AUSTRALASIAN JOURNAL OF
PARAMEDICINE

PARAMEDICS AUSTRALASIA

Commentary

COVID-19 – legal and ethical implications for your practice

Ruth Townsend BN, LLB, LLM, DipParaSc, PhD is Senior Lecturer and Honours Program Coordinator[1]; Michael Eburn BCom, LLB, BA(Hons), LLM, MPET, PhD is Associate Professor[2]

Affiliations:
[1]Paramedicine Faculty of Science, School of Biomedical Sciences, Charles Sturt University, Bathurst, New South Wales
[2]Australian National University College of Law, Canberra, ACT

https://doi.org/10.33151/ajp.17.796

Abstract

Most day-to-day decision making of paramedics is made in an environment where resources are not truly scarce, or not soon likely to be. Paramedics are therefore able to apply an ethical approach to their work that upholds their duty to provide patient-centred care that is in the best interests of the patient. Paramedics can and do apply a broader community-minded approach to triage at mass casualty events. However, what may be new and associated with the unprecedented public health emergency that is COVID-19 is that paramedics will now be required to make such rationing decisions across a much longer period of time for a far larger number of people. This short commentary aims to begin the discussion about the legal and ethical changes to paramedic practice that are likely to occur over the next 6 to 12 months in response to the COVID-19 crisis.

Keywords:
COVID-19; paramedic; ethics; medical services; law

Corresponding Author: Ruth Townsend, rtownsend@csu.edu.au

Most day-to-day decision making of paramedics is made in an environment where resources are not truly scarce, or not soon likely to be. Paramedics are therefore able to apply an ethical approach to their work that upholds their duty to provide patient-centred care that is in the best interests of the patient. Paramedics can and do apply a broader community-minded approach to triage at mass casualty events. And by this we mean that paramedics do not forsake the patient as an individual but rather decisions made about resource allocation are shifted from giving every individual the maximum number of resources available and necessary to save the patient, to a rationing approach that allows paramedics to make decisions about the minimum amount of resourcing necessary for a patient's survival and that leaves further resources (that in other circumstances would be given to that patient) available for others who have an equal chance of a good outcome. These extraordinary triage rules for resource allocation currently exist but they are rarely used.

This method of managing resources is usually time-limited and the number of people affected by the decision making is also relatively limited. This utilitarian approach to managing resources is not new to paramedics. However, what may be new and associated with the unprecedented public health emergency that is COVID-19 is that paramedics will now be required to make such rationing decisions across a much longer period of time for a far larger number of people. Paramedics will be faced with a conflict of duty between their duty to the patient to provide patient-centred care, and their duty to the broader community to limit the use of public health resources for the greater good. It is acknowledged that 'significant moral distress is likely to arise for providers who must adhere to disaster-based protocols that require giving or withholding treatment, especially life-sustaining treatment, over the objections of patients or families' (1). This short commentary aims to begin the discussion about the legal and ethical changes to paramedic practice that are likely to occur over the next 6 to 12 months in response to the COVID-19 crisis.

On 13 March 2020, the Paramedicine Board of Australia issued a joint statement alongside all other registered health professions setting out the regulators' response to the COVID-19 crisis. The Board notably said, 'we recognise that in these challenging circumstances, there may be a need for you to adjust established procedures to provide appropriate care to patients and clients' (2). It is inferred from the statement that the regulator has recognised that in the unique situation of being faced with a serious pandemic, there will be decisions that have to be made that may be contrary to established norms of practice for paramedics. The Board goes on to say:

> 'if a concern is raised about your decisions and actions, as always, the specific facts will be considered, including the factors relevant to your working environment. We would also take account of any relevant information about resources, guidelines or protocols in place at the time. The universal prevailing principle in dealing with large numbers of patients in situations where there are resource limitations is to always do the greatest good for the greatest number' (2).

Although most paramedics are familiar with the concept of triage, which is founded on the utilitarian philosophy of providing the greatest good for the greatest number, the experience of actually applying this philosophy in a pandemic is unique to this generation of Australian paramedics. Understanding how to 'do the right thing' (ie. the ethical thing) in such a situation is likely to be a complex issue and therefore a source of confusion. We would argue that it is critical that paramedic services develop a 24/7 clinical ethics framework resource that provides support to clinicians experiencing uncertainty and distress and if possible, set up a consultation group for the most complex and difficult cases. Further, ambulance services who have policies that do not currently support paramedics autonomously making decisions to leave patients at home rather than transport them to hospital, or have a policy that supports leaving patients at home as an exception rather than the rule, should amend this policy. There is no lawful or ethical reason why paramedics working in any state or territory would not be sufficiently qualified to make a decision as to whether a patient should remain in their home. Indeed, if the decision is an ethical one, then the benefit to keeping a patient at home is likely to outweigh any potential risk they may face in going to hospital (with the exception of cases who require high level intervention and are likely to be saved).

Paramedics will not only be required to make decisions that involve leaving more patients at home, but they will have to adapt to the fact that as resources become scarcer operational quality will drop. They will simply not be able to provide the level of individual care that they have provided in the past. It is likely that supplies of drugs and other equipment will reduce. Staffing levels will also likely reduce, where intensive care paramedics would normally be responded to certain jobs, it is likely that they will no longer be deployed to patients suffering from certain conditions. It may be necessary for others to perform atypical roles. For example, students or lay volunteers may be required to perform roles that only an employed paramedic may have performed previously. It is also likely that certain interventions used for particular purposes will no longer be able to be used. For example, therapies such as bag-valve-mask ventilation, nebulisers and airway manoeuvres will be restricted or avoided because of the severe risk posed to paramedics by generating viral aerosols in an enclosed space.

The legal standard of care that will be expected of a paramedic working under these unique pandemic conditions will remain 'was the defendant's conduct reasonable in all the circumstances?' However, what may alter is what might be

considered ‘reasonable care’. It is likely that what is considered ‘reasonable care’ in a pandemic is not the same as ‘reasonable care’ under normal circumstances. The ‘reasonable’ standard of care is the standard of care established by the defendant’s paramedic peers, associated clinical guidelines, policies and codes of conduct. Paramedics should know that the statement issued by the Paramedicine Board of Australia is essentially providing support and reassurance to paramedics that the regulator is aware of the potential for the standard of ‘reasonableness’ to shift and that paramedics should not practise defensively in the hope of avoiding being sanctioned by the regulator. Paramedics are still required to do the best they can for their patients, but there is a recognition that there are limits now to what that may entail that perhaps did not exist before.

In short, extraordinary times require extraordinary measures and it is the case that paramedics will be on the frontline having to make decisions about the use of the limited public resources available including staffing, equipment, drugs, transportation and other interventions. The ethical model formally relied on by paramedics to put each individual patient’s interests first, is likely to be superseded by an overriding obligation to the broader community that will alter the resources given to individual patients. Provided the justification for the decision-making regarding the allocation of resources is informed by strong clinical assessment in line with registered paramedic (new) norms, that is, decisions are made on the basis of objective clinical criteria not patient identity criteria (such as race, gender, religion), then paramedics can be confident that they will be acting ethically and legally to provide the best care they can under immensely challenging circumstances.

Conflict of interest

The authors have no competing interests. Each author of this paper has completed the ICMJE conflict of interest statement.

References

1. Berlinger N, Wynia M, Powell T, et al. Ethical framework for health care institutions and guidelines for institutional ethics services responding to the novel coronavirus pandemic. The Hastings Centre, NY; 2020. Available at: www.thehastingscenter.org/ethicalframeworkcovid19/
2. Paramedicine Board of Australia (2020). Statement from the Paramedicine Board and AHPRA in response to COVID-19. Available at: www.paramedicineboard.gov.au/News/2020-03-12-covid-19.aspx