

The other main component to ethical theories is a theory of value. **Value concepts** evaluate people and things – not actions – in terms of good and bad. A **theory of value** is "an account of the nature of value" and has two smaller components: a theory of moral value, and a theory of nonmoral value. Only people (moral agents) can possess moral value because they can be blamed or praised for an action. A theory of moral value takes the form *some agent* X *is good if and only if that agent acts in a way that does* Y. States of affairs, objects, and events can possess **nonmoral value**, which simply means that these things cannot be blamed or praised for an action. **Intrinsically valuable** things are valuable in and of themselves, while **extrinsically valuable** things are valuable insofar as they relate to something that is intrinsically valuable. Ethical theories have two aims: a practical aim and a theoretical aim. The **theoretical aim** of a moral theory is to identify features of actions and persons that make

them good, bad, right, or wrong, and the **practical aim** is to create a procedure that can be used to guide moral reasoning. Moral principles are used to satisfy the theoretical aim, which is then used to satisfy the practical aim (Timmons, 2003).



(**a**) (**b**) (**c**)

Figure 2. Basic Structure of a Moral Theory. The theory of right conduct is most basic for Deontological systems (**a**). The theory of non-moral value is most basic for consequentialist theories (**b**). The theory of moral value is most basic for virtue ethics (**c**).

Moral theories can be categorized by which of the two types of basic moral concepts they consider to be most basic. Some theories make value concepts the most basic, of which utilitarianism, egoism, and altruism are all examples. These theories make evaluation of the good most basic and subsequently determine right actions in terms of what is valuable. Value-based theories can be further distinguished by those that make nonmoral value most basic and those that make moral value most basic. For example, consequentialist theories make intrinsic nonmoral value most basic; right actions are determined by how they distribute intrinsic non-moral value. Virtue ethics, however, makes moral value the most basic; actions are judged in terms of the good or virtuous person. Theories that make deontic concepts most basic consider the concepts of right and wrong more basic than concepts of good and bad. Deontological theories evaluate actions independent of outcome.

Evaluating Moral Theories

Once I reconstruct each moral theory, I will use Mark Timmons' (2003) evaluation principles to evaluate each independent of, and in relation to, ethical dilemmas in EMS. According to Timmons, ethical theories should be evaluated on (1) consistency, (2) determinacy, (3) applicability, (4) internal support, (5) external support, and (6) explanatory

power. A moral theory should consistently arrive at a verdict in all moral evaluations; an action cannot be both right and wrong if a theory is **consistent**. It is important to note that a theory is not inconsistent simply because it considers an act wrong in general but right in a specific case. **Determinacy** requires that one should be able to arrive at a definite moral verdict in a wide range of situations. **Applicability** requires that the theory's moral verdicts are based on information that humans can easily obtain and evaluate. Theories that have **internal support** consistently reach the correct moral verdict in cases that are generally agreed upon – *considered moral beliefs*. Evidence of **external support** is found when a theory does not conflict with beliefs and assumptions from fields outside of morality, like science. Finally, **explanatory power** is a theory's ability to explain why actions are right or wrong and why things are good or bad.

Teleological Ethics

The consequentialist framework is a group of theories that are concerned primarily, and sometimes solely, with the outcomes or consequences of possible actions. In other words, the morality of an action is determined by the consequences of that action. As I explained in the "Structure of a Moral Theory" section**,** consequentialist theories make the concept of intrinsic non-moral value most basic. Teleological theories ground the theory of right conduct in the theory of nonmoral value; right actions are evaluated on how they distribute intrinsic non-moral value amongst an affected community. To give a thorough and useful account of the Teleological framework, I will first discuss two very limited consequentialist theories, egoism and altruism, followed by the more applicable and widely accepted *Utilitarianism*. While it will not be particularly useful to apply altruism and egoism to discrete ethical dilemmas in EMS, they are useful to the extent that they demonstrate the general thought process of deriving and explaining normative theories. To demonstrate how the theories work in practice, I will employ examples provided by the theorist, other ethicists, or myself. I will

also evaluate each theory according to the basic evaluation factors outlined by Timmons (2003). While these three theories are united in their emphasis on favorable consequences, they are greatly set apart by *whom* those consequences should be favorable for.

Egoism & Altruism

Egoism: Ethical Egoism is a consequentialist moral theory, holding that ethical actions are those which promote and do not hinder the moral agent's self-interest. The ethical egoist assumes that humans are psychologically predisposed to secure things that promote our own self-interest. Given that the promotion of self-interest is human nature, I ought to act in a way that promotes my self-interest. Not only must I act in a way that promotes my own self-interest, I have no moral obligation to promote the interests of others. Further, promoting the interest of others at the expense of my own interests is, for the egoist, a wrong action. In the next paragraph, I will reconstruct the basic structure of ethical egoism and address its individual components.

The ethical egoist will argue that the one intrinsically good thing is my own wellbeing or happiness; things are extrinsically good insofar as they contribute to my own happiness, as the moral agent. This constitutes the **theory of nonmoral value** for ethical egoism. The ethical egoist argues that the promotion of self-interest is the way to maximize individual well-being. Therefore, the **theory of moral value** is *some agent x is good if and only if that agent acts to maximize her own wellbeing.* Subsequently, the **theory of right conduct**, grounded in the value theory, is *some action x is right if and only if, out of all available actions, that action maximizes – and does not detract from – the wellbeing of the moral agent*. The **theoretical aim** is satisfied by the following: (1) whether or not an action positively contributes to the wellbeing of the moral agent makes that action right or wrong, and (2) whether or not a person acts to increase her own well-being determines whether the person is a good or bad moral agent. The decision-making process that satisfies the **practical**

aim is as follows: For some given moral dilemma, first consider the outcomes of each available action. For each action, consider if, and to what extent, the consequences will contribute to your own well-being. Finally, choose the action that maximizes to the greatest extent your own wellbeing.

To demonstrate ethical egoism in action, consider the following scenario. Imagine that you just found out that you have the winning numbers in a multi-million-dollar lottery jackpot. Upon receiving your winnings, you essentially have four broad options for how to use your lottery winnings: (1) you can keep all of the money for yourself, reserving none for others; (2) you can keep most of the money for yourself, reserving some for others; (3) you can give all of the money to others, reserving none for yourself; or (4) you can give most of the money to others, reserving some for yourself. In this example, I am assuming that the money has extrinsic value in that it will ultimately be used in the acquisition of intrinsic value – i.e. my own happiness.

To approach this scenario, I must first identify the question at hand. In this case, I am asking how I should distribute the lottery money, a thing that holds extrinsic nonmoral value. Next, I identify all available actions, as I have done above. If I am an ethical egoist, I must choose to keep all of the winnings for myself and spend this money in a way that maximizes my own well-being. For the egoist, *option 1* is an obligatory action because, of all available options, it best maximizes my own wellbeing. *Option 2* may only be permissible if sharing some of my money will better foster my own wellbeing. For example, the honor bestowed upon me because I donated a significant sum to charity might be more extrinsically valuable than the money itself; *option 4* may also be permissible in the same way. However, from the given information, I will assume that the money is more extrinsically valuable as it relates to my happiness, so all other options must be wrong.

Altruism: Antithetical to ethical egoism, Altruism holds that the right action is the action that maximizes value for everyone except the moral agent. Like egoism, Altruism holds that individual wellbeing is intrinsically valuable. However, altruism focuses on the wellbeing of others, not of one's self. It is important to note that the agent simply having selfless tendencies or motivations does not constitute an act as morally right, as altruism in the consequentialist sense is concerned only with the outcome of actions. To accept altruism in a weak sense is to require that the action be motivated in part by the maximization of wellbeing for others. Altruism in a strong sense requires that the agent act in the interest of maximizing the wellbeing of others, even in spite of that action resulting in a negative or neutral contribution to the wellbeing of the agent.

The **theory of nonmoral value** for altruism is that individual wellbeing is the one thing that is intrinsically valuable. Things are extrinsically valuable insofar as they contribute to individual wellbeing. For example, food is extrinsically valuable because it promotes my wellbeing by nourishing and sustaining me. The **theory of moral value** is *some agent x is good if and only if that agent acts in a way that maximizes wellbeing for others*. Given that individual wellbeing is valuable and an agent has a moral obligation to the wellbeing of others, the **theory of right conduct** is *some action x is right if and only if that action, of all available actions, maximizes the wellbeing of everyone* except *the moral agent*. The **theoretical aim** is satisfied by the following: (1) Actions are judged on whether or not they contribute to the wellbeing of others. An action is **obligatory** if it adds to the wellbeing of others. **Wrong** actions subtract from the wellbeing of others, and **Permissible** actions do not add or subtract from the wellbeing of others. (2) moral agents are judged on whether or not they act in a way promotes the wellbeing of others. A good moral agent acts in a way that maximizes the wellbeing of others. A bad moral agent acts in a way that does not maximize the wellbeing of others. If I revisit the lottery jackpot example above, I may be tempted to

choose the option that allows me to keep some of the money for myself. However, any action in which I keep some or most of the money for myself will deprive of others more potential wellbeing. Thus, options *one, two,* and *four* would all be forbidden for the altruist. The option that *best* maximizes the wellbeing of others is option *three,* the one altruistic – thus, obligatory – action.

Since I will not be applying egoism or altruism to any of the EMS dilemmas, I will provide a brief evaluation of both. Egoism and altruism are both consistent in that they never allow the possibility that a given action will be right *and* wrong; the right choice will always be the one that *best* maximizes value for the agent or others, respectively. For this same reason, they are both sufficiently determinant. However, neither is sufficiently applicable because they both rely on information that is too often inaccessible. The agent is forced to compare likely consequences instead of definite consequences. Further, egoism lacks much external support; it almost always conflicts with considered moral beliefs. Both altruism and egoism fall short in explanatory power because they do not explain much about right making principles of actions but instead focus on value determination and distribution. It seems that my status as target or moral agent should not, on its own, determine my entitlement to happiness.

Utilitarianism

Utilitarianism is a value-based theory that makes most basic the theory of nonmoral value and prescribes a theory of right conduct requiring the maximization of happiness for everyone affected by an action. The utilitarian theory of nonmoral value is that happiness is the one intrinsic good. For the utilitarian, all persons affected by an action are given equal consideration regardless of status as the moral agent, the target of an action, or some other affected person. Given that happiness is intrinsically valuable and that all affected persons are given equal consideration, the utilitarian theory of right conduct is *some action* X *is right if*

and only if, out of all available actions, that action produces the greatest amount of happiness for everyone affected by that action. For some given dilemma, the obligatory action is the action that best maximizes happiness for everyone affected. Permissible actions are those that neither contribute to nor detract from the happiness of everyone affected; these are neutral. Wrong actions are those that, of all available actions, do not *best* maximize happiness for everyone affected or those which diminish the happiness of everyone affected. The theoretical aim is satisfied by (1) evaluating actions as *obligatory*, *wrong*, or *permissible* in terms of how they augment the happiness of everyone affected by that action and (2) evaluating things as good or bad in terms of their utility in securing happiness, i.e., the one intrinsic good. The practical aim is satisfied by the theory of right conduct given the theory of nonmoral value.

To effectively understand, evaluate, and apply utilitarianism, I will now discuss some of nuances that spring from it. First, when considering a community or affected group, the community is synonymous with all individual members of that community. It follows that the interest of the community as a whole is the sum of the interests of all members within that group. Next, to say an action has utility is to say that this action has a tendency to augment happiness of the community to a greater extent than it diminishes it. As utilitarianism requires us to compare degrees of pleasure in respect to different affected parties, it is important to prescribe how to compare degrees of pleasure. The happiness or suffering produced by an action, in respect to the individual, can be evaluated in terms of its intensity, duration, certainty, propinquity (how far in the future the it is), fecundity (the chance it will be followed by sensations of the same kind), and Purity (the chance it will not be followed by the opposite sensation) (Bentham, p.105-106). Pleasures can be distinguished in hierarchy by higher pleasures and lower pleasures. Higher pleasures are distinctly human pleasures like

pursuit of knowledge and appreciation for nature. Lower pleasures are those in the physical realm, like satisfaction of hunger (Mill, p.109-115).

Another factor to consider is that the degree of pleasure or pain produced for an affected person is influenced by certain purely personal factors. First, any two persons will have different things that they value extrinsically insofar as they contribute to happiness. Another consideration that will likely come up in my application section is the person's age or how long that person potentially has to benefit from the pleasure. For example, I may be tasked at deciding which of two lives to save, that of a healthy toddler or of a terminally ill elderly person. Given that I can only save one of them, the most happiness will be produced by saving the toddler. The moral agent's relationship to other affected persons can affect the degree of happiness, as it is usually more painful to be hurt by a friend or family member than by a stranger. Note that, in these cases, persons are not given differential consideration because we are still only comparing degrees of happiness.

Additionally, a proper evaluation and application of utilitarianism requires a more thorough decision-making procedure to satisfy the practical aim. For this, Jeremy Bentham provides the following procedure: First take any one person directly affected and account for (1) the value of each pleasure produced *in the first instance* by an action; (2) the value of each pain produced *in the first instance* by an action; (3) value of each pleasure produced *after the first instance* by an action – fecundity of first pleasure and impurity of first pain; (4) the value of each pain produced after the first instance by an action – fecundity of first pain, impurity of first pleasure; (5) sum up the value of total pain on one side and total pleasure on the other, and the prevailing side will determine if that action has a good or bad tendency with respect to the individual; Finally, (6) repeat *1-5* for each affected person to determine good or bad tendency with respect to each individual; next, determine the action's prevailing tendency with respect to the whole community.

To briefly demonstrate utilitarianism in practice, I will apply it to a version of the well-known trolly problem. Imagine that you are at the controls of a trolly without brakes speeding towards a fork in the track. On the first track there is one doctor, whom you know to be the only transplant surgeon able to perform a very specific but lifesaving procedure. On the other track, you see three of your best friends with no notable lifesaving abilities. The only available options are to steer the trolly down the track with the doctor or to steer it down the track with your three friends. As a good utilitarian, I first account for the value of each pleasure and each pain in the first instance for each affected person – myself (the moral agent), the doctor, and each of the three friends. In the first instance, the happiness produced by staying alive is given equal value for the doctor as is given for each friend. Since my own life is not at stake, the degree of happiness produced for me is insignificant in comparison. Without consideration for fecundity or purity at this point, I would be obligated to steer the trolly towards the doctor because the greatest amount of happiness for the whole is produced by saving three lives at the expense of one. However, when I consider the values of happiness and suffering produced after the first instance, it becomes clear that more lives will be saved if the doctor lives. In this case, the happiness produced by initially allowing the doctor to die lacks fecundity and is impure because the initial pleasure is soon replaced with pain in the form of the death of his future patients. Therefore, the obligatory action is to steer the trolly towards the three friends because this action, of all available actions, produces the most happiness for everyone affected by it.

Deontological Ethics

It may be helpful to think of deontology as a response to consequentialism in that it denies that actions can be judged solely by the states of affairs that the action produces. Consequentialism seemingly permits that in some cases it is okay – actually obligatory – to kill an innocent person if killing that innocent person produces more of what is valuable; the

value produced justifies an action that our basic moral intuition leads us to think is never right. In the deontological framework, actions like these will be unequivocally forbidden. For the deontological ethicist, we cannot judge actions against the things or states of affairs that action produces; value production is not the right making feature of an action. Instead, for the deontological ethicist, the right making feature of an action is that it be performed out of a sense of duty. From this, we get the term deontology.

Kantian Deontology

For the deontological framework, I will be reconstructing and applying Emmanuel Kant's theory of the categorical imperative as presented in his *Groundwork of the Metaphysics of Morals (1788).* I will first give an overview of the theory as a whole as well as the basis from which it is derived. Next, I will break it into its two main components to give a more in-depth analysis of both formulations of the categorical imperative. Finally, I will derive from this analysis a procedure of moral deliberation through which I will consider discrete ethical dilemmas from EMS.

Central to Kant's system of morality is the idea that the one unqualifiedly good thing is the will to do good, which is to act from a sense of duty. The good will is not simply a desire to bring about good things; it is strictly the will to act out of duty for what is right. The good will does not derive its value from its consequences. Instead, the entirety of its value is in itself and, therefore, cannot be rendered more or less valuable by some thing or state of affair resulting from it. Other things, such as virtues, may be considered *extrinsically* good insofar as they presuppose the will to do good. It now makes sense to ask exactly what determines the will to do good.

Kant argues that it is the idea that the principles of one's actions should be acceptable for all. From this, Kant gives us the first formulation of the categorical imperative (CI^1), which is, "act only on that maxim whereby thou canst at the same time will that is should

become a universal law." From this formula, the maxim of a wrong act, when willed as universal law, will lead to contradiction because as soon as that maxim becomes universal law, the action becomes impossible. In other words, the action would destroy the maxim. Thus, for Kant, morality is simply practical reason, and the good will is something found within rational beings, to be accessed through reason.

Therefore, to act morally is to act rationally, and to act rationally is to act on principles by which all rational beings may be universally bound. Given that acting from a good will is to act rationally, it follows that rationality is intrinsically good insofar as it is synonymous with the good will. Therefore, rational life must be considered intrinsically good, or in other words, as an end in itself. From this, Kant provides a second formulation for the categorical imperative (CI^2): "so act as to treat humanity, whether in thine own person or in that of any other, in every case as an end withal, never as a means only…"

It seems that Kant's fundamental objection to consequentialism is in its subjectivity, as it permits subjectivity of a will that is fundamentally objective. If humanity is to be bound by some moral law, that law must be binding to all rational beings. For Kant, human interaction is essentially that of means and ends, so what results from the consistent application of the categorical imperative is a society that Kant calls the "kingdom of ends". He envisions a society of rational beings united under universal moral law, motivated by the good will, and guided by the categorical imperative.

Now, I will provide a more in-depth discussion of both formulations of the categorical imperative. For clarity, I will be reconstructing the account of Kant's moral theory given by him in his *Groundwork of the Metaphysic of Morals*. However, to give an adequate account of Kantian ethics, I will employ some supplemental texts that further explain some of Kant's central concepts. To demonstrate moral deliberation through Kant's categorical imperative, I

will use Kant's own examples along with some of my own. I will first consider formulation one (CI^1) of the categorical imperative:

> **CI^1**: "act only on that maxim whereby thou canst at the same time will that is should become a universal law."

Kant's first formulation of the categorical imperative is used to identify those maxims – principles guiding an action – which can be prescribed as a universal moral law. Underlying this formulation is the idea that consistency is essential to rationality. For a moral law to be consistent, it must be one to which all rational beings may adhere (Holmes, p.154), and this requires that the maxim not contradict itself when elevated to universal law. If a contradiction follows, that action is irrational and thus immoral.

To best understand this, it would befit me to further explain some of Kant's terminology. First, I will tackle the concept of a categorical imperative. For Kant, an imperative, in general, is a command of reason addressed to rational beings. An imperative is comprised of an antecedent – *if* clause – which refers to some desired end, and a consequent – then clause – which refers to the means one *ought* to employ to attain the end (Holmes, p.156-158). For example, if I want do well in my ethics class, I ought to do all assignments to the best of my ability. This is an example of a **hypothetical imperative** because the *ought* is only binding if I desire the end. These sorts of imperatives cannot constitute objective law because the end is subjective, so the *ought* is not necessarily binding to all humans. For an imperative to be universal, it must have a fully objective end, and as I discussed earlier, the good will is the sole end in itself. For this reason, the universally binding imperative guiding free will reads only as a consequent. In other words, I simply *ought* to do what is right. Therefore, the **categorical imperative** is an absolutely binding command for all rational beings in all circumstances and reads as shown above in **CI^1.** To apply the categorical imperative, it is also important that I explain maxims and how to derive them. A maxim of an action is the

principle on which I see myself acting. For example, I called my mom today on the maxim that one ought to keep in touch with one's mother. All intentional actions will have at least one maxim, and to derive that maxim I simply remove the particulars from the intention of an action (O'Neil, p.167).

CI^1 can alternately be understood in terms of the basic ethical theory structure discussed earlier. For CI^1, the **theory of right conduct (**TRC^1**)** is: some action X is right if and only if I can will the maxim of that action to become universal law. This is the most basic component of Kantian ethics as it is not rooted in or in reference to any consequences; it stands alone as right in itself. However, this theory is not completely void of value judgements; rather, the theory of value is rooted in the theory of right conduct. Thus, the **theory nonmoral** value is (1) the one unqualifiedly good thing is the will to do good, and (2) things can be extrinsically good insofar as they presuppose the good will. Since the good will is guided by the theory of right conduct, the theory of right conduct is more basic. The **theory of moral value** is: some agent X is good if and only if that agent acts in such a way that she can will the maxims of her actions to be universal law. Together, these identify the right making features of actions and the value features of persons and things, satisfying the **theoretical aim**. Finally, the **practical aim** is satisfied by the following procedure: for any given action, (1) identify the maxim on which the action is done, and (2) consider if that maxim can be willed to become universal law; if that maxim can be willed as universal law, that action is right, but if that maxim, when elevated to universal law, is contradictory, that action is wrong.

To demonstrate this procedure, I will use Kant's own example of the false promise. Consider the following scenario: I am in need of money, and I know that I can borrow this money, whether from a person or financial institution. To borrow money, I must promise to repay that money by a certain date; if I do not make this promise, I will not be given the

money. However, I know that I will not be able to repay the money. I must now consider whether or not I would be acting morally by borrowing money in this way. First, I identify the maxim of this act as: if a person is in need of something, that person may make a promise with no intention on fulfilling it in order to obtain that thing. Next, I ask myself if I can will this maxim to become universal law. If this is now universal law, any person in need of something may now make promises with no intention of following through. If this were the case, no one would enter into a promise, and the concept of the promise – and of borrowing money – would no longer be possible. By definition, a promise must include the intention of fulfillment. It is in this way that the act of making a false promise would destroy the very concept of the promise, and would thus contradict itself. Because I cannot will this maxim to be universal law, that action is wrong. Next, I will consider Kant's second formulation of the categorical imperative:

> **CI^2**: "so act as to treat humanity, whether in thine own person or in that of any other, in every case as an end withal, never as a means only…"

This second formulation allows us to apply the categorical imperative in terms of how we treat rational beings, whether that be ourselves or others. As I explained earlier, rational life is the one end in itself. If we are to respect the intrinsic value of rational life, we must never treat a human as a mere means. To treat something as a mere means is to make it a tool or object to be used in the pursuit of some end. Treating someone only as a tool or an object denies that person as an end in herself, which denies rational life as an end in itself. This, clearly, is forbidden by CI^2. However, our interactions with people do require us to treat each other as a means to some extent, so the difference between treating someone as a means and as a mere means will require further clarification.

Two important questions immediately come to mind: "what does it mean to treat someone as an end in herself?" and "what does it mean to treat someone as a means only?"

For something to be an end in itself is for that thing to be intrinsically good. To treat someone as such is to never deny that she is intrinsically valuable as a rational being. Further, in using someone as a means, the action must also foster to some extent, that person as an end. For example, the person reading this paper is using me as a means to her obtaining information. However, she is also fostering my end, which is, in a sense, intellectual fulfillment. For treating someone as a *mere* means, Onora O'Neil (p.168) interprets this to mean involving that person in an action to which she would not consent. In other words, we should ask, "if a rational person would not consent to my use of her in this way, given that she knew all relevant information, I may not use her in this way." This is still open to counterexamples; a discussion of which would fall beyond the scope of my project. Fred Feldman (p.171-178) does so and also attempts to clarify other potential interpretation, but nonetheless concludes them all to be inadequate. I understand that this will require some reckoning, but I will do so through its application in my "EMS application" section.

I will now identify the moral principles of CI^2 in terms of the basic ethical theory structure discussed earlier. For CI^2, the **theory of right conduct (TRC^2)** is: some action X is right if and only if that action treats persons as ends-in-themselves and not as a mere means. The **theory of nonmoral value** is that rational life has absolute intrinsic worth. Other things may only have extrinsic value relative to their existence as means to an end. The **theory of moral value** is: some agent X is good if and only if she acts so as to treat persons as ends-in-themselves and not as a mere means. Note here that saying someone is valuable insofar as she is a rational life is not the same as saying she is good as a moral agent. It is also important to note that the second formulation still makes the theory of right conduct most basic. In other words, I treat others as ends-in-themselves not because they are valuable; I treat them this way because I am acting out of the will to do good, guided by the categorical imperative.

To revisit Kant's example of the false promise, I must now ask, "if I borrow money from someone under the false promise to repay it, am I treating her as an end in herself and not as a mere means?" Clearly, the transactional nature of a loan requires that I use this person as a means to some extent, even if it was under a true promise. If I were to borrow this money under a true promise, I would be treating the person as an end in herself because she would consent to this in theory – or in this case, has done so expressly. However, if she knew that I had no intention on repayment, she would not consent and would therefore be treated as a mere means. Further, I am not fostering her end of being repaid; I am actually completely denying her end. Therefore, under CI^2, it would be wrong for me to borrow the money under a false promise.

Now that I have extensively explained both formulations of the categorical imperative, I can derive a decision-making procedure that encompasses the theory as a whole. If I want to know if the principle of a given action is guided by the good will – i.e., the right making feature – I will test the maxim of that action through $\mathbf{TRC^1}$. In other words, the principle of my action must be one on which every person ought to base an action of the same type. For cases in which I want to know if an action is guided by the good will, insofar as it respects persons as ends-in-themselves, I will test that action through $\mathbf{TRC^2}$. It follows that, if an action treats persons as ends-in-themselves and not as mere means, that action is based on the universal maxim CI^2, thus satisfying TRC^1 by way of TRC^2. An action that fails to satisfy TRC^1 because its maxim cannot be willed to apply to all rational beings, will also fail to satisfy TRC^2 because acting on subjective maxims denies rationality as an end in itself. Therefore, if an action fails in one formulation but satisfies the other, it can only be through the misapplication of the categorical imperative or a conflict of duties. Therefore, in situations in which the ambiguity of CI^2 leads to confusion, I will attempt to also formulate them in terms of CI^1.

It makes sense to think that an applied ethics for EMS be deontological in spirit, at least to some extent, because we as EMS providers act from a sense of duty to our community and to humanity. On the other hand, it also makes sense to consider consequences because, as many of us have seen, consequences in this field can be extraordinarily dire. It is precisely these two broad intuitions that my following application section will explore.

III. APPLICATIONS IN EMS

In this section, I will present a series of ethical dilemmas that EMTs and Paramedics may face in the provision of emergency medical care. To do this, I will first give a vignette or narrative that contains a major moral dilemma. Next, I will identify the ethical question at hand, the parties involved, the reasonable potential actions and their possible consequences, and any other factor that may hold weight in ethical deliberation. For each vignette, I will derive the right action prescribed by both ethical frameworks in their pure forms. Once I apply each theory in its strict form, I will discuss any nuances or conflict between the theories; when such nuances and conflicts exist, I will discuss supplemental resources and alternative variations. My objective in applying normative theories to these vignettes is not simply to solve a series of moral dilemmas. Instead, my goal is to engage the EMS reader to think critically about her moral intuitions and to challenge her to question existing EMS protocols. I also hope to engage all readers in an exploration of unique and perhaps unknown ethical challenges. For this reason, I have chosen topics that I think will best highlight the unique constraints of EMS and unique challenges to moral deliberation in general. Nonetheless, these are all situations that EMS providers are extremely likely to face if they have not already.

Ethical Triage

You and your partner have been dispatched to a motor vehicle collision on the highway. You are the paramedic on the ambulance, and your partner is an EMT. On your way to the call, dispatch informs you that this is a mass-casualty bus rollover with about 50 passengers on board. Dispatch also informs you that the next closest responding unit is about 30 minutes away because you work in a rural, resource-limited area. Before arriving on scene, you and your partner devise a plan of action in which the EMT will manage the less-critical patients in accordance with her skill set and you, the paramedic, will manage the more

critical patients. You arrive on scene to find the bus on its side. You and your partner immediately start to triage the patients and inform dispatch of your needed additional resources. Your partner gathers about 30 patients with minor injuries who are not in need of immediate care and 10 with moderate injuries, which the EMT begins treating.

At this point, you safely enter the bus to assess the remaining patients and find the following: 2 critically injured adults and 1 critically injured child. All other persons in the bus are clearly deceased. You quickly assess the 3 patients and consider your available equipment and supplies, making the following purely practical calculations: (1) each of the 3 patients is equally likely to die without treatment; (2) the child, patient *A*, can be saved by interventions that will require all of your available time and resources; (3) the two remaining patients, *B* and *C,* can both be saved if you do not spend any time or resources on patient A. In other words, you can save *patient A* while *B* and *C* die, or you can save *B* and *C* while *patient A* dies.

Utilitarian approach: I will first take the utilitarian approach to this scenario. My first step is to identify the ethical question at hand. All considerations that were made in the first half of the scenario were purely practical. The immediate triage of patients did not pose any ethical questions and was simply the proper way to manage the scene, evaluate resources, and assess patients. Further, the practical calculations done while assessing the four critical patients were merely to gather information. In other words, everything that I did before reaching the last 3 patients was a practical triage whereas everything after will be an ethical triage. With this information, I must now ask myself, “is it right to save the one child while letting two adults die, or is it right to save the two adults while letting one child die?” Therefore, my two options are: (1) save *patient A*, or (2) save *patients B and C.* Note that there is no possible option to save all three.

For option 1, I will now calculate its value production in reference to each patient, or affected person. Considering only effects to patient *A,* the first instance of option 1 will produce an insignificant degree of suffering and a very high degree of happiness. After the first instance, the happiness will long persist because patient *A* is a child and will theoretically have a longer life. Because *patient A* is a child, the positive value produced by survival and negative value produced by death is higher than that for an adult patient. However, to what degree will be a point of controversy. For this scenario, I will assign a value of [+3] for the value of happiness produced by a child's survival and [+2] for that of an adult based purely on potential persistence of life and to avoid making claims like *1 child = 2 adults*. However, it is possible that any additional information about the patients could change this value. In terms of patient *B,* option 1*,* the death of *patient B* would produce a negative value both in the first instance and after the first instance. This value is proportional to 2/3 that of the value for patient *A*. The only information known about *B* and *C* is that they are both adults, so their values will be equivalent. From this information, I calculate that the value of the tendency of option 1 in reference to the community as a whole is [-2].

For option 2 in terms of patient *A,* the resulting death of the patient will produce a negative value [-3] proportional to the positive value resulting from her survival; this will apply to the first and subsequent instances. In terms of patient *B,* this option, resulting in her survival, will have a positive value [+2] proportional to that of her death in option 1 for the first and subsequent instances. The same will hold true for patient *C*, giving *C* [+2] for each instance resulting from option 2. Thus, the value of the tendency of happiness for option 2 on the community as a whole is [+2]. I have calculated that the value of option 2 for the community is greater than that of option 1. Therefore, the right action is to save patients *B* and *C* and let patient *A* die, or in terms of the theory of right conduct: in this specific

scenario, saving the two adults while letting the child die is right because, of all available actions, that action best maximizes happiness for everyone involved.

Option 1	First instance	Subseq. instances	**Total**	**Option 2**	First instance	Subseq. instances	**Total**
A	+ + +	+ + +	+6	A	- - -	- - -	- 6
B	- -	- -	-4	B	+ +	+ +	+ 4
C	- -	- -	-4	C	+ +	+ +	+ 4
		Total:	**-2**			**Total:**	**+2**

Table 1: Summary of Value Calculations for Utilitarianism**.**

Kantian approach: I will now consider how I might approach this scenario as a Kantian paramedic. First, we will assume that in choosing either of the two options, I will be acting purely from the will to do the right thing, that is to treat the patient as an end in herself by saving her life. Thus, I am not concerned with the consequences of my choice, only that it be out of good will in accordance with the categorical imperative, i.e., it is done on a maxim that I can will to be universally binding. Since this scenario primarily deals with how I ought to treat other rational beings, I will first look to the second formulation of the categorical imperative. I could therefore propose the first option in the form: if I choose to save patient *A* while letting patients *B* and *C* die, am I acting in a way that treats all persons as ends in themselves and never as means only?

From this, I must now consider whether or not I am using *B* and *C* as mere means. One way I might look at this is by asking if the existence of *B* and *C* have any utility to how I treat *A*. Hypothetically, if *B* and *C* were not in the accident, the injuries to *A* would be exactly the same; thus, my treatment of *A* would be the same should I choose to treat her. I should also ask whether the clause *choosing not to do X* is a means at all. Consider this example: the construction of a shelf from Ikea is my end. Ikea included two identical tools in the box, tool *A* and tool *B*. To construct the shelf, I choose to use tool *A*. It would be nonsensical to say that I construct the shelf by means of not using tool *B*. Instead, I did so by using tool *A.* My

not using tool *B* was simply a consequence of my choice to use tool *A*; *not doing X* can never be a means but only a consequent of a choice to do something else. By this argument, not saving *B* and *C* is just a consequence of saving *A.* I could then conclude that saving *A* is right because I did not use any person as a means. However, by this very argument, I could likewise conclude that it is right to save *B* and *C*, so I should consider CI^1.

Perhaps I can find some action with a maxim that satisfies CI^1. I have three potential maxims: (1) some agent, when unable to help all, may act to help the most; (2) some agent, when unable to help all, may act to help any one person; or (3) some agent, when unable to help all, may act to help children over adults. None of the three maxims would violate $\mathbf{CI^1}$, but I should not consider maxim 2 because it will not help in determining the right action, only that I may act in the first place. I could act on maxim 1 without violating $\mathbf{CI^1}$. However, I would be borrowing my maxim from the consequences, which is wrong if I apply Kant purely. If I act on maxim 3, it is from a sense that adults have a responsibility and duty to protect children, which does not borrow from consequences. Thus, it seems Kant would require me to save the child. Note, however, that pluralistic deontological theories would require that I consider conflicting duties, in which case I would find one duty to be of a higher necessity than the other.

Conclusion and Discussion: First, I must note that this application does not imply that it is always right to save the most at the expense of the fewer for the utilitarian. Since utilitarianism grounds the theory of right conduct in value judgements of consequences, the real ethical deliberation takes place in the assigning of value. Any information about the patients could have changed my valuation. For example, If I knew only that the child theoretically has exactly four times as many years than the adult left to live, I might have proposed that the happiness value of one child's life is equivalent to four times that of the adult; in that case, I would be obligated to save the child at the expense of the two adults.

Conversely, if I learned that the adults were married with a child at home, I might ask whether it is better to leave a child without parents or parents without a child. This is all to say that my choice as a utilitarian EMT will be solely influenced by the value I assign for each patient, which will be influenced greatly by the availability of information. This also allows me far too much subjectivity in considering what I think is more or less valuable. In this way, utilitarianism is often difficult to apply, especially when less information is available. The Kantian approach to this scenario also emphasizes that EMS personnel, and humans in general, will quite often face strong conflicting duties. This does not mean Kantian deontology is inconsistent but that not all duties are absolute; for situations like these, it may be necessary to take a pluralistic approach while staying true to acting out of the good will guided by reason.

Victim or Aggressor?

You and your partner are dispatched to a domestic assault with injuries; you are instructed by dispatch to stage nearby until law enforcement secures the scene. While you are staging, you notice that another unit has just been dispatched to your incident and has an ETA of 30 minutes. Dispatch advises that you are clear to continue to the scene but there are now two patients. You arrive on scene to find that the aggressor has been critically injured following an exchange of gunfire with law enforcement. Your partner quickly assesses patient *B* while you assess patient *A,* so you note the following: Patient *A*, the assault victim, has sustained very serious, but not immediately life-threatening, injuries. If the patient is quickly transported to a trauma center, she is likely to fully recover, but if treatment and transport are delayed, severe disability is all but certain. Patient *B*, the aggressor, has sustained injuries that are immediately life threatening; if he is not immediately treated and transported to a trauma center, death is all but certain. The closest trauma center is 45 minutes away. Your EMS agency co-responds with paramedic firefighters, but they are in a fire

engine; this allows you to leave the scene without waiting for another ambulance, but you can only take one patient. Thus, if you take patient *A*, patient *B* is unlikely to survive. If you take patient *B,* patient *A* will likely survive but will have severe disabilities. If you perform a practical triage according to protocol, you must take the patient with more severe injuries, patient *B*. However, you were originally dispatched for patient *A*. Further, patient *B* is the cause of patient *A*'s injuries, so you wonder if your protocol might be requiring you to do something unethical.

To briefly summarize the relevant information: Some person *B* assaults some other person *A,* severely injuring *A*. *A* calls for help, so law enforcement and medic 1 both respond. Law enforcement arrives to help *A*. In an attempt to prevent *A* from being helped, *B* is critically injured. *B* now requires help, so medic 2 responds. Medic 1 arrives to help *A.* Medic 1 is prompted by protocol to help *B* instead of *A.* If medic 1 helps *A, B* likely dies. If medic 1 helps *B, A* is likely disabled.

Kantian Approach*:* If I take a Kantian approach to this scenario, I might first want to ask if I have any clear duty before I consider possible actions. Patient *A* is the patient whom I was originally prompted to help, and my efforts and intention to help that patient began when I responded to the call. Further, patient *A* is the victim of an assault, so I feel an even higher sense of duty to aid her. Since I have already accepted these duties and initiated care of this patient, my ethical question is not one of which patient I should help. Instead, a practical aspect of my job – the triage protocol – is calling upon me to stop helping patient *A* in order to help patient *B.* The second ambulance has the same responsibility in respect to patient *B* because the injury of *B* is the incident they are responding to. In purely practical terms, the only reason patient *B* is a consideration for me is his physical proximity to patient *A*. Thus, the ethical question posed to me is whether it would be right to abandon patient *A* in order to help patient *B*. I can now try to test this against **CI²**. While I showed earlier that choosing not

to help one patient in order to help another is not a means but a consequence, it seems that abandoning a patient to help another might be. If I were to abandon patient *A* so that I could go home early, I would consider this using patient *A* as a mere means. This is different from choosing one person over another because abandonment is an intentional act rather than a consequence. Further, she would never consent to this, and I would not be sharing in her end. Thus, it is wrong to abandon patient *A* to help patient *B* because in doing so, I would be treating patient *A* as a mere means. However, if the scenario was the inverse, I could not abandon patient *B* to save patient *A*, his victim, for the same reason; this is not contradictory *per se* because that is not the act in question. For the original scenario, the Kantian framework in its strict application tells me that abandoning *A* would be wrong. Nonetheless it seems to at least be worth considering if CI^1 gives me a clear duty to aid and assault victim over her aggressor.

I may act from a duty to never abandon a patient. I may also act from a duty to always aid the victim of violence inflicted by humanity. Hence, I can imagine if the situation were simply *B* assaults *A*, and *B* gets hurt in the process, the question would now just be a choice between aiding *A* or aiding *B*. Person *B's* end was simply to harm *A*, so if I aid *B*, I am knowingly contributing to his end of causing more harm to *A.* As soon as *B* realizes that his aid deprives *A* of her own, *B* becomes undeniably motivated at least partially by this, thus involving me in his scheme. I may not be bound to a duty to always prevent someone from causing harm to another, but I am bound to a duty to never knowingly join someone in that end. Each of these duties or maxims can satisfy CI^1 without any references to consequences. To return to the original formulation of the scenario, I can sufficiently argue that patient *B* wills, at least in part, the continuation of harm to patient *A.* Patient *B*'s fight with the police was clearly an attempt to continue to harm and deprive aid to patient *A*. Thus, for Kant, I should not knowingly join him in this end; also, the only maxim by which I could help *B*

borrows from that action's consequences. If the only maxim on which I could act to save patient *B* over patient *A* is to always prioritize the more severely injured, it is not objectively wrong *per se* but is rooted in consequences.

Utilitarian Approach: If I take a purely utilitarian approach, I can simply consider a choice between helping patient *A* or helping patient *B* because my original responsibility to one patient or the other has no real weight on the utilitarian theory of right conduct. Now, I will first be considering the option to help *A:* This option, for patient *A,* will have a net positive effect on happiness in both instances of the act because she will fully recover and will be relieved of further harm from *B*. For patient *B,* this act will have a net negative value for both instances from his death and his inability to continue harm to *A*. For myself and all other responders on scene, this will have a fairly insignificant positive effect because helping the victim would feel better in the end – not many would argue. If I consider the choice to help *B*: This will have an intense negative effect in both instances on the happiness of patient *A* because it will result in her disability and the possibility of *B* harming her again. For patient *B*, this option will have a positive effect on happiness in both instances. For the responders, this will have an insignificant negative effect on happiness.

However, I could simplify this scenario because the only significant effects are in reference to patients *A* and *B.* First, I need to compare the degrees of suffering produced by death with that produced by severe disability; since disability will produce more intense physical and psychological suffering well into the future, I should conclude disability to be more severe under these circumstances. Further there is significant psychological suffering for patient *A* resulting from her knowing that *B* was prioritized. From this, I can conclude that the choice to help patient *A* will produce less suffering for everyone than the choice to help *A.* Also, the loss of a violent aggressor from the community will have a neutral effect at worst,

but the loss of his victim will cause at least some suffering. Therefore, helping patient *A* is the right choice because that choice best maximizes happiness for everyone affected.

Conclusion & Discussion: In this scenario, we see that both theories were able to deliver a determinant conclusion from the available information without any significant inconsistencies. Further, both theories reached the same conclusion, which is also generally supported by the common moral intuition that a victim should be helped over her aggressor. While Kantian deontology does give us a definitive answer for the original scenario, a pluralistic comparison of conflicting duties might be needed in similar situations. Also, remember that any information about consequences can potentially flip the utilitarian conclusion under the same exact constraints. Some situations with victims and assailants will require different maxims, duties, ends, and means. Therefore, the EMS provider should not assume that the conclusions from this scenario can be universally applied to all dilemmas of the same nature.

Deception of a Patient

You and your EMT partner are dispatched to a residence in reference to a 78-year-old male patient with chest pain. Upon arriving on scene, the patient's wife is waiting in the driveway. She tells you that the patient does not know she called 911. She has been trying to convince him to let her take him to the hospital for his chest pain, but he insists on waiting it out. You enter the residence to find the 78-year-old patient. You notice that he clearly looks sick. You are able to convince him to let you perform an electrocardiogram, but he tells you that if you do not find definitive evidence of a heart attack, he will not let you take him to the hospital. You perform the EKG but find no clear evidence of a myocardial infarction (MI). The patient still complains of chest pain and your full patient assessment leads you to strongly believe he is having an MI. It is important to note that an EKG can indicate the

presence of an MI but it does not rule it out. You now consider if it is ethical to lie and tell the patient that the EKG shows evidence of a heart attack.

Kantian approach: I will first look at the Kantian approach because Kant does address lies of a different sort. While Kant demonstrates that telling a false promise for my own end fails **CI[1]**, I still need to determine if my lie would be done on the same maxim or on some other maxim. The maxim for the former, as I discussed earlier, *is if a person is in need of something, that person may make a promise with no intention on fulfilling it in order to obtain that thing*. One distinguishing aspect is that I did not enter into a promise with the patient. Further, I am not in need of something in the same sense; my end is strictly to benefit the patient. My maxim would instead be that *some moral agent may deceive her target if that deception is in the best interest of her target.* If I will this maxim to be universal law, however, it would be impossible to deceive my target because there is no longer a general assumption of truth when I speak. An act of deception will always require the target to first believe my deceit to be the truth. If my target knows I may deceive him, he will not believe my deceit to be true in the first place. If I still attain my end, it would not be by deception but by the target's acceptance that my attempted deception could only be in his pursuit of his self-interest. My target might very well agree with my end, but I would not be able to deceive him to attain it. Thus, lying to my patient to help him would fail **CI[1]** because the act would kill the law, so the act would be wrong.

I could have likewise considered this scenario through **CI[2]** by asking if, in deceiving the patient to help him, I am treating him as an end in himself and not as a mere means. In lying to my patient for his own wellbeing, I think that I am doing so only to treat him as an end in himself and for no other reason. I also think that I am not using him as a mere means insofar as he would agree with my use of him if he knew all of the relevant information; he does not understand the nature of his illness and he does not understand how my assessment

tools work, but I think he would agree with my assessment if he had that understanding. However, this could all be easily challenged. Clearly, if I deceive a person in pursuit of some end, the deception of that person is the tool or means by which I attain my end. However, does my sharing in the target's end clear me of using him as a mere means? Without considering the deception of my patient, does this patient actually share my end of helping him?

Onoro O'Neil (p.170) argues that when a person's stated intention ignores the predictable results of it, we infer that it was not the person's true intention. To will – not just desire – an end is to also will the means of its attainment. If I infer that the patient's end is to be helped, I would have to also infer that he wills the rational means to that end, i.e. to come with me to the hospital, so this must not be his intention if he is refusing my help. He may be misguided in pursuing an irrational end, but that is his end nonetheless. I could say that a fully rational person would share my end, but I cannot say that this patient must share my end. likewise, if consent is a necessary condition to not treating someone as a mere means, I could not use the patient in this way because it is theoretically impossible to consent to deception. Further, anytime I act to deceive a person, I am not treating him as an end in himself because deception is an attempt to deny his free will and rationality. If I am to treat rational life as an end in itself, I must respect the free will and rationality internal to it. This is precisely the same conclusion that I reached through **CI**^{1}. Thus, it is wrong to deceive my patient in this way because doing so treats him as a mere means (**CI**^{2}) and is done on a maxim that, when willed universal law, renders deception impossible (**CI**^{1}). Any act done on a maxim of deception would fail the categorical imperative in this way and is therefore always wrong.

Utilitarian Approach: My first available act is to tell the patient that I see no clear evidence of a heart attack but explain that I still think he is having a heart attack based on all

other signs and symptoms; however, all information indicates he will still refuse. On the other hand, I could tell him that he is having a heart attack and promptly transport him to the hospital. I must now consider how this will affect happiness with respect to each affected person. If I choose not to lie to the patient: the patient's happiness will be slightly increased in the first instance because he does not want to be transported [+1]. His happiness after the first instance will be greatly decreased by death in the worst case and delay of care in the best case [-4], so option 1 has a net decrease of happiness with respect to him [-3]. For the patient's wife, her worry for her husband in the first instance [-1] and her suffering from his death or illness after the first instance [-3] will have a net decrease of happiness with respect to her [-4]. Happiness with respect to myself is also decreased because I adamantly want to help the patient [-1]. Thus, option 1 decreases happiness with respect to the whole [-8]. For option 2, the happiness for the patient is decreased in the first instance [-1] but will greatly increase after the first instance once he receives proper care [+4], having a net positive effect on his happiness [+3]. Happiness for the wife [+4] is increased in both instances as is my own [+1], giving option 2 an increase in happiness with respect to everyone [+8]. Therefore, it is right for me to lie to the patient because doing so would best maximize happiness with respect to everyone.

Conclusion & Discussion: It is tempting to assume that both theories will usually yield the same conclusion and differ only in what constitutes the right making feature of the action. However, the two theories – and others – often produce directly opposing right actions. Any theory in its pure form is open to counterexamples and challenges to its basic moral concepts. Pure Kantian deontology will sometimes lead to seemingly disastrous consequences, a reckoning for which some other theory may be necessary. Likewise, pure utilitarianism will often prescribe a right action that at least seems contradictory to moral intuition. In the deception scenario, I may feel a strong duty to always act in my patient's best

interest, but my means for doing so is forbidden by the categorical imperative. For this scenario, basic moral intuition is not necessarily obvious; it is equally likely that someone would feel wrong about deceiving this patient as someone feeling wrong about the consequences of not doing so. It is important to remember that while the categorical imperative will always forbid this sort of deception, utilitarianism may forbid it or not forbid depending on the available information. The time-constraining nature of medical emergencies in the field presents a unique ethical challenge.

Termination of Resuscitation Efforts

You and your EMT partner are dispatched to a residence for a cardiac arrest. You arrive on scene to find a pulseless and apneic (not breathing) 74-year-old female patient. You and your partner immediately begin recusation efforts. In the residence, there are 3 family members and a home-healthcare nurse. The family members inform you that the patient has a do-not-resuscitate order (DNR); however, they are unable to find the documentation. The nurse confirms that the patient does have a DNR and is terminally ill. In cases such as these, you are required to contact the medical control physician for permission to terminate CPR. You call medical control and provide all information, but the physician orders you to continue CPR and transport to the hospital unless the documentation is found before. You and your partner consider whether or not to comply with this order.

If you decide to comply with this order, there are two possible outcomes, the first being the most likely: (1) resuscitation efforts remain completely futile and the hospital terminates efforts upon arrival, or (2) resuscitation efforts are successful and the patient continues to suffer from the terminal illness along with the significant complications that follow successful resuscitation. If you decide not to comply with the order, the patient will not be resuscitated, and you and your partner are now at a high risk of being terminated for insubordination and may lose your licenses. Since the physician has much more legal leeway

in his decisions, he has a much lower risk of losing his license or being sued, but the risk exists nonetheless.

Kantian Approach: I may be tempted to ask if it is right to refuse a physician's orders if I find the order to be unethical. I will quickly show that this is not at all the ethical question at hand. If I refuse to follow the physicians order, I am acting on the maxim *someone may refuse to follow an order.* Willing this to be universal law would have no effect on the possibility of an order because an order does not carry with it the assumption – but rather, the strong desire – that it will be followed. Conversely, if I will it universal law that someone must always follow an order, it renders it impossible to follow an order because to *follow* an order requires the free will to either follow it or not follow it. This is essentially the same as asking if it is right to refuse to perform a wrong action.

Instead, I actually want to know if the act I was prompted to perform – following the physician's order to continue resuscitation efforts – is wrong; if it is wrong, I am forbidden from doing so. I will consider CI^2 because I think this action to be wrong by the way it requires me to use the patient. First, I must determine what my end is in performing this action. Clearly, the documentation issue is the only reason I was ordered to continue resuscitation; if the DNR is found, it is no longer an option. Further, I have sufficient evidence that the patient does not want to be resuscitated. She is terminally ill, and the nurse and three family members all confirmed that she did not wish to be resuscitated. Thus, my end is only to avoid the potential repercussions of insubordination. This end is not shared at all by the patient, but instead directly denies her ends altogether. In following the order, I am also using the patient as a means to my end. Performing CPR on someone to save that person is not using that person as a mere means because I am doing so to foster her as an end in herself. She would theoretically consent to my use of her in this way. However, almost no one, if any, would consent to this use for any other ends. One might try to argue that I am not

using a person in this way because the person is now dead, but cardiac arrest is not sufficient criteria for death; clearly, reanimation is a possible outcome. Thus, it would be wrong to follow the physician's order because in doing so I would not be treating the patient as an end in herself but as a mere means to my own end.

Utilitarian Approach: Now, I will consider how the utilitarian would approach this scenario. It is not necessary or helpful to the utilitarian to determine maxims or prompts as I did for Kant. Instead, I need only ask which action of all available actions best maximizes happiness for everyone. My only two options in this scenario are to continue or discontinue resuscitation efforts. That being said, the unpredictable nature of the consequences of both available actions will make my value determinations more complicated. Also, I must consider the patient, 3 family members, myself, my partner, and the physician as directly affected persons.

First, I will consider the option to continue resuscitation. The patient is the person most immediately affected by this action, so I will consider her first. Since it is most likely that resuscitation will be unsuccessful, this potential consequence will hold more weight, but the possibility of reanimation must be accounted for nonetheless. If this is the case, the affects to happiness of the patient are likely neutral but possibly detrimental, so I will give this a negative value to account for that possibility [-2]. Regardless of the effort's fruition, the happiness for each family member will be decreased in both instances because they do not want to see the patient suffer {[-1-1] x 3}. This choice will have a neutral effect on the physician in both instances because it would be nonsensical to say that this choice adds to his happiness; it merely avoids the decrease of happiness [0]. Since EMS crewmembers are the utilitarian moral agents, they would not feel guilty or particularly satisfied if they see this as the right action, and the avoidance of job loss would simply avoid loss of happiness, so it is

essentially neutral [0]. Thus, continuation of efforts would have a net decrease of happiness for the whole [-8].

If I choose to discontinue efforts, this action would have a neutral effect on the patient because it results in her death – or rather the *non*-reversal of her death – as she willed [0]. This would also have a neutral affect for the family members because it merely avoids suffering [0]. This choice would have a neutral effect on the physical in the first instance, but the potential legal repercussions will have a negative effect [-2]. For myself and my partner, loss of employment and potential loss of our licenses after the first instance will have a negative effect greater than that for the physician {[-4] x 2}. Thus, the discontinuation of efforts will have a net negative effect on happiness for the whole [-10]. The decrease in net happiness caused by the discontinuation of CPR [-10] is greater than that caused by the continuation of efforts [-8], so I must continue efforts and transport the patient to the hospital.

Continue	First instance	Subseq. instances	**Total**	**Discontinue**	First instance	Subseq. instances	**Total**
Patient	[0] [-2]	[0] [-2]	-2	Patient	[0]	[0]	0
Family (x3)	[-1] x 3	[-1] x 3	-6	Family (x3)	[0]	[0]	0
Physician	[0]	[0]	0	Physician	[0]	[0] [-2]	-2
EMS (x2)	[0]	[0]	0	EMS (x2)	[0]	[-4] x 2	-8
		Total:	**-8**			**Total:**	**-10**

Table 2: Summary of Value Calculations for Utilitarianism**.**

Conclusion & Discussion: It is interesting to point out that, in this scenario, basic moral intuition would almost always lead the paramedic to think that following this physician's order is morally wrong; I cannot go as far as to say that the paramedic will always – or even usually – refuse the order, but she will almost always feel a sense of guilt if she does not. Kantian deontology often coincides with basic moral intuition as it looks to show the rational basis for many of our commonly held intuitions. In this sense, Kantian Deontology, has applicability insofar as the information necessary to make ethical judgements is accessible through reason alone. For this same reason, it has explanatory power

as well. It also has internal support in that it reaches verdicts that are consistent with considered moral beliefs. In contrast, Utilitarianism falls short on the same points. Often, utilitarianism will conflict with our considered moral belief, but this alone is not sufficient reason to reject it altogether. Instead, I should consider other ethical theories too or employ a type of Kantian-utilitarian pluralism, so that I may determine a hierarchy of ethical obligations. There may be a scenario similar in nature to the one above but with consequences dire enough to sway basic moral intuition. Likewise, utilitarianism might reach the same conclusion as Kant in a similar scenario.

IV. CONCLUSION

To quickly recap what I have gone over, I began by briefly painting a picture of daily life in EMS and addressing the need for such a project. Next, I provided an introduction to the study of ethics followed by an in-depth discussion of Utilitarianism and Kantian Deontology. Finally, I applied my reconstruction of both theories to a series of potential scenarios from EMS. It was my intention that this project contribute to both EMS and the field of philosophy. It was not, however, my intention to argue for or against any theory, nor was it to prescribe that the EMS provider act in accordance with any one theory or with my own conclusions. This project is meant to be a first step in providing EMTs and Paramedics with an educational resource relevant to the nature of the field; however, this is merely a first step. I specifically chose the scenarios that emphasize what I believe to be the most important issues we face in EMS, and I have shown that a pluralist view is needed in creating a unique applied ethics for such dilemmas. In applying normative theories to EMS scenarios, I have encountered some unique and challenging real-world constraints that are not always found in ethical thought experiments. Scenarios like these offer the ethicist a unique testing ground for moral theories, and this type of academic approach to ethics offers EMS providers an opportunity to match the public's unparalleled expectations for superior moral reasoning.

WORKS CITED

American Academy of Orthopaedic Surgeons [AAOS] (2017). Preparatory. In A. N. Pollak & D. Edgerly (Eds.), *Emergency Care and Transportation of the Sick and Injured* (11th ed., pp. 1–20). Burlington, MA: Jones & Bartlett Learning.

American Academy of Orthopaedic Surgeons [AAOS] (2017). Preparatory. In A. N. Pollak & D. Edgerly (Eds.), *Emergency Care and Transportation of the Sick and Injured* (11th ed., pp. 9–10). Burlington, MA: Jones & Bartlett Learning.

American Academy of Orthopaedic Surgeons [AAOS] (2017). Preparatory. In A. N. Pollak & D. Edgerly (Eds.), *Emergency Care and Transportation of the Sick and Injured* (11th ed., pp. 102-103). Burlington, MA: Jones & Bartlett Learning.

Code of Ethics and EMT Oath. (n.d.). Retrieved November 10, 2019, from https://www.naemt.org/about-ems/emt-oath.

Kraut, Richard. "Altruism." *Stanford Encyclopedia of Philosophy*, Stanford University, 31 Aug. 2020, plato.stanford.edu/entries/altruism/.

Sinnott-Armstrong, Walter. "Consequentialism." *Stanford Encyclopedia of Philosophy*, Stanford University, 3 June 2019, plato.stanford.edu/entries/consequentialism/.

Sinnott-Armstrong, Walter. "Consequentialism." *Stanford Encyclopedia of Philosophy*, Stanford University, 3 June 2019, plato.stanford.edu/entries/consequentialism/.

Timmons, M. (2003). *Conduct and Character: readings in moral theory* (4th ed.). Belmont, CA: Wadsworth.

What is EMS? (n.d.). Retrieved October 20, 2019, from https://www.ems.gov/whatisems.html.