MACOVA 2020

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# What do ethics have to do with vascular access?

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# Introduction to Ethics of Vascular Access

- ***Role of ethics and law in protecting patient well-being and welfare:***
- ***Law***
- ***Clinical Governance***
- ***Care Quality Commission***
- ***Impact of ethics***
- ***Negligence: vascular access and consent***

Emily Carr 1917 Totem Walk At Sitka

# Vascular Access: Role of: Ethics V Law

- Ethics- ‘how should we live?’
- Or in healthcare- ‘how best should we treat this patient?’
- ‘Best’ standard of care

- Autonomy
- Beneficience
- Nonmaleficience
- Justice

- Law- what do we have to do for patients?
- Or what shouldn’t we do?
- Protects patients through
- Minimum standard of care that care should meet:
- 1. Negligence- compensates patients for harm caused by negligent medical treatment
- 2. Patient consent- law of battery and negligence

# Colwill V Oxford Radcliffe Hopsitals NHS Trust [2007] EWHC 2881 QBD

- Ms Colwill is admitted to the Infectious Diseases Unit of Churchill Hospital in Oxford on 21.09.02 with a temp of 38 and a DD of malaria, typhoid/yellow fever, hepatitis or viral infection
- IV cannula was inserted into right ante-cubical fossa, because it was standard protocol on admission via A and E (despite hospital policy of need for assessment for IV cannulation). Dr used that vascular access point because she had just finished a renal rotation
- 22/9 well other than temp of 38, no IVI fluids, meds
- 23/9 well, apyrexial

# Case of Colwill

- 24/9 Cannula removed by nurse as pt was complaining of pain at the IV site, no record of cannula on relevant hospital form
- 25/9 patient pyrexial and deteriorating, disputed descriptions of IV site, judge preferred the relatives description, Dr did not consider infection from the IVI at that time
- 26/9 patient further deteriorating, antibiotics prescribed when positive blood cultures
- 2/10 transferred to ITU in respiratory distress and Staphylococcal bacteremia- long term effects on patient, serious cognitive and physical disability

# Questions?

- 1. Was the insertion of the cannula a necessary part of the patient's care?
- 2. Was insertion into the ACF negligent?
- 3.Was it negligent not to remove the cannula before 24/9?
- 4. The system: i/was the system of documentation adequate? ii/ did the operation of the system fall below a proper standard?
- 5. Was it negligent of the DR not to recognise the infection on 25/9 and thereby fail to start antibiotics?

# How law ensures patient well-being and welfare

**To be negligent in law:**

1. The defendant: HCP must owe the claimant patient a **DUTY OF CARE**

**2.** The HCP must be in **BREACH** of that duty (ie. careless/negligent)

- **3.** This breach must **CAUSE** the patient's harm

Frida Kahlo 1926 The Accident

# Civil Negligence: Bolam Test

- A HCP will not be negligent if they act in accordance with a practice accepted as proper by a responsible body of HCP opinion
- **Common practice** therefore is the standard and is not set by the GMC/NMC/UKCC
- This is known as the ***Bolam* test or *Bolam*** *defence*
- Ordinary skilled and experienced HCP- not the best
- Objective standard of care:
- ***What would the reasonable HCP have done?***

Barbara Kruger 1997
Not Ugly Enough

# Case Study: *Bolam*

- Patient was mentally ill and was to receive Electric Convulsive Therapy (ECT) as medical treatment. No relaxant drugs were used and the patient was largely unrestrained apart from some manual control of the lower jaw. The patient suffered from a dislocation of both hip joints and a fractured pelvis. There were 2 schools of opinion on ECT: (1) that control(drugs and/or restraint) should be administered (2) Such control was in itself dangerous.

- ***The patient sued; do you think he won the case?***

# Reasonable and Responsible Practice

- The Bolam test has been modified by the case of *Bolitho v City 1997*
- Now HC practice is subject to a reasonableness and responsibility test
- Which means that the court can review common practice to ensure that it is reasonable and responsible
- May hear the Bolam standard now referred to as the Bolam/Bolitho standard

Franz Von Stuck 1920 Sisyphus

# Need to assess the risks of type of vascular access and what is to be administered

PRACTITIONERS CANNOT RELY ON 'EVERYBODY DOES IT'

# Negligence

***Treatment or Diagnosis***

- Poor clinical practice

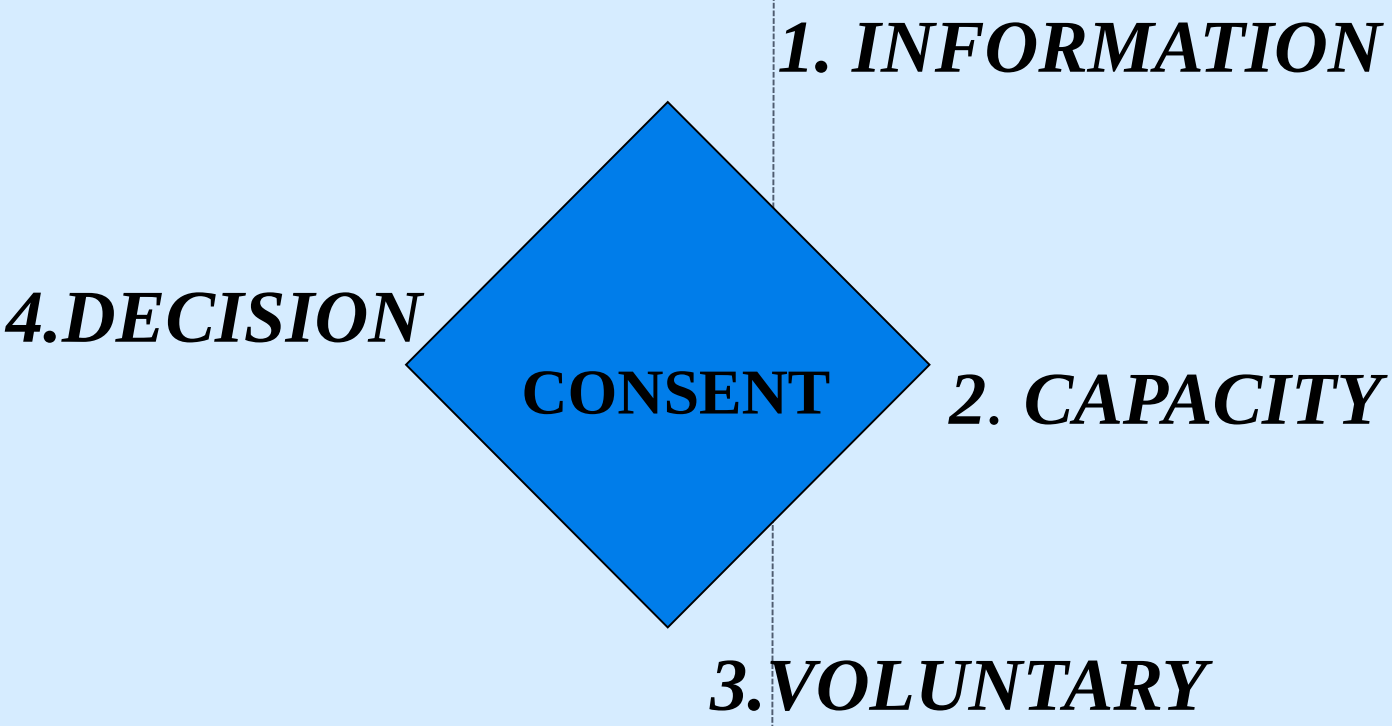
***Consent***

- ***Not enough information given about the side effects and risks of the treatment and therefore if the patient had known all of the information they would not have consented to the treatment and would not have suffered the risks or side-effects***

# Moral significance of consent

- **Respect for persons - autonomy**
  - its my body
  - being self- governing from own values
  - making mistakes and living with them
  - absolute
- **Protects the patient - nonmaleficience**
  - best person to do this is the patient
  - depends upon circumstances - e.g. what if patient will be harmed?

# WHAT YOU WOULD WANT TO KNOW?



# *Case: Chester v Ashfar* 2004 HL

- The Defendant, an eminent spinal surgeon recommended surgery to Mrs Chester for chronic back problems. Unfortunately she suffered a complication, namely cauda equina injury. The Court found that the surgeon had failed to warn the Claimant that there was a risk of her suffering this complication but it was not found that she would not have undergone surgery only that she would have delayed surgery and sought a second opinion.
- ***Would this constitute negligence?***

# Need informed consent for any vascular access

# Case: *Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland) [2015] UKSC*

- Ms Montgomery, a diabetic, gave birth via vaginal delivery; the baby's shoulders got stuck and as a result the child was born with cerebral palsy. The Obstetrician did not warn the patient of the 9-10% risk of shoulder dystocia as a diabetic- which is considered an obstetric emergency.

# Implications of *Montgomery* 2015

- The doctor is under a duty to take reasonable care to ensure that the patient is aware of any material risks involved in proposed treatment, and of reasonable alternatives, *e.g. peripheral IVI compared to for eg. a PICC line for chemotherapy*
- A risk is "material" if a reasonable person in the patient's position would be likely to attach significance to it, or if the doctor is or should reasonably be aware that their patient would be likely to attach significance to it

# Implications of *Montgomery* 2015

- Ask: *What would the prudent patient want to know? E.g. risks, benefits of vascular access options &*
- *Ask: What does this particular patient want to know? E.g. risk of infection*
- *No more Bolam for informed consent- Per Lady Hale: "A patient is entitled to take into account her own values and her choices must be respected, unless she lacks capacity. She is at least entitled to information enabling her to take part in the decision."*

# Implications of *Montgomery* 2015

- There is now no difference in the UK between the GMC standard, the law and ethics

- So when citing a device for vascular access- need to get informed consent from patient including: benefits, risks, side effects should be included if common, (e.g. discomfort, restriction of mobility) or if serious (any quantifiable serious risk should be explained), alternative access options should be discussed including the effects of not having vascular access

# Human Error: Vascular Access

- THERE ARE TWO WAYS OF VIEWING HUMAN ERROR: THE PERSON-CENTRED APPROACH AND THE SYSTEM APPROACH.

# Questions?

- 1. Was the insertion of the cannula a necessary part of the patient's care?
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# Case of Colwill

- Judge found  on a balance of probabilities the failure to remove the cannula on 22nd or 23rd of Sept did lead to cellulitis which in turn progressed to sepsis and pneumonia
- Judge also found that had antibiotic therapy been started on 25/9 the infection would have checked and its progression prevented and the DR had fallen below the standard of care by not prescribing antibiotics on 25/9

# Summary: Ethics of Vascular Access

- Limits of the Legal system to set clinical standards: individual responsibility not team, always retrospective not prospective, therefore will not drive a positive advancement in standards- stick rather than carrot

- Minimum standard not best practice, defensive medicine- because negligence system is fault based

- Benefits: enforces baseline of clinical skills, and patient expectation because of individual accountability, but does respond to changing practice as illustrated by *Chester*, *Bolam/Bolitho*, and *Montgomery*

# Summary: Ethics of Vascular Access cont…

- Ethics of Vascular Access- benefits- can be about best clinical practice, and can also be forward looking rather than merely retrospective. Focus on individual accountability can be both a carrot and stick

- Not limited again by philosophical focus on individual accountability- most health care delivered in teams

# Summary: Ethics of Vascular Access cont…

- Aimed at healthcare teams and how an individual can affect change- and to identify near misses as well as accidents as learning opportunities- move away from an individual blame culture

- Limits- the aim is increased awareness of the role of individuals to act as advocates for best practice in vascular access, check colleagues teamwork and act as “goalie” for each other