

# Law and ethics around a clinical situation essay sample



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The aim of this assignment is to identify and outline a clinical situation that occurred whilst on placement. It will explore the ethical, legal and professional principles around the 'Do Not Resuscitate' (DNR) order; it will also discuss ways that the law and ethics enlighten the effects and actions around this.

To protect the patient's confidentiality and to adhere to The Nursing and Midwifery Council's 'The Code' (NMC 2008) a pseudonym will be used. Throughout this assignment, the patient will be referred to as Mary.

Mary is 76 years old and was admitted to the ward with breathlessness and severe pain in her right side. She was found to have pleural effusion caused by her secondary breast cancer; this meant that the cancer cells had spread into the membrane lining of her lungs.

Mary had previously been treated for this condition and had had discussions with her consultant about sealing the two layers of the pleura together to prevent the fluid from building up again. She was malnourished due to a decline in her appetite and appears to be deteriorating rapidly. The Multidisciplinary team (MDT) caring for Mary became increasingly concerned about her wellbeing and contacted Mary's family asking them to attend a consultation with the MDT. During the meeting Mary's family informed the doctors of a 'living will' their mother had signed several years ago. She had made it clear that if her cancer spread she did not want any life saving treatment that would prolong her agony. In light of this and a lengthy discussion with Mary's family about her condition and other factors, it was

decided that a DNR order was to be put in place and documented within Mary's Medical file.

Was the writing of this DNAR, ethically or legally sound?

A DNR order gives the rescuer the permission not to attempt resuscitation this would be based on the patient's medical condition. (Thygerson and Benjamin 2005). However, Jevon (2001) argued that patients maybe successfully resuscitated and continue a good quality of life. On the other hand McDermott (2002) believes that patients who are brought back to life experience the prolonged dying process and this denies them dignity and a peaceful death.

The Nursing and Midwifery Council (NMC 2008) ' The Code' states that registered nurses are “ personally accountable for ensuring that you promote and protect the interests and dignity of patients and clients, irrespective of gender, age, race, ability, sexuality, economic status, lifestyle, culture and religious or political beliefs. 2. 2.

The decision-making process on the future and the care desired for the dying person (Mary) is complex and can be distressing. (Payne, Hardey and Coleman 2000). One approach to ethical issues would be through, weighing and balancing the four basic principles: autonomy, beneficence, non-maleficence, and justice. (Mauk and Schmidt 2004). However, the consultant in charge of Mary's care had the overall responsibility for the DNR decision. This was made after a consultation that had considered all of the aspects relating to her condition.

The views of the MDT, Mary and her family may all be valuable in forming the consultant's decision. (Payne, Hardey and Coleman 2000). Once a decision has been made, it must be communicated effectively to all of the clinical staff who maybe involved in Mary's care. Any discussions or decisions should be documented signed and dated in Mary's records. (NHS 2001)

Communication is essential in ensuring that those who care for the patient are fully informed. By communicating with relatives and multidisciplinary team about the DNR order eases unnecessary anxiety, misunderstanding and stress. When a DNR decision has been put in place, it is important to explain why. A DNR decision is based on the quality of life considerations, and the patient cannot express a view, the opinion of relatives or people close to the patient may be sort with regards to the patient's best interests. (BMA 2007)

Jevon (1999) indicates that if a nurse believes that cardiopulmonary resuscitation (CPR) will not be appropriate for a particular patient, or has been made aware that the patient does not want it in the event of a cardiac arrest, they should raise the issue to senior medical staff at the earliest opportunity.

The Resuscitation Council UK (2004), state that when a patient is in their last stages of an incurable disease and death is expected, CPR will most likely be unsuccessful. Furthermore, the decision not to attempt CPR applies only to CPR and not any other treatment, treatment and care appropriate for the patient will continue.

Life and death decisions over whether or not a person is to be resuscitated can lead to difficult situations for nursing staff and others. Clarity of instructions based strongly on the legal principles is essential both to protect the rights of the patient and to protect the position of staff. (Dimond 2004)

Individual decisions and policies regarding CPR ought to comply with the Human Rights Act 1998. The act includes most of the rights set out in the European Convention on Human rights into the UK law. To meet requirement within the Act, health professionals should show that their decisions are well matched with the human rights as set out in the articles of the convention. (BMA 2007)

In 2002 Ms B a mentally competent 43 year-old woman had her Human Rights violated. After a devastating illness left her to become tetraplegic, and paralysed, she no longer wished to be kept alive by means of artificial ventilation.

She said in evidence that she was a Pentecostal Christian but this illness had dented her belief. The doctors acted unlawfully and overrode her refusal of life-preserving.

One year later Ms B finally went to court. Once there, the legal decision was obvious, that her right to choose must be respected. This violation breached the Human Rights Act for failing to accede to her wishes. (Hamilton 2002)

It took her a year to get to court. Once there, the legal decision was obvious, that her right to choose must be respected. She was a most impressive woman and I had rather hoped she might live and inspire others but given

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the choice to which she was entitled she required the ventilator to be turned off. Since a competent adult may refuse medical treatment, even if the likely result will be their own death. Refusal may be for reasons which are rational, irrational, unknown or non-existent. (Parker and Dickenson 2001)

The valued decisions that doctors occasionally used in order to restrict patient's access to their desired treatment raised obvious concerns about protecting autonomous patients from unwanted medical paternalism. (Rubin 1998). Paternalism within health care mirrors that of a father and child, whereas the father has the child's best interests at heart and guides them through decisions. Doctor paternalism sometimes forces the patient into making a decision without considering the patients values or beliefs, encouraging them to be the passive recipient of healthcare. Today we seem to be steering away from paternalism and towards respecting a patient's autonomy. (Bowman, Spicer and Higgs 2007).

Provisions particularly to decisions about attempting CPR include the right to life, to be free from inhuman or degrading treatment, to have respect for privacy and family life, plus the freedom of expression, which includes the right to hold opinions, to receive information and to be free from discriminatory practice in respect of these rights. The aim of the act is to promote human dignity and clear decision-making, is reflected in these ethical guidelines. (McDermott 2002)

Dimond (1995) states that within the UK the legal system is divided into two sections; Public Law that is concerned with the order of society and Private Law that considers mainly disputes between individuals. This is then divided

again into Criminal Law that deals with actions or behaviours that are seen as wrong and Civil Law is which deals with conduct and conflicts between people. The law is derived from statute and case law. Brooker and Waugh (2007) describe statute law as an act of parliament, which denotes legislations such as: – The Mental Health Act, The Children Act, Health and Safety at Work Act and The Human Rights Act. McHale and Tingle (2001) indicate the case law as a subject to a system of standards where an earlier decision made by a higher court must be followed by a lower court.

McHale and Tingle (2001) reveal that there is a third law ‘ profession law’ that is governed by the NMC. This corporate body regulates the nursing profession with legal requirements that must be adhered to. It guides the nurses into making the right decisions when planning and delivering care. Within the nursing profession the issue of neglect is the most frequently abused section of the law. This is due to nurses taking on extended roles in patient care, which involves more responsibility and accountability.

The ethical duty to benefit patients is reflected by a legal and professional duty of care requiring professionals to treat patients with all appropriate care and skill. Professionals who fall short of their duty and cause harm to their patients may be found negligent. Being found negligent does not imply that the harm was intended but in determining this, the Bolam Test (Bolam v, Friern Hospital management Committee 1957) would be applied. The test is an English tort law case that lays down the typical rule for assessing appropriate standards of reasonable care in negligence cases involving skilled professionals. Where the defendant has represented themselves as having more than average skills and abilities, this test expects standards

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that must be in accordance with a responsible body of opinion, even if others differ in opinion. (BMA 2005)

Pierce (1997) identifies that registered professional nurses are in the best position to advocate for the rights of their patients and are frequently involved in ethical issues and ethical decision-making processes. Ethical dilemmas arise daily when the nurse is confronted with a choice, in which ethical reasons both for and against the choice are equally desirable.

Perspectives (1997) declares that many nurses have faced and will face the ethical dilemma of the do not resuscitate (DNR) order. Ethics is a study of principles that are right or wrong behaviours. These principles encircle end of life decisions and resuscitation helping the nurse to understand the individual's values and beliefs. (Baskett and Nolan 2005)

These principles should be the ethical key to deciding a DNR order. Butts and Rich (2005) distinguishes these principles as autonomy, which is the prime principle for recognising that patients are people that are entitled to human rights such as choice, privacy, treatment, and decisions about their own lives. Beneficence: which means the duty to do good and help patients by promoting and safeguarding their health and wellbeing. Non-maleficence imposes a duty to do no harm or to minimize harm and lastly, the most complex of the principles, justice that requires no discrimination of sex, race, religion, age and so on.

Although all decisions should attempt to balance all four principles, it is easy to dwell on one and compromise the others. Autonomy is usually the



dominant principle this is because of the importance placed on the patient, whether they will consent to treatment or refuse. (Kinsella and Booth 2007)

Deontology and utilitarianism are the two most recognized ethical theories in healthcare practice. While they provide directly contrasting or opposing philosophies, the contrast of right and wrong is central to both. (Tschudin 1992). Edwards (1996) identifies that the principle of Non-maleficence is not to do harm or to minimize harm yet McDermott (2002) realises that this would oppose performing CPR when it is inappropriate or the outcome will cause harm.

Immanuel Kant claims that the deontological approach supports an action as right, if it accords with moral rule, irrespective of the out come or purpose. This approach would rationalise the nurse performing CPR as he/she would be following legal, professional and NHS trust rules that he/she is bound. By contrast, the utilitarianism formulated by Jeremy Bentham also James and John Stuart Mill in the mid nineteenth century is an ethical principle in which an action is morally right if it produces good consequences. (Nobel-Adams 1999)

The NMC (2008) code of conduct states that when a nurse is faced with professional dilemmas, as nurses our first consideration in all activities must be the interests and safety of the patient/client. Also that we must respect patients and clients autonomy – their rights to decide whether or not to undergo any health care interventions- even where refusal may result in harm or death to themselves. Therefore, in Mary's case, her autonomy has

been respected and life saving treatment concerning CPR has been withdrawn.

However, her mental state could be challenged, through her prolonged progressive illness Mary could be seen to be suffering from depression. Baines and Jindal (2003) indicate that depression can serve as an important risk factor to the onset of secondary cancer because of living with the reality of an enduring prognosis. For this reason, should the doctors respect Mary's right to refuse life saving interventions? Rudnick (2002) suggests that patients who suffer from depression could refuse treatment sometimes because of their depression. Hence, the question is raised whether such individuals are competent to refuse treatment.

In the case of Ms B, she was found to be mentally competent, therefore won here battle to refuse life saving interventions. Therefore, Ms B was allowed to die and did so peacefully some weeks later. In Mary's circumstances, at the time of making a living will she was mentally competent which makes her rights legal moreover due to her illness and other health factors the decision by the MDT was ethical.

The Resuscitation Council (2007) express that where the benefit of attempting CPR is outweighed by the burdens, the patients informed views are of vital importance. If the patient/client lacks capacity, the families should be involved in decisions to discover the patient/clients wishes, feelings, beliefs and values.

The Mental Capacity Act (2007) plans to protect people who lack Capacity in making decisions furthermore encourage them to participate in decisions <https://assignbuster.com/law-and-ethics-around-a-clinical-situation-essay-sample/>

that are proposed to help them. However, this presents the medical profession with a new challenge, nevertheless, will elucidate actions in complicated situations.

In 2007, the Mental Capacity Act 2005 introduced the Mental Capacity Tool Kit, this tool kit is to act as a prompt for doctors when they are providing care and treatment for people who lack, or who may lack, the mental capacity to make decisions on their own behalf. The tool kit consists of a series of cards relating to specific areas of the Act, such as how to assess capacity, the Act's basic principles, advance refusals of treatment, research and Lasting Powers of Attorney (LPAs). (BMA 2008)

BMA (2007) states that people who understand the implications of their choice can state in advance, through a 'living will', how they wish to be treated if they lost mental capacity. The living will is legally binding and health professionals are generally bound to comply when the refusal specifically addresses the situation that has arisen. Therefore, Mary's refusal of life saving interventions has been her own choice from when she was competent and was acknowledged within the consultation, this has upheld her human rights.

In Conclusion, the DNR decision was both ethical and legal. Though the impact of law and ethics surrounding terminally and critically ill patients leaves the health professional with very difficult choices as to whether they should live or die. The legal and ethical frameworks that guide the practice of withholding or withdrawing treatment and making a DNR order have much in common in that they recognise that even though human life is special, yet

the patient/ clients quality of life should be taken into account when decision-making. It appears that legal and ethical approaches to end of life decisions and the principles that guide them have many similarities.