

The legal and ethical issues in nursing essay sample

[Health & Medicine](#), [Nursing](#)



Introduction

The following is a discussion regarding a *critical incident analysis*, that centers on a problem encountered by the medical staff of an emergency hospital. The goal of this discussion is to critically evaluate what happened and using reflective practice look at what could be gleaned from the errors made.

Aside from trying to get to the bottom of things this study will also look at the underlying ethical dilemmas faced by all those concerned during and after the incident. This includes the roles of the doctors, nurses, the family of the patient and the patient himself.

When all these things are put together, it is also the goal of the ensuing discussion to find ways on how to prevent the same mistakes made by the health workers. Moreover, it would be best if others can find ways on how to make the errors preventable after going through this study.

Critical Incident Analysis

Before going any further it is important to define the tool called *critical incident analysis* and the related learning technique called *reflective practice*. Judith Thomas comments on the increasing need for students and medical practitioners to learn, in and through work. Thomas added that there is pressure to, "...carry dual roles of worker and learner.." (p. 101).

Stephen White then highlights the importance of *critical incident analysis* in the course of understanding problems found in work and he said, " Critical

incident analysis helps teams understand troublesome symptoms in problematic situations. It is possible that the most careful triangulation of data can fail to reveal patterns..." (p. 95). White further clarified this by saying that, " Critical incident analysis uses soft data, not unlike the need for narratives to give the story behind the numbers" (p. 96).

Reflective practice on the other hand is, " The process of creating and clarifying the meaning of experience in terms of self in relation to both self and the world. The outcome of this process is changed conceptual perspective" (p. 2). Both these tools will be used to look into the report to learn in a more deeper way how to improve the existing health care system.

Critical Incident Report

A 55 year old man who will be named as Patient 1 was admitted in an emergency hospital at 5 in the afternoon. After 12 hours in confinement he was transferred to the High Dependency Unite (HDU) because his condition has worsened overnight. The initial diagnosis was Acute Pancreatitis.

The consultant Surgeon ordered to place a naso gastric tube (Ryle's tube) via the left nostril and placed on free drainage. On the third day, the patient was visited by the Consultant Surgeon. In the evening that same day, the patient's condition deteriorated further. He had developed respiratory problems on top of the initial Acute Pancreatitis. Another diagnosis was also made; the patient has Pulmonary Oedema and Respiratory Failure.

On the 4th day the, the patient's condition was improving. Then the following morning, on the 5th day, the same Consultant Surgeon ordered the commencement of enteral feeding. A nurse (Nurse A) inserted a fine bore naso gastric tube via the right nostril. When the Consultant Surgeon was later asked about such procedure he could not remember giving such an order. So a new tube was inserted even though the Ryle's tube was still in place.

Since Nurse A could not obtain any gastric spirate from the fine bore tube, there is no other way to ascertain the position of the tube. So the doctor (PRHO) was informed and a chest x-ray was performed to confirm the exact position of the fine bore tube. When the PRHO studied the results of the x-ray, he could no determine whether the said tube was in the stomach or not.

He then asked the assistance of a more senior doctor (SHO 1) and requested that he should determine the exact position of the tube. After looking at the x-ray, SHO 1 was able to ascertain that the tube was indeed in the stomach of Patient 1 and then proceeded to authorize for enteral feeding to commence. Enteral feeding commenced at 25 ml per hour and then doubled to 50 ml as dictated by the Fine Bore Feeding Tube Protocol.

Six hours later the patients condition deteriorated. Patient 1 was having fever in the highs of 39. 5 Celsius. The patient was extremely restless, agitated, and experienced shortness of breath. A junior doctor (SHO 2) was asked to check on the patient. On several occasions SHO 2 visited on Patient 1. A third chest x-ray was made and reviewed by SHO 2 together with the

anesthesiologist. They were able to conclude that there is a need to start Continuous Positive Airway Pressure Ventilation or CPAP.

On the sixth day at 0100 HRS the SHO 2 discontinued enteral feeding. At 0200 HRS the feed was started again. Two hours later the patients condition did not improve. The SHO hinted on removing the Ryle's tube if it hindered with the CPAP. The Nursing Staff did not remove the Ryle's tube because there was concern that doing so would dislodge the fine bore tube. Thus, two tubes were in place inside the body of Patient 1.

On the morning of the sixth day (9AM-11AM), a Physiotherapist worked on Patient 1. Th Physiotherapist then reported that the patient looked tired and had a dry cough without the ability to expectorate. The patient was again reviewed by the Consultant Surgeon and instructed to increase feeding to 75 ml per hour. All of these came even though they could not pinpoint the exact location of the fine bore tube.

In the afternoon of the same day (1400 HRS) the Physiotherapist reported the presence of enteral feed in the patient's sputum. Enteral feeding was promptly stopped. A fourth chest x-ray was performed on Patient 1. The Charge Nurse who was on duty examined the x-ray and was able to discover that the the fine bore tube was misplaced. The fine bore tube as it turned out was in the patient's lungs. The Charge Nurse then had the tube removed.

Two hours later, the patient was transferred to the Intensive Care Unit (ICU) with a diagnosis of Respiratory Failure and Acute Pancreatitis. On the 7th day the ICU personnel spoke to the family of Patient 1 and told them that the

patient had multiple organ failure, a complication of the Acute Pancreatitis. They were also informed that a naso gastric tube used for enteral feeding may have been accidentally placed in his lungs. This then may have inadvertently caused the passing of food into the bronchial tree which in turn aggravated his condition.

Analysis of Events

What happened with Patient 1 can be attributed to human error. A human error that resulted in his being critically ill. The mistake was avoidable and in the said hospital and medical staff can greatly improve on their practice to avoid the same thing to happen in the future.

The first thing that one could notice from the incident report was the high number of health workers involved for the health care of one man. This is to be expected in a world that is keen on specialization. This is must also be expected in the modern age where there is no concept of bedtime and that there are shifts working round the clock.

In the case of this hospital, there can be at least three nurses working on a single patient. There was also a consultant surgeon who obviously could not be around everyday or even the whole day when he is scheduled to be in that particular hospital. An interesting point to note is that aside from the consultant there was a senior and junior doctor and add to that a Physiotherapist and Anesthesiologist. To add more confusion to the system, all the doctors mentioned above can technically order every nurse available to do a particular task. Adding all these together then one has a potential

communication nightmare ready to wreck havoc. It did in this particular case.

The consultant surgeon first ordered for the placement of a Ryle's tube ready for enteral feeding when the patient's condition worsened on the second day after admission. On the fifth day when the condition of Patient 1 deteriorated further the same consultant ordered for the commencement of enteral feeding. Since this is already the fifth day and assuming that the patient will be in the hospital for a long time, Nurse A placed a fine bore tube to be used for enteral feeding. In the subsequent investigation following the accident, the consultant denied ever ordering Nurse A to put a fine bore tube into Patient 1.

Thus, there are now two tubes inserted through the patient one directly into the stomach while the other one placed inadvertently into the bronchial region. This resulted in the collapse of the patient's bodily system and gave rise to this critical incident analysis.

The role of Doctors

Leadership is the key role of a doctor inside a hospital facility. Aside from the necessary skills needed to function as a competent professional it is his leadership skills that can spell life and death in any medical situation. It is true that a good doctor can help save a person's life but without properly delegating the activities and work load necessary to cure that person, it would be too daunting a task for a single doctor to do the job alone. He will be

in need of nurses and other health care workers who will form as a team to combat diseases in a clinic or hospital.

One of the primary function of a leader in any field is the ability to communicate clearly and effectively. This skill is mastered so as to ensure efficiency and precision in a kind of work that demands excellence each and every time; because this profession is in the business of saving lives.

According to Dr. Mark Gorney, “ Faulty communication is among the most common underlying causes of medical error and frequently erodes the doctor-patient relationship [...] The breakdown is usually between doctor and patient but may also be involve miscommunication between physician and nurses or between physicians and family members” (p. 65).

One effect in a breakdown of communication is when two parties are going into assumptions. Since there is no communication occurring then it is normal to just assume that the other person has understood the instructions given and that there is no need to follow-up since it was already understood what needs to be done.

In this case the consultant surgeon was complacent and vacated the role of an active leader. The consultant upon ordering the commencement of enteral feeding assumed too much. He assumed that the nurses will do all that they could and follow protocol. The problem is not that the nurses did not follow protocol but they did it by the book without a doubt that the consultant surgeon could have made an error.

In this case, the consultant surgeon ordered the placement of a feeding tube on the second day and then ordered the commencement of enteral feeding five days after. What would be the first reaction of the nurse? It would be to think that since the consultant surgeon did not mention any changes in the routine then it is plausible that he intended to follow protocol and it is the placement of a fine bore tube when dealing with a patient who is going to be at least a week in the hospital (see Downie, Mackenzie & Williams, 2003).

This is not the only time that the doctors made assumptions. When Patient 1 developed complications in the respiratory system they assumed that it was due to his previous diagnosis. No one verified if this was the case or not (see Philip Woodrow, 2000).

Moreover, there was a further breakdown of communication when the doctors did not inform the family of the complications - not until it was already too late and the patient has already suffered multiple organ failure.

The role of Nurses

The major function of a nurse is to be a helper to the doctors. They are also the main caregiver and provides warmth and assistance to the patient to make their stay in sick bay to be as pleasant as possible. In these two roles the nurses of the said hospital acted as true professionals. But every nurse has a secondary role and that is to provide the necessary support structure for doctors to function. Part of this is the diligent keeping of records. And there is also an expectation that nurses facilitate the communications process when the orders are vague and when they feel that something is

wrong. They could not bypass the doctors but they could help them make the job easier by keeping records and by stimulating communication within the team.

If correct records were made and if the same were made readily accessible to all concerned then Nurse A would have known that there was a previously inserted Ryle tube.

The Role of the Patient

In the intricate system of health care, the patient and the medical practitioners are in one complex dance where each one are partners. For the interaction to be meaningful and practical the patient could not afford to be passive. The doctors and nurses on the other hand should not dominate the person and just do what they feel is the right thing to do.

The patient on the other hand must be well informed about the nature of his sickness and also the means of treating it. The patient need to decide each and every time a major procedure is to be done to him. If the procedure is routine the patient still has to be informed about it.

If the right of the patient to be informed was strictly followed, then Patient 1 would have known that a second feeding tube was inserted on the 5th day. This would probably lead him to question what is the need for a second feeding tube when one is already installed a few days earlier. Is it not enough for one feeding tube to do the job? When he was already experiencing difficulty in breathing he may have realized that the two tubes

one going through his left nostril and the other one going through his right nostril could possibly be the culprit.

Although the main reason why he was having complications is not necessarily due to the two tubes placed through both nostrils but technically it was that one tube was misplaced and went straight to the lungs. Still, he would have made a query regarding this and very possibly will alert the doctors and nurses on duty regarding the anomaly.

An ideal situation was given by Roney and he wrote, " Patients are increasingly assuming responsibility for their health care and often come to the doctor armed with information they have obtained from health related websites on the Internet. They expect the doctor to listen to their complaints. They often have sufficient knowledge about their condition to ask intelligent questions..." (p. 66). Unfortunately this is not the case with Patient 1.

Ethics

What was outlined above is an ideal scenario where a doctor, nurse and patient can live out their roles without interference, difficulty, and hesitation. But in the real world there are many factors and many hindrances for a health worker and even a patient to exercise their rights or to function in a way they believe is appropriate (see Thompson, Melia, & Boyd, 2000).

One of the major obstacle to excellence and efficiency is the perennial problem regarding the lack of resources. The lack in resources could mean,

less ideal facilities, sub-standard equipment, limitations of technology, inexperienced co-workers, high cost of health care etc.

Most of the time when these problems are placed in front of health worker, various ethical dilemmas develop into something that immobilizes a health worker from doing his or her job effectively.

According to Sarah Fry and Megan-Jane Johnstone there are two major classification of ethical theories which can help in sorting out the various ethical dilemmas a professional faces in the work place: 1) consequential theories (utilitarianism); and 2) nonconsequential theories (deontology).

Fry and Johnstone expounded on this idea by saying that:

Consequential theories are those theories that look at the consequence of acts. They claim that an action is right to the extent that it produces good consequences and wrong to the extent that it produces bad consequences [...] Nonconsequential theories on the other hand, are those theories that maintain that certain acts are right and others are wrong because they have or do not have right-making characteristics (p. 21).

Fry and Johnstone proceeded to give a rough sketch on what is expected of nurses and they remarked:

Common themes in contemporary nursing codes of ethics include the nurse's relations with co-workers; the nurse's responsibility to report the incompetence of other healthcare workers; the nurses accountability in delegating functions to others; the obligation to respect the life and

dignity of the patient; the nurse's responsibility for maintenance of patient confidentiality (p. 51).

Fry and Johnstone went further to discuss about other roles and responsibilities of the nursing profession but in this case study there are only three themes that are relevant. First of all as mentioned earlier, nurses have to be aware of their working relations with others. This relationship must be nurtured professionally because it can be a major factor in the overall success of the facility. The nurse can draw from both consequential and nonconsequential theories to guide him or her into the right behavior.

It does not matter what theoretical framework the nurse will choose for in this particular theme both are useful. In the consequential theory for example the nurse is encouraged to foster good working relationships with his peers and other medical practitioners because it will surely result in positive results. Using the nonconsequential theory on the other hand would also compel the nurse to create rapport and great working relationships with co-workers since it is the right thing to do. Moreover cultivating a healthy relationship with others can help the nurse tackle two distinct ethical themes as discussed by Fry and Johnstone - delegation and reporting of incompetence.

With regards to delegation, this obligation could not be fulfilled if co-workers do not communicate with each other. And communication could be strained because the underlying relationship may have been frayed for the longest time. How then can another nurse turnover duties and responsibilities when

the shift is over? How then can a fellow nurse ask the help of others when her plate is already full and there is a great need for assistance. All these could not be accomplished without first establishing good relationships with others (see Allen, 2001).

In this case study, the nurse has to make a report on the negligence of the doctor who ordered a second enteral feeding without advising the nurse that previously a Ryle's tube was already inserted a few days ago. It is important to note that this is related to the obligation to foster good working relationships. How so? If the nurse is at odds with the doctor then there is a possibility that his or her report is biased against the doctor and so the doctor would not receive a fair trial.

On the other hand there is also a flip side to this. The strong rapport within the medical staff can easily stifle the need to report on malpractice (see Nilstun & Ovretveit, 2004). The doctors are looked upon as superiors and practically are bosses to the subordinate nurses. Will it be beneficial or practical to be a whistle blower. In the given scenario the consultant surgeon denied the fact that he ordered the insertion of a fine tube bore. It is the case of my word against yours. Who will win and perhaps more importantly will the nurse have the resolve to go through all that?

Moral Issues

It is clear from looking at the report that the hospital and the medical staff had to answer for the medical malpractice that occurred on their watch. This is on top of the initial problem of not communicating properly to the family

and then to the patient regarding the ongoing progress and methods of treatment that were given to the patient. As mentioned earlier if the patient or the family had been updated on the case then they would have alerted the staff about the presence of the first enteral feeding mechanism inserted on 2nd day.

But the most glaring moral issue is the cover up made by the doctor or possibly the doctors, when they tried to deny that there was indeed an error with regards to putting in two tubes inside the patient. It was implied that the nurse was at fault. This is serious because it reveals the common complaint about doctors that seemed to be untouchable. Another underlying issue here is the audacity of the doctor to risk the career of Nurse A in order to save his own skin. This has to be addressed in trying to find ways on improving UK's health care system.

What needs to be done

Aside from the ethical obligation to do what is right there is another major reason for improving health care service. It is the fear of being sued in the event of medical malpractice. To many this is a more potent incentive to do an excellent job rather than the promise of a good clear conscience by being mindful of ethics.

There is in fact a disturbing increase in number of malpractice cases being filed in this century as opposed to a hundred years before. Mchale and Hervey cited a 1901 case where a certain Lord Kilbrandon was quoted saying: " This action is certainly one of a particular unusual character. It is an

action of damages by a patient against a medical man. In my somewhat long experience I cannot remember having seen a similar case before” (p. 11).

This may be true at the turn of the 20th century but not anymore. In fact Mchale and Harvey made a comment that would make any medical practitioner anxious, “ At a basic level, lawyers have become more interested in health because there was simply more litigation” (p. 11) One could easily imagine sharks being drawn to blood and in this case blood in the hands of doctors who committed critical errors.

Conclusion

If the number of litigation rises then there will come a time when lawyers are the only people who will be happy with the outcome. So changes must occur. In this particular case there is a need to improve on communication between those involved. The doctors must also realize that they are in a critical leadership role that their word is law and no one will question or second guess them. It is therefore important for doctors to be approachable and cultivate an atmosphere in the workplace where everybody are encouraged to ask questions. There must be a culture that does not seek to humiliate the inexperienced but help them grow into veterans. Replenishing the ranks of skilled workers is a boon to the profession and to all mankind. The doctors will have less problems and the nurses too will lessen their hectic pace when there are more experienced hands on board.

Finally, there must be major developments in terms of record keeping – at least in this hospital. The facility should benefit from the recent great strides

made in Information Technology. If the hospital can afford it then it must look into acquiring tools to electronically record and track data. These equipment can be carried around by nurses and they can input wherever they are but all the information will be stored in one repository where nurses or doctors on the next shift will have access to.

Consider the case of Patient 1, if a similar system was already in place then the doctor and the nurses will immediately be informed that a Ryle's tube was already inserted and ready for use. With just a push of a button this critical information would have been ready at that time. But unfortunately there is nothing similar to it in the facility. If the hospital in question cannot afford to purchase gadgets such as these then they can resort to the old method of pen and paper. But this time the protocols and other standard procedures must be enhanced to ensure that no information can leak through the cracks and also that there is less of assumptions but more on double checking the facts.

Having said all that the proponent realize that in order to achieve all these there is a need to have a change of culture and a change of mindset. The medical staff in this particular hospital could not forever go on covering their tracks and not being transparent. This is difficult to do at first specially if doctors are used to be treated as the final authority.

Schwartz, Preece and Hendry believe that the United Kingdom is on track to minimize the incidence of medical malpractice and they asserted, " In the UK, the government is taking steps to promote a culture of clinical

excellence by making individuals accountable for setting, maintaining, and monitoring standards” (p. 67).

This translates to urging the General Medical Council to do the following, “... inculcate in junior doctors attitudes of self-criticism, openness, and continuous professional development. Being held to account is now an integral part of being a doctor” (Schwartz, Preece, and Hendry, p. 67).

Dialog to improve health services must also be encouraged so that the community can voice out what they think is lacking in the system. But these dialog would have to be a two-way process. The community must also realize the pressure and problems faced by the medical practitioners.

In this world where nurses and doctors can choose to work in any place in the world, some communities may experience shortage not only of medical personnel but experienced ones. A doctor or nurse are humans who need ample rest and incentives in order to work at such a very high level of commitment. If their needs are not met then it is impossible to expect that they can meet the needs of patients and the community.

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