Dr. David Keast Addresses Ethics in Wound Care: The Case of the Problematic Order

Dr. David H. Keast

David H. Keast, MSc, MD, FCFP, is at Parkwood Hospital, St. Joseph's Health Care, London, Ontario. He is President of the CAWC.

Q What do I do when I'm asked to participate in an activity I don't ethically agree with?

A The clinician has several options for dealing with such a conflict. The case study, below, can serve to illustrate possible strategies.

Case Vignette

You have been asked to see Mrs. Mary White, a 70-year-old woman with a right lower extremity ulcer who has been referred to home care for treatment. The order sheet requests saline irrigation, a hydrocolloid dressing and a four-layer bandage system changed twice weekly. When you remove Mary's bandage, you note some dependent rubor in the leg. The ulcer is over the medial malleolus and is shallow, quite fibrotic and appears punched out. As per your agency's lower extremity protocol, you do a screening ankle brachial pressure index (ABPI). The value is 0.4 in the right leg and 0.5 in the left leg. The waveforms are monophasic. Mary admits that she was previously a heavy smoker, but stopped after her heart attack five years ago. You are quite concerned about the requested treatment, as high compression therapy is contraindicated in a person with such a low ABPI.

Introduction

Health-care professionals are expected to behave in an ethical manner. By this, we mean behaviour consistent with a moral code or with accepted principles of conduct. In health care, one of those accepted standards is that we must first cause no harm.[1] In our case scenario, the application of the ordered therapy may in fact cause harm to the patient. At the same time, however, the clinician has an obligation to carry out the ordered treatment. How does the clinician then deal with this conflict? The process can be viewed to have several steps.

Assessment of Threat

The first step is an assessment of the level of potential threat to the patient. Will the ordered treatment cause immediate and serious harm to the patient? In our example, high compression therapy in a limb with poor arterial supply may cause limb-threatening ischemia and could result in the loss of the limb. This threat is immediate and serious, and the ordered therapy should not be instituted. Indeed, the clinician has a moral obligation to not implement the ordered treatment. Good and clear documentation explaining your decision is essential. On the other hand, had the order been to start saline wet to dry dressings, the threat is less immediate and less severe. While the ordered treatment is less than optimal by today's standards, it could be safely implemented while the clinician advocates for a better therapy. Once the clinician has determined that the ordered treatment is either dangerous or less than optimal, the next step is to seek a change, initially by moral suasion.

Moral Suasion

All health-care professionals believe that, above all else, they must do no harm. When approached in a professional and collegial manner, most clinicians will be grateful that a potentially serious error has been averted. In mature interdisciplinary teams, members expect this collegial support. In our example, the ordering clinician can be approached with the value of the ABPI and the information regarding

the contraindication for high compression therapy in patients with evidence of significant arterial disease. It is likely that the clinician will agree to a change in therapy. In less life- or limb-threatening instances, the moral suasion route may be more difficult. Again the professional should take a collegial and non-threatening approach. This may often be accomplished by providing the other clinician with information and allowing them to come to their own conclusions. This process respects our colleagues as thinking persons who want the best outcomes for their patients. It could also be accomplished by offering to continue the ordered treatment for a period of time and evaluating the effectiveness, while simultaneously obtaining agreement to try another approach if the ordered treatment is not effective. Once again, you should clearly document your assessment, the reasons for wishing to alter the therapy ordered and the strategies you have employed to facilitate change. If the direct approach is not successful then the clinician may have to enlist the help of a colleague or superior.

Consult a Colleague or Superior

It is always helpful to discuss an ethical dilemma with a trusted colleague or with your superior. Clearly, if you have made a decision not to implement a treatment that in your opinion poses a serious and immediate threat to the patient, you must notify and involve your supervisor. In less threatening dilemmas, your supervisor may be able to offer strategies to overcome the perceived problem and will be able to support your decision. One such strategy may be to enlist the help of a champion.

Enlist a Champion

We have moved a long way toward interdisciplinary and transdisciplinary care, but clinicians still tend to pay more attention to advice that comes from a trusted peer. In many instances, peers who have become knowledgeable in a certain clinical area have become change agents within their organization or profession. Identifying, supporting and cultivating these champions is a key strategy in changing practice patterns. If one wishes to reduce orders for saline wet to dry dressings, one should identify a sympathetic champion and enlist their help in changing to more interactive dressings. Champions may also assist on a one-to-one basis with specific issues with specific colleagues. Given the growing number of expanded-role nurses, champions need to be cultivated not only among physicians but also among expanded-role nurses. If all avenues of initiating change have been exhausted, one avenue remains: one can withdraw from providing what is deemed to be unsafe care.

Withdraw

No health-care professional can be required to provide care that they find to be unsafe or contradictory to their personal code of ethics. However, if one is going to withdraw from the provision of care, the clinician has an obligation to arrange for an alternative care provider. Clearly, this measure is a last resort and requires good documentation and support from your supervisor. It is also important that the health-care provider explain clearly to the patient their reasons for withdrawing from the provision of care and the alternate arrangements that have been made. In our case scenario, if all avenues had been exhausted and the ordering clinician continued to insist on high compression therapy, one could withdraw from provision of the ordered treatment with full support of your agency and supervisors, and care could revert to the referring clinician.

Conclusion

In our case scenario, the home-care nurse called the ordering clinician with the value of the ABPI and the contraindication to high compression therapy. The clinician was grateful for the information. Together, the clinician and the home-care nurse problem-solved and came up with strategies to further assess the patient's circulation and to provide interim care for the ulcer. The home-care nurse reported her success to her supervisor and documented the outcome on the patient's chart.

Reference

1. Bell SE. Community health nursing, wound care and ethics. *JWOCN*. 2003;30(5):259-65.