Case Study Reflective essay

Student name

Affiliation

Date

1. **Establishing the fact ( clinical/ psychosocial)**
2. **Clinical : Diagnosis / prognosis**

Patient: William Bartling

Age : 70 Years old

Marital status: unknown

Gender: male

Presenting complaints: At the time of admission (18 April 1984) he was in ICU having chest tube and respirator for breathing. He compliant for his chest pain due to respirator and want to remove it .

Diagnosis: he was suffering from 5 fatal diseases including; emphysema, diffuse arteriosclerosis, coronary arteriosclerosis, inoperable lung cancer and aneurysm.

Risks/ complications: If his respirator removes that his death can occur.

Medication: unknown

1. **Psycho social**

Patient is an old man with five fatal diseases and he was permanently on respirator and chest tube .Patient feels discomfort and often tries to remove chest tube by himself. Mr. Bartling hands were tied with bed to stop him removing chest tube.

More than thirty years of the existence of this interdisciplinary direction, combining biological knowledge and human values and representing systematic research in the field of life sciences of human behavior in the light of moral values and principles, is associated with the dynamics of bioethical perspective: biomedical ethics gradually moves from an empirical description of medical morality to philosophical reflection on the moral issues of scientific research in the field of biology and medicine. And starting from the second half of the 80s, along with the ethical examination of biomedical technologies, a powerful layer of ethical and philosophical knowledge is formed, transforming the conceptual foundations of the traditional model of medical ethics.

1. **Relevant value and principles**

Death is a very individual event. Approaching death is a physical, psychological, social, and spiritual / existential process in which medicine has its own function. The proximity of death, on the other hand, reduces things, and on the other hand brings new problems to be solved. When the time is limited, its value is weighed more closely. The solutions made are subject to a more detailed assessment. Setting the limits of treatment requires judgment so that the patient is not burdened with unnecessary treatments and is not left without the necessary care and mental support.

Human value, human dignity, is emphasized as death approaches. In a treatment system, a person dying must be treated as a unique individual who needs good, human care. The patient’s expectations hopes, and feelings must be heard and appreciated. Ethical values ​​such as respect for life and individual rights are emphasized in the vicinity of death. The neglect of these values ​​is perceived as an insult and a throw away by medical staff. In the vicinity of death, it is time to move from disease-centered thinking to human-centered thinking.

As a sociocultural phenomenon, biomedical ethics largely determine cooperation and mutual enrichment of legal and moral consciousness in our society, setting benchmarks for biology, medical practice and managerial decision-making. It provides a moral climate in the scientific community and medical teams, an adequate moral choice of medical professionals, biologists, biotechnologists, determining the extent of their intervention in the living and the extent of their social and legal responsibility to society for the results of scientific and practical activities.

According to Callahan, argument in favor of euthanasia divided in to four categories including; the moral claim of self-determination, the moral irrelevance of the difference between killing and allowed to die, the third is the supposed scarcity of evidence to show likely harmful consequences of legalized euthanasia and the last is the compatibility of euthanasia and medical practice. (Callahan, 1992). In this case study if Mr. Bartling want to get rid of respirator while knowing that it can lead to his death is simply his will and according to Callahan it is moral claim of self-determination.

There is no distinction between "non-moral" and I think it is the biggest weakness of utilitarianism. In fact, utilitarianism does not include "non-moral behavior", but mixes "non-moral behavior" in "moral behavior" and "immoral behavior". In utilitarianism, "moral behavior" contains at least some moral behaviors. This is the case where utilitarianism mixes "non-morality" with "morality" and "immorality."

Brain activity also obliges as a standard for death. Modern intensive care is capable of supporting the lives of patients who are not capable of either independent breathing or thought processes. Therefore, there are new moral problems associated with patients on the verge of life and death.

The question of euthanasia generally arises when the patient has permanently lost awareness; when dying, he experiences strong, intolerable suffering, obliging doctors to keep the patient in a semi-conscious state or when the neonatal has functional and physiological shortcomings discordant with life. Ethical behavior has been part of the work of a physician for 2 500 years. According to the Hippocratic oath, it is the task of the physician to promote the best of the patient, to avoid producing the illusion, and to preserve the patient's trust and patient secrecy. It has been the primary responsibility of the physician to take care of the patient's illness.

The rulers have been very early in trying to influence the doctors' activities with different regulations. The oldest known laws on the rights and duties of doctors are contained in the law collection of King Babylon's Hammurab administration (1792–1750 BC). It also included penalties for medical deaths and other errors due to negligence or inadequacy of the doctor. These acts are more than a thousand years older than the earliest ethical guidelines for doctors we know.

Medical ethics are evolving over time, and new therapies create new ethical issues. Historical medical ethics focused on the clinical problem of individual patient care. Your doctor may have based his or her care decisions on conscience, intuition, accumulated experience, and general practices. Historical medical ethics also focused more on what is now considered more of a behavioral label. These include consultation methods, doctors' attitudes towards patients and colleagues, the right attitude towards teachers, and a collegial way to inform reception.

1. **Conflict of values/ principles**

The emergence of biomedical ethics is associated with a number of circumstances. The first of them is the need and need for understanding and moral evaluation of rapidly developing research in the field of biology and medicine. Their achievements have clearly demonstrated the possibility and danger of treating a person as an object of observation, experimentation and manipulation. The reason for this was the grandiose changes that occurred in the technical and technological re-equipment of the medicine of the twentieth century, cardinal changes in medical and clinical practice, which found expression in the success of genetic engineering and cloning, organ transplantation, the latest biotechnology, and the possibilities of maintaining the dying patient for a long time. Under these conditions, the need to improve not only biomedical technologies, but also ethical and humanistic factors in the professional activity of physicians and biologists has become urgent.

In this case Mr. Scott, the attorney of Mr. Bartling argued that his client is not terminally ill or mentally dead, or vegetative state so he can take decision for him. So, the doctor and hospital administration agreed to discontinue it. However, the hospital attorney simply refused and stop staff to do this. Mr. Scott proceed this case to Superior court of Los Angeles. Where he argued that Mr. Bartling is mature and legally capable to take decision about him. But the hospital attorney argued that Mr. Bartling is undecided about his death. And it can be proved by his statements when he said “I dont want to die” and “ I don’t want to live on the respirator”. It means if respirator removed than it will be an assistance for him towards homicide.

Court gave no decision regarding removing respirator or freed his hands. But later on appellant court ruled that , “if the right of a patient to self determination as to his own medical treatment is to have any meaning at all, it must be paramount to the interests of the patient’s hospitals and doctors. The right of a competent adult patient to refuse medical treatment is a constitutionally guaranteed right which must not be abridged”( Bartling Vs Superior CT)

Moreover, the incorrectness of bringing axiological, moral, and humanistic values ​​beyond the limits of the system of scientific knowledge, which most clearly revealed itself in the field of biomedical research, has become particularly noticeable. It took a rethinking of the paradigm of the value neutrality of scientific knowledge, characteristic of the technocratic thinking of classical science in general and the technical engineering model of the relationship between a doctor and a particular patient, within which a person was considered as an object of experimentation and manipulation. The emergence of such a new interdisciplinary field of research, such as bioethics , contributed to the actualization of a more adequate model of the doctor-patient relationship based on modern humanistic and democratic values.

This circumstance, which caused not only the legitimacy, but also the necessity of the emergence and functioning of biomedical ethics, is the ever-growing attention to human rights in the context of the humanization of society . The fundamental problem of modern biomedical ethics is the protection of human rights (in medicine these are the rights of the patient, the subject, etc.) when he comes in contact, forced or voluntary, with medical and biological influences and manipulations. The task of biomedical ethics is the protection of life and health, considered as the right of every person , and not the priority right of a limited circle of people (physicians and biologists), who previously considered this to be their corporate professional privilege. This interpretation of the modern biomedical ethics of the interaction of stakeholders is associated with certain cultural traditions, in particular, with the importance of legal institutions in a democratic society. It is the human right to protect one’s health that today determines many ethical and legal problems in the field of practical medicine and biomedical research and requires its own legal regulation.

However, if the mutual influence of moral and scientific discourses in biomedical ethics is very organic, since its central issue is the development of moral norms and principles governing human behavior in the life sciences, man, and wildlife (bios), then the legal status of bioethics is , unfortunately, is still in its infancy. True, by the end of the twentieth century. Many scientists have already called for the creation of a set of special laws to regulate scientific research in the field of medicine and biology and even the introduction of a scientific tribunal to resolve controversial scientific issues, and in the European bioethical community there is such a thing as bio law.(Mittelstadt & Floridi, 2016).

Today, the Western model of bioethics is an institutionally organized social technology with a system of standardized liberal values ​​that ensure the observance of individual human rights and freedoms in the field of biology and medicine. Protecting the rights of citizens from the negative consequences of the application of modern biomedical technologies is carried out here through developed ethical codes, laws, increasing the responsibility of medical professionals and biologists, expanding their social responsibilities, enshrined not only at personal, moral, but also at legal levels. Ethical mechanisms of control over the actions of doctors and scientists are complemented by a developed system of legal regulation, the formation of special bioethical committees, improving bioethical education. (Kearl,1989).

Knowledge of the approach of one's own death touches upon the fundamental questions of human existence. It initiates a spiritual process of preparation for death, which continues until the last moment. Patients often have the desire that a physician experienced in safety will understand his mental distress in front of death and also encounter him as a listening neighbor. This encounter is affected by how the doctor himself has formed a relationship with death. The nearness of death can awaken the same feelings in the doctor as the patient. Therefore, it is good for the physician to treat these feelings in some way, for example, at work guidance. Experience increases your capability. You can also learn how to interact.

1. **List of preparation**

The patient's first reaction to death near hearing can be a fight or rebellion. He may be afraid of being left alone or abandoned. There may have been unresolved issues between the relatives and the patient. Fear can also arise from the patient's experience of not managing the situation. Death threatens your own existence and the unknown is scared. The inexplicability of the life view may increase anxiety. The proximity of death raises strong feelings on the surface: anxiety, anger, bitterness and guilt or the unhealthy life. You need another person to handle them. The patient's sense of security is enhanced by the knowledge of the proximity of those who are willing to discuss with him. The physician should show that they are available for discussions with patients and patients alike.

The patient goes through the values ​​of his life as he approaches death. She is going through her relationships and doing things and not doing her. Preparing for Death is a process in which the entire living life and its meaning get the ultimate perspective. An essential part of good care is to support this process so that the patient eventually matures to face death.

Discussions must respect the patient's beliefs. The patient often raises issues as he or she is ready to deal with them, but the doctor may also be proactive. The conversation usually releases anxiety. Honest encounters and handling of emotions and unfinished business will lead to their clarification. Death is easier to face when you have been able to find out the questions that have pushed your mind and to get away from "living enough". Dealing with death is often more difficult for everyone when it comes to a child. The child's approach to death must be told very carefully. The method and timing of the report should be agreed with the parents, as well as who will tell. Parents also need special support, so they can be along with their child.

1. **Recommendations**

Talking about treatment solutions with the patient will clarify the situation and dispel the patient's fears. The patient will make sure that his / her pain is adequately treated and that his or her will is respected, for example, by refraining from the treatments and studies he considers unnecessary. The golden rule that one should do what he wants to do for himself is helpful in reflecting on the boundaries of treatment. This is based on empathy, the desire to understand the circumstances affecting another person's life and the ability to make the best for the neighbor. One can speak of empathic coexistence as a basic feature of being a physician.

It is good for the physician and the patient to have a common understanding of how the patient's quality of life is best achieved in the last stages of life. For others, the quality of life is more important than the length of life. The declarations of intent recorded by the patient clarify the making of decisions. It is important that the patient can feel involved in the end-of-life solutions. Therefore, you should use medications that blur the clarity of thought.

The doctor has different interests in cross-pressure when making treatment decisions. He meets the patient's expectations, the demands of the relatives and the health care system, and the financial interests. In care solutions, the physician should primarily work for the best of the patient. Other interests are secondary. The lack of medical staff or lack of treatment options may make it difficult for the doctor to act. In prioritization situations, solutions must be based on humane starting points that take into account the individual's psychological and social situation. The age or economic circumstances of the patient are not in themselves the primary basis for treatment. Patients should be able to rely on equal treatment as they die.(Mittelstadt & Floridi, 2016).

The following questions will be answered when deciding on treatment for a dead patient. Does the treatment that technical means continue with life benefit the patient? Is the patient conscious and aware of his / her environment? Is the patient able to interact? Is he aware of his existence? Is he able to feel pleasure? Does he have the ability to do something independent? Does the patient have an important goal for which he wants to live a little longer? If the treatment does not cure or preserve any of the abovementioned abilities, there is no reason to prolong the treatment. It is always important to maintain a safe, hopeful and trust-creating care atmosphere.

The complaints made by the relatives in the end-of-life care decisions often reveal that they have not heard their opinion or will. When dealing with complaints, there is a perception that most of these complaints would not have been made if the physician had the opportunity or the ability to discuss more thoroughly with the relatives about the treatment choices. The importance of the doctor's interaction skills is emphasized in these situations.

In this case, the doctor and the patient jointly develop a strategy and treatment methods. The doctor applies his medical experience and gives explanations regarding the prognosis of treatment, including the alternative to non-treatment; the patient, knowing his goals and values, determines the option that best suits his interests and plans for the future. If social norms do not have an ethical or legal dimension, they will have to give up in case of conflict. Instead, the conflict between legal and ethical standards is more complicated. The substantive legislation on health care and medicine (eg patient relationship legislation) often consists of ethical principles converted into legal standards, so the relationship between law and ethics in the healthcare sector is very close . The problem, then, is that there is no legally independent entity that all members agree on the correctness of the ethical system behind the legislation. Democratic laws are often the outcome of the negotiation

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