

Ethical principles in healthcare



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Introduction

The Department of Health (DoH) (2003) highlighted the importance for all professions currently regulated by the Health Professions Council to demonstrate competence through continuing professional development (CPD). CPD is a systematic, ongoing, structured process that encourages the development and maintenance of knowledge, skills and competency that assists us in becoming better practitioners (Chartered Society of Physiotherapy (CSP), 2003). As a result of the Health Act (1999) and for registration with the Health Professions Council (HPC), CPD is a legal requirement (HPC Standards of Proficiency, 2007) that must be completed in accordance with the (HPC) Standards of Continuing Professional Development (HPC, 2006). This essay allows for demonstration of life-long learning using evidence from clinical practice and critical evaluation to contribute to my CPD.

Learning outcome 5 will be demonstrated throughout this essay. Throughout this essay the reader is directed to the appendices to support theory with evidence of practice. I considered my motivations for undertaking CPD before writing this essay and reflected upon them again on completion (Appendix 1).

Demonstrate professional behaviour with an understanding of the fundamental, legal and ethical boundaries of professional practice.

Beauchamp and Childress (2001) identify four ethical principles; Autonomy, Beneficence, Non-maleficence and Justice. These ethical principles can be used to morally reason whether an action or decision is right or wrong when

used in conjunction with a set of guidelines (Kohlberg et al, 1983).

Professional codes of conduct are developed within moral, ethical and legal frameworks to help guide and regulate practice (Hope et al, 2008). Every practitioner has clinical autonomy, therefore they are professionally and legally accountable for their actions. The following will discuss the importance of consent and duty of care for both legal and ethical reasons with regards to case 1 (Appendix 2), encountered on practice placement 6 (PP6).

Rule 9 of the HPC standards of conduct, performance and ethics (2008) states you must gain valid consent from a patient for any treatment you may perform or else you could face trial for assault, battery or negligence under civil or criminal law (Hendrick, 2002). It is a fundamental ethical principle that every person has a right to exercise autonomy (Article 9; Human Rights Act, 1998) and is reflected in the Core Standards of Physiotherapy Practice (CSP, 2005). Performing a procedure without gaining consent, undermines the moral principle of respect for patient's autonomy and human dignity (Sim, 1986). However, inability for Patient X to conform to the Mental Capacity Act (2005) meant he was treated in his best interest in adherence to section 1. 5 of this act and Rule 1 of the HPC (2008) standards of conduct, performance and ethics.

Assuming the medical management of Patient X, a legal and professional duty of care was established (Rule 6; HPC, 2008). As part of this duty and in accordance with standard 2 of the CSP Core Standards of Physiotherapy, all interventions were explained to patient X despite his inability to consent. Had I not treated Patient X on the basis he had swine flu, this would have

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been failing to do justice to him, acting outside of the Disability Discrimination Act (2005) which states everyone should have equitable access to and utilisation of services regardless of disability and also Article 14 of the Human Rights Act (1998) in that no one should be discriminated against based on their health status. The Bolam Test (1957, cited in Dimond, 1999) states if duty of care to a client is breached and subsequent harm to the patient occurs, professional standards have not been kept and therefore negligence can be assumed. Although not legally binding, the CSP rules of professional conduct effectively have the same status as law and failure to comply with them means they may not only be used in disciplinary hearings but also in legal proceeding as a civil case under the tort law of negligence (Dimond, 1999; Hendrick, 2002).

In summary, a sound understanding of the legal implications surrounding consent and duty of care can help avoid unwanted litigation, however they should not undermine the ethical implications. Appendix 3 demonstrates how I have learnt from this experience.

Assess the needs of a range of service users and, with reference to current professional knowledge and relevant research, apply, evaluate and modified physiotherapeutic intervention

A service users is anyone who utilises or is affected by a registrants service (HPC, 2008). The complex needs of a service user encompass a range of issues including social, environmental, emotional and health related, the extent of which varies from person to person. For the purpose of this essay, the physiotherapeutic management of two patients treated whilst on PP6

with differing severities of chronic obstructive pulmonary disease (COPD) exacerbations (Appendix 4) will be discussed.

The National Institute for Health and Clinical Excellence (NICE) guidelines (NICE, 2004) in conjunction with the guidelines for physiotherapy in respiratory care (British Thoracic Society (BST), 2008) advocates the use of active cycle of breathing technique (ACBT) with expiratory vibrations on the chest wall for the treatment of COPD to help aid airway clearance.

Inability for patient A to comply with ACBT indicated the use of manual hyperinflation (MHI) to passively inflate the lungs and aid mucociliary transport (Ntoumenopoulos, 2005). As identified by Finer et al (1979), atelectasis is a common problem observed in mechanically ventilated patients for which MHI has been found to be beneficial in reducing it in a well controlled clinical trial by Stiller et al (1996), scoring a PEDro rating of 6/10.

Absence of a cough reflex in patient A, resulted in sputum retention and the increased risk of infection indicating the use of suctioning (Pryor and Prasad, 2002) by which, copious amounts of viscous secretions were cleared.

Shorten et al (1991) supports the use of saline instillation to loosen secretions prior to suctioning however, conflicting arguments by Blackwood (1999) and Kinloch (1999) question its effectiveness. Patient B's compliance with ACBT replaced the need for MHI and suctioning.

Patient A developed bilateral shoulder subluxations due to his lengthy intubation for which subluxation cuffs were applied, as suggest by Zorowitz et al (1995) with positive effect. Despite this study being on stroke patients, the results can be generalised to other patient groups as proved.

The importance of mobilising patients with regards to respiratory function is highlighted by Ciesla (1996), however mobilisation of critically ill patients is restricted as they are often non-ambulatory. A high quality, randomised control trial using fifty-six participants by Mackay et al (2005), identified mobilisation as superior to other respiratory techniques, therefore Patient B was encouraged to sit out and treated using a graduated walking program. In the case of Patient B, mobilisation constitutes any change in position therefore the use of postural drainage positions and positioning into the cardiac chair setting on the bed were used (BTS, 2008).

The range of problems service users present with means practitioners need to be adaptable, drawing on current evidence, professional knowledge from different fields of physiotherapy practice and experiences through CPD to deliver individualised patient-centred care.

Appraise self management of a caseload and modify practice accordingly, demonstrating effective teamwork and communication skills

Caseload management typically refers to the number of cases handled in a certain timeframe by an individual for which they have a duty of care towards (Scottish Executive, 2006). It is the management of time effectively through appropriate priority-setting, delegation, and allocation of resources to meet the service demand of its users (Curtis, 2002). Self-management of a caseload and adaptability to changing circumstances is expected of a registrant (HPC, 2008).

Well developed time management skills can make a workload more manageable and improve the effectiveness of treatments and quality of time

with patients. Prioritising patients to the order in which they will be seen based on their needs is encouraged by SARRAH (2010), however Nord (2002) argues whether it can be justified to prioritise those in most need if their potential benefit may not be as great as those in less need. In my experience prioritisation is dependant on a variety of factors for example, the trust where PP6 was completed, enforced protected meal times which did not run alongside staff meal times. Therefore, to prevent there being a void in the day, patients were still prioritised according to need but consideration had to be given to see patients that would be eating first and treat those that would not be during protected meal times.

It is essential to consider that a therapists workload includes not only patient care, but also administrative and research tasks in which delegation to others can be a valuable strategy to assist with workload management. Curtis, (1999), identifies the need for practitioners to show greater awareness of other disciplines competencies so delegation can be more effective. Feedback systems should be enforced to ensure task completion and objectives are being met (Curtis, 2002).

Inter-professional collaboration refers to the process by which different disciplines work together to improve healthcare (Zwarenstein et al, 2009). Poor collaboration amongst healthcare professionals contributes to problems in quality of patient care and consequently poorer outcomes (Zwarenstein and Byrant, 1997). Liaison with members of the multi-disciplinary team (MDT) is encouraged by Shortell and Singer (2008) as practitioners are less likely to work off their own autonomy, ensuring patient safety, as demonstrated during handover in (Appendix 5).

The learning objectives on PP6 to develop MDT collaboration and caseload management have been achieved as demonstrated in the feedback from my educator (Appendix 6) which identifies that improvement in self confidence will allow further development of the skills discussed.

Demonstrate partnership with more junior students and/or appropriate others through the development of mentoring skills

Mentoring is a process aimed at transferring knowledge, skills and psychological support from a more experienced person to a less experienced person, where the desired outcome is for both persons to achieve personal and professional growth (Anderson, 1987). An effective mentor facilitates, guides and empowers the mentee in becoming an independent learner (Coles, 1996) in which the relationships developed are based upon mutual respect, trust, confidentiality and shared beliefs and values (Lyons et al, 1990). The CSP (2005) acknowledges the importance of integrating mentorship into CPD, in which the mentor develops a range of skills transferable to other CPD activities. This section focuses on peer mentoring as a concept, its practice and clinical application on an informal basis.

Having identified the characteristics of a mentor (CSP, 2005), a SWOT analysis (Appendix 7) was completed to assist recognition of my personal learning needs.

There are four stages to the mentoring life cycle (Appendix 8), in which the mentor needs to adopt and develop new skills to accommodate the mentee and guide them through the process.

A qualitative study using a moderate sample size by Chan and Wai-Tong (2000) encourages the use of learning contracts (Appendix 9) to help establish rapport and facilitate autonomous learning which aids progression to stage two of the cycle. This is further supported in a recent review of the literature by Sambunjak et al (2009).

Gopee (2008) recognises the importance of analysing the mentee's needs. Foster-Turner (2006) states that different people approach the learning process in different ways therefore, matching the learning styles of the mentor and mentee will produce a more productive and successful relationship (Mumford, 1995; Hale, 2000). Honey and Mumford (1992) suggested people tend to have a predominant learning style and can be classified as activists, reflectors, theorists or pragmatists (Appendix 10). Boud (1999) identifies raising self-awareness as an essential tool used in lifelong learning and through analysis of learning styles using Honey and Mumford's (1992) questionnaire, this allowed for reflection on the style of learning that would best suit the mentee to help meet their learning needs (Foster-Turner, 2006) (Appendix 11).

As identified by the learning style inventory, the mentee and myself were both reflective learners, therefore we arranged sessions where we could reflect on a clinical experience and discuss how new learning could be applied to future events.

A feedback form from the mentee (Appendix 12) and a SWOT analysis (Appendix 13) demonstrates how through increased self-awareness and review of the literature, I have developed a better understanding of the

mentoring process, the skills required and its application in into clinical practice. Developing others is central to current and desired practice (DoH, 2000a, 2000b, 2001, 2002) in which mentorship offers all the key attributes to the process. Preparation of an individual for this role, through self assessment, is central to its success, in which the skills developed are lifelong and can enable development into management and leadership roles later on in life.

Demonstrate skills of career-long learning

Lifelong learning is used synonymously with CPD and is concerned with practitioners critically reviewing their skills and knowledgebase with the ultimate goal of providing a better standard of care to all service users (French and Dowds, 2008). A recent inquest into a practitioner who did not maintain his competencies, demonstrates the possible consequences of poor CPD (Appendix 14). Appendix 15 details a range of formal and informal activities that can be undertaken to contribute towards CPD, evidence of which can be documented in a portfolio.

The importance of staff development is recognised by the DoH documents (2000a, 2000b, 2001, 2002) which sets out the Governments vision of an NHS that prepares allied health professionals with the skills to take advantage of wider career opportunities and realise their potential. By using the competency based framework; The NHS Knowledge and Skills Framework (2004), physiotherapists can participate in development reviews which identify development opportunities and contribute to the fulfilment of personal development plans.

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