Professional Nursing 2

Not for Resuscitation is an ethical issue that concerns nurses throughout their careers. One problem that is faced is related to whether or not to resuscitate a patient at the end of their life when technology exists to either prolong or end life in the form of resuscitation orders. Discuss current ethical theory relating to resuscitations. Provide a theoretical base for your discussion by relating it back to the main ethical principles.

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Throughout history, nursing has been a complex profession into which multiple concerns with ethical principals arise. We as people, create technology and procedures within health professions that we use as a means in which to prolong or end life where we see fit.

We as human beings have grown accustomed to an ideal that we can prolong our lives, add years to our life, and treat life-threatening illnesses, (Parker & Aranda, 1998).

We have grown from a civilization that once treated death as a physical end to a spiritual life. As a deviation from what once was considered a normal constraint of mortality, we have begun to question whether we, as beings, have to have an end, (Parker & Aranda, 1998).

Such advances within our thinking and understanding include the introduction of death preventative procedures and orders. Such as resuscitation orders, and procedures that can state how far an able-minded and willing individual can take their life when faced with situations where they may not normally be able to do so, (Crisp & Taylor, 2009)

However, while an individual has the right to choose their path of life or death, we govern these complex decisions under ethical principals that we hope will allow us to make informed and just decisions. The ethical principals are; autonomy, beneficence, non-maleficence and justice, (Farrell & Dempsey, 2011). However, often we fall into a grey area where the ethical theories we attempt to abide by, may or may not be a just method of action that should be taken by an individual. Such as; is it right and just to allow one person to decide their future existence at a time when they cannot know how they will feel in the future. Or are procedures such a resuscitation orders and do not resuscitate orders, a premature, ill-thought attempt at prolonging life or ending life before we know the quality and outcome of it?

This essay will address whether or not current ethical principals and theories are right when applied to resuscitation orders when we, as people strive to create technologies and procedures that we then provide which may possibly cause premature and possibly regrettable decisions in nursing care and a patients life.

Within a nursing environment, the ethical principals govern the way in which a nurse administers care. Nurses are and have always been ethically bound to uphold and create an environment of the most basic as possible and advanced standards of care they can possibly provide to a patient, (Gordon & Jones, 1998). We are held to these strict set of ethical principals; autonomy, justice, beneficence and non-maleficence. These principles govern the way we as nurses move and work within a medical environment. They are a set of guidelines that help create a sense of direction for not only Nurses but also patients alike, (Crisp & Taylor, 2009).

The inclusion of Autonomy and Justice, are broad and contemporary terms. They are two bases for the ethical principals and govern an individual’s rights, privacy and choice. They mean, that instances that are alike, should be treated alike. They are generic, but effective principals that entail that an individual should have the ability to make a choice free from external (Nurses, Doctors and Family) restraints, while also being informed, (Farrell & Dempsey, 2011). The last two ethical principals, Beneficence and Non-maleficence, in terms of nursing, refer to a nurse’s abilities and duties to do good. To be able to perform decent acts of moral and ethical standards, and to not inflict harm upon those they are caring for, (Farrell & Dempsey 2011).

In relation to the ethical theory behind resuscitation orders and their adverse counterparts, these principals are crucial in the way we interact with and care as nurses. Ethically, we must uphold and create an environment of the most basic and advanced care that we can provide to a patient, (Gordon & Jones, 1998). This must be done regardless of how we as the carers feel a person’s life should be treated and conducted, because our patient’s perception of quality of life is entirely theirs. Because of this, it is often debated as to whether a resuscitation order is in fact, an ethically appropriate means of choosing an outcome to a situation we have not yet experienced ourselves. Due to this fact, it is argued that a resuscitation order that instructs the health professional to cease resuscitation on a patient who previously stated that they wished to have it stopped, is in fact, a flawed system due to this perception of being unable to know what one will feel and perceive in the future, (Bishop & Brothers & Perry & Ahmad, 2010).

In theory, the ethical principals provide a sturdy boundary for us as nurses to move about potentially grey areas such as resuscitation orders. They provide us with a means to educate the patient in their decisions. For instance, resuscitation, applied at the right time on the right patient, is effective at sustaining life. However, there are instances where a patient may experience an irreversible disease in which cardiac arrest, while being unforeseen or predicted even, is seen as a merciful end from a suffering. This leads on to the argument that attempts at resuscitation would then be unethical as the patients standards of living before cardiac arrest were not desirable to a decent quality of life, (Gordon & Jones, 1998).

In order understand the complexity of these ethical principals and their application and how it surrounds the decisions we make when it comes to resuscitation orders, its important to review the history of its enactment and creation. (Chang & Huang & Lin, 2010) It has been argued that throughout history we have seen ourselves and have perceived ourselves as spiritual and physical beings. We have always accepted that death is an end to a physical existence as a spiritual being, (Parker & Adana, 1998).

Our view as a spiritual being in a physical body in the past in regards to death and dying was one of acceptance and knowledge that it cannot be prevented. But as our technology progressed, and progresses so does our understanding of science and how it affects, or can affect our bodies. This applies more so for perceived positive influences than negative in regards to death prevention. The invention of such procedures to prolong life, such as resuscitation orders, or their adverse, to end a patients life, particularly do not resuscitate orders, are intended to facilitate appropriate care and choice for a patient towards or at the end of their life, (Sulmasy & Sood & Texiera et al, 2006). We have invented these procedures as a means to dictate how we wish to be cared for. They are once again; governed by these ethical principals, which we created to, in theory form guidelines so that appropriate, properly executed and informed consent and administration of these procedures can take place. More so they govern; do not resuscitate procedures, which fall into an ambiguous grey area of what is killing and caring, (Harrison & Daly, 2001).

These Resuscitation methods and their counterparts we as nurses have implemented in and outside of health care settings for over 40 years. It stems from the “breakthrough” procedure developed in the 1960’s known now, as it was when it was created, as the CPR or cardiopulmonary resuscitation procedure. It was created for the immediate and perceptively successful treatment of cardiopulmonary failure, and ultimately as a way to prevent death in a patient, (Bishop & Brothers & Perry & Ahmad, 2010).

The ethical principal guidelines were established and proper protocols for the delivery of the procedure and its conduction were implemented, and while, being successful in the prevention of death at immediate use, were only minor in its prevention when cardiopulmonary heart failure was presented. From this other factors arose that became negatively associated with resuscitation. Such as, if a patient were unconscious too long, they may retain brain damage, or bodily damage. In fact, resuscitation, while being able to prevent death in some cases if often a pseudo-option that will not result in a satisfactory restoration of health, (Bishop & Brothers & Perry & Ahmad, 2010). From this stemmed the idea of a not for resuscitation procedure to be implemented upon those who wish it.

This idea of a do not resuscitate procedure was largely adopted and still is, as form of a patient’s autonomy over their own life in a situation where they felt they may not wish to be revived, (Harrison & Daly, 2001). The current guidelines that govern a do not resuscitate or DNR procedure, vary slightly from health practice to health practice. However they are kept heavily within the ethical principals and theoretically protect a patient’s rights to choose their outcome, and be subjected to appropriate care as they see fit, be immune to negligent care and seek justice if their requests are not met in an emergency situation that relates to a cardiopulmonary arrest. These guidelines include in depth consultation with the patient or their surrogate and a medical professional who is qualified, and the patient or their surrogate must be informed of the outcomes from their decision, (Farrell & Dempsey, 2011).

While praised as an appropriate method of a patient being able to chose their path of life-or-death-treatment, It is often misinterpreted by patients and their surrogate (Family or Otherwise) that when they sign for a DNR procedure they are giving up their quality of care, (Crisp & Taylor, 2009). A misconception often held by many who opt for a DNR. To add further confusion and ambiguity to potential problems, often in terms of a patient who is put on life support, the nurse in place of care for the patient is put in the uncomfortable position of continuing life-support and not enacting a DNR order when perhaps the patient may wish otherwise, (Farrell & Dempsey, 2011)

In theory, resuscitation and do not resuscitate orders are both relevant and grounded in their use. They are guided heavily by the ethical principals laid out to protect the patient who is thinking of using them. However, sometimes, while being clear-cut, there are loopholes within this theoretical basis that allows for mistakes to be made when a nurse is implementing this specific type of care. These constraints can sometimes adversely affect a nurse into perhaps not treating that individual patient accordingly as they wish.

A study conducted showed that, patients often make the choice of a DNR procedure approximately a day before their death, (Chang & Huang & Lin, 2010). This shows that patients, while still being able to be subject to the loop-holes of ambiguous resuscitation care, are in fact, making these decisions nearer to the event in which it is not so unethical to allow a person to decide their fate if they were ever to have cardiopulmonary failure. The nursing code of ethics have long featured as guides in our ethical professional conduct in nursing. Just what they are however, and how the function has not always been clearly understood, (Crisp & Taylor, 2009).

We as humans, have, over the centuries, moved our focus as a spiritual being living a temporary physical experience, to one of physical beings attempting to live a spiritual experience, (Parker & Aranda, 1998). We have created methods of a temporary immortality when it comes to death. We invent preventative measures to ensure that we create a quantitative life, which overrides, sometimes, one of quality. Our Ethical principals govern how we conduct ourselves when we attempt to prolong our death or accept it. How we do it, is essentially our own decision, (Sulmasy & Sood & Texiera et al, 2006). Resuscitation orders and their counterparts are and may possibly always remain, a theoretical grey area for nurses. No one can say whether they are right or wrong, only the patient deciding to enact either or. The ethical guidelines are in place to protect them and the choice is theirs alone. It is a personal experience and a personal experience alone.

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