# TRAUMA PATIENTS' RIGHTS DURING RESUSCITATION

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## ABSTRACT

Doctors and nurses working in hospital emergency departments face ethical and moral conflicts more so than in other health care units. Traditional curricular approaches to health professional education have been embedded in a discriminatory societal context and as such have not prepared health professionals adequately for the ethical realities of their practice. Furthermore, the discourse on ethical theories and ethical principles do not provide clear-cut solutions to ethical dilemmas but rather serve as a guide to ethical decision- making. Within the arena of trauma and resuscitation, fundamental ethical principles such as respect for autonomy, beneficence, non-maleficence and justice cannot be taken as absolutes as these may in themselves create moral conflict. Resuscitation room activities require a balance between what is " ethically" correct and what is "pragmatically required". Because of the urgent nature of a resuscitation event, this balance is often under threat, with resultant transgression of patients' rights. This article explores the sources of ethical and moral issues in trauma care and proposes a culture of human rights to provide a context for preserving and protecting trauma patients' rights during resuscitation. Recommendations for education and research are alluded to in concluding the article.

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## INTRODUCTION

Rescue and resuscitation have become second nature in the clinical practice of trauma personnel: the South African trauma scenario providing ample opportunities for the rehearsal of resuscitation activities. The text that follows describes the fundamental ethical principles both as beacons for the preservation of patients' rights and also as a potential source of moral conflict during resuscitation. Selected human rights are extracted from the Bill of Rights to provide a legal context for translation into patients' rights. Suggestions are made in relation to research in ethics and the education of health professionals for improved ethical practice.

## FUNDAMENTAL ETHICAL PRINCIPLES

### Respect for autonomy

Autonomy refers to the capacity to think, decide and act on the basis of such thought and decision, freely and independently (Gillon, 1992) By virtue of this definition, autonomy can be subdivided into autonomy of thought, autonomy of will and autonomy of action. To respect autonomy is thus to respect individuals' thinking, decision making and action provided that these do not limit or infringe upon the autonomy of others. Respect for autonomy is binding on all health care professionals unless it is superseded by another principle such as beneficence or when patient autonomy is impaired. Two crucial questions now arise. How much autonomy is needed for a person to have his/her autonomy respected? Does hospitalization equate with impaired autonomy? In the first instance, disease and disability tend to impair patient autonomy to a greater or lesser extent. Seeking health care or admission to hospital, however does not mean that the patient gives up his/her autonomy. Neither is respect for autonomy a guarantee that the patient will make the " right decision" about health matters. It is here when doctors and nurses must guard against authoritarianism and paternalistic interventions. Where feasible, the patient must be provided with adequate information upon which to base informed choice and appropriate action.

Trauma and resuscitation however, offer a more complex environment for operationalising patient autonomy. The sudden and dramatic impact of a trauma event leaves the victim in a state of physical and/ or emotional shock sufficient to impair autonomy of thought, will and action. The administration of sedatives, muscle relaxants and narcotic analgesia and the use of intubation which impairs verbal expression of the patient's

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thoughts and decisions, are additional sources of reduced autonomy. When patient autonomy is sufficiently reduced, paternalistic intervention by doctors and nurses becomes a moral imperative and often seems justified. Here, the most plausible justification for paternalistic interventions should be encapsulated in the principle of beneficence to ensure patient survival, facilitate recovery and to limit disability. No other reason such as professional superiority or the patient's race, socio-economic status and education level should justify decisions to override patient autonomy. This is not only seen as unethical conduct but an offence against the Constitution.

### Beneficence and Non-Maleficence

Beneficence refers to the duty to do or promote good while non-maleficence is the duty not to inflict harm (Pera & van Tonder, 1996) It is argued that these principles cannot be separated in clinical practice and that the duty to do good must be tempered by the duty not to do harm. In the process of doing good physical, psychological, spiritual or moral harm, including harm to human dignity should not be inflicted. Within a resuscitation room context, it is assumed that feelings of benevolence of doctors and nurses towards seriously injured patients are a source of additional moral obligation to do good. Swift treatment of physical trauma, visible and concealed, become the primary feature of beneficence and the prevention of death and disability, the primary feature of non-maleficence. Preventing harm to non-physical aspects such as human dignity become of secondary importance during trauma resuscitation and may inadvertently contribute to gross human rights violation. Non maleficence is also described in relation to the principle of sanctity of life and quality of life which all health professionals are obliged to preserve. The sanctity of life principle asserts that life has value and as such epitomizes all resuscitation room activities. The dilemma arises when saving a life takes precedence over the quality of life principle which asserts that some lives are of a quality not worth living. Judgements on quality of life are variable and are determined by individual life experiences, values and belief systems. Under no circumstances, should inherent biases against age, gender, race, ethnicity or socio-economic status influence moral decision-making about the sanctity and quality of life during resuscitation.

### Justice

Justice is seen as the unifying principle in health and health care ethics as it embodies the concepts of resource allocation and fairness (Pera & van Tonder, 1996) The principle of justice can hardly be ignored in a country where discriminatory legislation guided (or misguided) resource allocation with resultant inequities in health care. Resuscitation room practices require the use of sophisticated technology and a multiplicity of therapeutic interventions by highly trained personnel. Moral conflicts may arise when evaluating the utilization of advanced technology, expensive drugs and personnel time in the light of patient outcomes, costs and benefits. There are several theories of justice which are varied and complex; as such a single, substantive answer cannot address this moral dilemma. Implicit to all theories of justice is Aristotle's formal principle of justice which demands impartiality, fairness and formal equity. (Gillon. 1992). Rational, clinical decision-making in the resuscitation room may give rise to perceived inequalities in the allocation and use of resources. Such decision-making by trauma unit personnel however, should be contextual in human rights and according to Gillon (1992), not be based on mere opinion, partiality or preference.

## ADVOCACY REVISITED

Advocacy in health care is often misconstrued as power and control over a patient care situation. Advocacy is defined as speaking for and deciding on behalf of the patient when anyone else tries to prejudice the patient. (Pera & van Tonder, 1996) In this context, advocacy is seen as a basis for generating conflict between health care professionals, particularly between doctors and nurses. Professional nurses are legally obliged to fulfill an advocacy role in terms of their Scope of Practice Regulation (R2598) which paradoxically may enhance this conflict. Patient advocacy must be a shared responsibility between all health professionals to enhance collaborative trauma practice in the best interest of the patient and should be of primary ethical concern when a patient's decision making capacity is impaired.

## THE SOUTH AFRICAN BILL OF HUMAN RIGHTS

The Bill of Rights within the constitution of South Africa (Act 200 of 1993) enshrines the rights of all people and affirms the democratic values of human dignity, equality and freedom. It consists mainly of first generation rights which among others include the right to life, to human dignity, to privacy, to equality, to language and culture, to freedom of expression and to freedom of religion. First generation rights are inalienable and prohibit intrusion or interference by the state and those employed by or representing the state. The Bill of Rights also includes certain second generation rights such as the right to basic and further education, to safe environment and to have access to health care, food, water and social security. In contrast to first generation rights which prohibit government interference, second generation rights demand definitive action from the government to promote and fulfill these rights (Verschoor. et. al, 1997). Health care professionals as public providers of health care are directly governed by the Bill of Rights. The reason being that doctors and nurses albeit with benevolent and noble intent, intrude on precisely those aspects of human dignity that are protected by the Constitution. (Verschoor et.al, 1997) The Bill of Rights is the supreme law of the country and the protection it affords to its citizens and in this context the trauma patient, is absolute.

## PATIENTS' RIGHTS DURING RESUSCITATION

Traditional views on basic human rights in health care are confined to the right to treatment, the right to information and the right to privacy and confidentiality. If a culture of human rights is to be established within health care, this view must be expanded and health professionals need to align themselves with the Bill of Rights in order to translate human rights into patients' rights. Some of these include the right to equality, the right to respect of dignity, the right to freedom and security of persons and the right to freedom of religion, language and culture.

### Right to equality

The right to equality demands of trauma personnel to exercise good judgement in resuscitation decisions and in the treatment of seriously injured patients. No person may unfairly discriminate , directly or indirectly, against anyone on one or more grounds including age, race, gender, sexual orientation, language, culture, religion and social origin (Constitution Act, 1993 ). The culture of violence in South Africa brings an added dimension into the resuscitation room, where trauma personnel are expected to give equal treatment to victims of violence and the perpetrators of such violence. For some, the application of different ethical principles may cause a real impasse for which the only solution is one's moral conscience.

### Right to protection and respect of dignity

The Constitution of South Africa states that everyone has inherent dignity and therefore has the right to have their dignity respected and protected ( Constitution Act, 1993).The need for resuscitation stems from the trauma patient's inability to sustain physiological processes vital to life; similarly, the seriously compromised patient is unable to maintain his own dignity and personhood. The very nature of resuscitation procedures intrudes on those aspects of human dignity which are generally maintained by the person himself/herself and are specifically protected by law. The forceful removal of patient attire and full body exposure for physical assessment and invasive procedures may constitute assault, invasion of personhood and inhumane treatment. These actions may be pragmatic and medically justifiable, but it is only when they are exercised with care, empathetic understanding and reciprocity that such actions can be morally justifiable. On completing a physical assessment and where practical, body parts not under surveillance or treatment, should be appropriately covered to protect human dignity.

### Right to freedom and security of person

Freedom and security of person includes the right to bodily and psychological integrity in relation to the patient's security in and control over his/ her body. It implies freedom from all forms of assault, torture and treatment in a degrading, inhumane way; hence the right to freedom and security of the person is inseparable from the right to human dignity. Persons (patients) also have the right not to be subjected to medical or scientific experiments without their consent (Constitution Act 1993).Consent as a legal basis for any medical or nursing intervention in the resuscitation room is impossible ( and not an absolute requirement) because the patient is usually incapable of volition due to shock, loss of consciousness or intoxication. This waiver on consent does not exempt trauma personnel from providing the patient or relatives with a constant flow of information to minimize anxiety and preserve psychological integrity. Although emergency treatment may be given without consent in patients incapable of volition, it is of utmost importance that resuscitation procedures be carried out by skilled, competent personnel to ensure physical and psychological safety of trauma patients. Medical and nursing personnel in training must be carefully guided and supervised to prevent patients from being subjected to trial and error during resuscitation.

### Right to freedom of religion, language and culture

As persons in a democratic society, everyone has the right to freedom of religion and the right to use the language and to participate in the cultural life of their choice. However these rights may not be exercised in a manner which is inconsistent with the Bill of Rights. (Constitution Act, 1993). Cultural and religious affiliations are not easily identifiable and generally not known in severely compromised patients, but personal objects which express culture and/or religion are usually noticeable. One example is the wearing of string around the waist of a person and commonly referred to as "safety belts" in African culture (e.g. "Xitshungulu" in Tsonga culture).The relative importance of such cultural and religious objects should not be judged on the basis of personal or Western value systems. Where resuscitation conditions permit, these should remain on the person or upon removal, be taken into safekeeping according to standard procedure.

Since death is a potential resuscitation outcome, specific religious practices or rituals around death and dying by the relatives of the deceased should be respected, provided that these do not infringe upon the rules of the institution or the activities of the resuscitation room.

## RECOMMENDATIONS FOR EDUCATION AND RESEARCH

Several institutions and departments responsible for the education and training of health professionals have revisited their respective curricula. Those who found their undergraduate curricula deficient of ethics, have embarked on educational strategies to address this deficit. Here are some recommendations to assist with these curriculum changes.

- All health professionals need a common core of shared knowledge which is generic to health care ethics. Learning should be multi and interdisciplinary within small groups to breakdown traditional professional barriers and facilitate collaborative ethical practice.
- Ethics and human rights teaching must be submersed in a transformational curriculum approach to prepare students to challenge and change discriminatory aspects of their practice. When ethical content is simply added on or infused into a curriculum the basic assumptions and values of the dominant curriculum remain unchallenged and substantially unchanged.
- Ethical decision-making skills are best acquired through experiential learning approaches. These learning experiences must be contextualized within the real setting. Hence the placement of ethics within the broader educational programmes must be carefully considered. Where case studies and patient scenarios are used to learn ethical decision - making, these must be real or if modified, must have a high degree of authenticity.
- Effective application of decision-making skills in patient care settings is the litmus test for evaluating students' ethical conduct. Clinical preceptors and clinical tutors are important not only for evaluating students, but also to act as effective role models for students to emulate.
- For many in the fields of health research and teaching, medical ethics, bio ethics or health care ethics have generally been placed in a subordinate position in relation to other disciplines. To reverse this position:
- The value of qualitative research methods must be acknowledged to explore patients' experiences of illness and disabilities and their perceptions of health professional interactions and treatment. Evidence generated by appropriate research may be used for teaching purposes to provide insight into patients' experiences and for the development of empathy (Benatar,1997).
- Research in ethics at post-graduate and post-registration levels must be encouraged and supported with the same rigour as in other disciplines. It follows that in institutions of higher learning, a department or sub-department of health care ethics is of paramount importance to spearhead research and to raise the profile of health care ethics.

## CONCLUSION

Although the basic principles of ethics seem clear, the diversity of situations in which these principles are applied demand careful discernment by health professionals during ethical decision-making. As health care funding continues to shrink, human capacity to uphold vital services, in the context of escalating trauma and HIV/AIDS , will continue to be challenged. In facing these challenges, moral conscience and the art of professional conduct must prevail in patient care.

# REFERENCES


**Act no. 200 of 1993.** Constitution of the Republic of South Africa.

**Benatar, S. R. 1997.** Medical ethics. *The Leech* 66 (1) : 26 - 28.

**Ellis, P. 1996.** Exploring the concept of acting in the patient's best interest. *British Journal* of *Nursing* 5 (17) : 1072 - 1074.

**Clow, S. 1998.** Nurses and the Truth and Reconciliation Commission. *Nursing News*. 22(6) : 12- 14.

**Gillon, R. 1992.** *Philosophical medical ethics.* New York : John Wiley & Sons.

**Jenkins, T., Price, M. & Veriava, J. 1997.** Politics in medicine Preliminary submission to the TRC from the Faculty of Health Sciences . *The Leech* 66 (2) : 35 -41

**Kyriacos, U. 1996.** Practical Issues. Ethical aspects of a Nurses's Scope of practice. *Nursing News* 20 (6) : 8

**McClimens, A. 1996.** When rights can be wrong. *Nursing Times* 92 (37) : 61

**Mlinek, E. & Pierce, J. 1997.** Confidentiality and privacy breaches in a university hospital emergency department. *Academic Emergency Medicine*. 4 (12) : 1142 - 1146

**Mohr, M. & Kettler, D. 1997.** Ethical conflicts in emergency medicine. *Anaesthesia* 46 (4):275 -281

**Pera, S.A .& van Tonder, S. 1996.** *Ethics in Nursing practice*, Kenwyn : Juta & Co. Ltd.

**Quill, T. & Brody, H. 1996.** Physician recommendations and patient autonomy : finding a balance between physician power and patient choice. *Annals of Internal Medicine,* 125 (9) : 763 - 769

**South African Nursing Council. 1984.** *Regulations relating to the scope of practice of persons who are registered or enrolled under the Nursing Act, 1978.* Regulation R2598 of November 1984. Pretoria : Government Printer.

**Tsukamoto, Y. 1996.** Patient's autonomy vs doctor's professional integrity. *Medical law*,15 (2): 195 - 199

**Van Rensburg, H. & Fourie, A. 1994.** Inequalities in South African Health Care - part 1.*South African Medical Journal*. 84 : 95 - 99

**Verschoor, T., Fick, G., Jansen, R. & Viljoen, B.1997**. *Nursing and the law.* Kenwyn : Juta & Co. Ltd.