



CODEN [USA]: IAJ PBB

ISSN : 2349-7750

INDO AMERICAN JOURNAL OF PHARMACEUTICAL SCIENCES

SJIF Impact Factor: 7.187

Available online at: <http://www.iajps.com>

Review Article

RIGHT TO REFUSING MEDICAL TREATMENT NURSING REVIEW

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Article Received: October 2022 Accepted: November 2022 Published: December 2022

Abstract:

Patients may refuse medication for a variety of reasons, including religious views, dietary restrictions, misunderstandings, cognitive impairment, self-harming intent, and simple inconvenience. This decision provides a unique circumstance for pharmacists and staff members of long-term care facilities, particularly if patients have dementia. Therefore, we conducted this review through searching the relevant studies that were published in the electronic databases such as Medline and Embase, with English language up to 2022.

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Please cite this article in press Ahlam Eisa Mohammad *et al*, **Right To Refusing Medical Treatment Nursing Review.**, Indo Am. J. P. Sci, 2022; 09(12).

INTRODUCTION:

Medications have improved health and quality of life for a long time before pharmacists were available to oversee them. Former U.S. Surgeon General Charles Everett Koop observed, "Drugs do not work on patients who do not take them." According to current estimates, up to thirty percent of patients prescribed a new medicine would not take it, and up to seventy-five percent of adults will eventually become nonadherent [1]. Patients resist drugs and therapies for a number of different reasons. Certain patients may refuse therapy due to their religion, fear of side effects, insufficient medical knowledge, dietary restrictions, or mental state. Many bipolar patients, for instance, are so devoted to the manic phase of their illness that they refuse drugs that could mitigate euphoria [2]. By doing so, they could put themselves and others in danger. It is unethical to force people to take medications against their will, even if their refusal to do so poses risks to themselves or others. In the absence of medication-refusal policies, however, some physicians will medicate patients without their consent. They believe it is preferable than leaving people untreated or restricting them by force [3]. In a poll of nurses working in long-term care, 56.5% of respondents admitted to hiding medication in food or drink after residents spit out their doses, despite the illegality and unethicity of the practice. This is why pharmacists must comprehend not only the reasons patients decline their drugs, but also how to assist in an ethical and patient-rights-compliant manner [4].

One of the fundamental principles of medical law is that a competent adult must offer valid consent before to any medical intervention [5]. The law of consent must be considered on a daily basis in the healthcare setting to prevent a claim of battery or negligence by the patient. Before giving treatment, [6] healthcare professionals must ensure that the degree of permission necessary by law has been received and be knowledgeable of the law regarding consent to treatment. The Department of Health (DH) offers recommendations on consent to treatment and the implementation of consent principles. The law does not specify the form in which consent must be granted, but the value of various types of assent as evidence varies greatly [6,7]. Written consent constitutes expressive permission [7] if a patient agrees to a therapy. Written consent is the preferred form of consent evidence. Consent expressed verbally is also a legitimate form of expressed consent. However, it may be considerably more difficult to prove verbal agreement in court, as it is one person's word against another's [7]. Numerous modest procedures conducted on a regular basis are authorized verbally. Examples

include insertion of a cannula and intravenous fluid administration. The assumption underlying implied consent is that receivers demonstrate their agreement to treatment through their behaviors or behavior. This is susceptible to misinterpretation. It may be assumed that a patient's admission to a hospital signifies their agreement to any treatment deemed appropriate by a healthcare provider. Unconscious patients brought to the emergency department have not legally granted implicit agreement to be treated because they are unable to provide consent [8]. In this instance, the healthcare practitioner, in the absence of consent, is acting in accordance with their duty of care to the patient and out of need in an emergency, and could therefore defend any case for trespass to the person on these grounds [8].

When obtaining consent, the patient must be informed about the operation or therapy to be performed and the reason for doing so. According to [9], any healthcare provider with adequate expertise of the surgery and therapy may legally explain this information to the patient. All personnel participating in a patient's care should ensure that the patient receives and comprehends information. If agreement is acquired after a description of the nature, purpose, and expected effects of the therapy in general terms, there is no culpability for battery [10].

DISCUSSION:

Defining Refusal:

Refusal is a complex, multidimensional concept on whose language there is no consensus among experts [11,12]. The International Society of Pediatric Oncology defines "refusal" as "a decision to avoid recommended elective treatment," distinguishing it from "noncompliance" and "abandonment" but maintaining that all three are the result of a "lack of mutual understanding" between families and medical professionals [12]. Abandonment is a complicated issue that is closely tied to socioecological factors, affecting individual patients and families but also occurring at the institutional, health care system, and society levels [11,13,14], and it is outside the scope of this review. Hinds²⁸ identifies three categories of rejection in pediatric and adolescent patients: apparent, passive, and active.

In a few studies of treatment discontinuation in LMIC, researchers have impressively achieved this goal of valuing family perspectives [15]. Rossell *et al.* [16] performed in-depth, semi-structured interviews with 41 caregivers of children with cancer in El Salvador, all of whom were determined to be at risk of

abandoning therapy or had already abandoned treatment.

Dealing with Medication Refusal Medication:

There are both personal and public health dangers involved with refusal. This is prompting medical professionals to inquire about legal and ethical approaches to treatment refusal. Following a series of heinous experiments conducted during World War II, the Nuremberg Code of International Ethics mandated that all patients participating in medical research or treatment provide informed consent. By informing patients of the risks/benefits of having or refusing a medical intervention, informed consent enables patients to select treatment regimens that meet their needs and values. Informed permission has shifted education health care to a patient-centered approach, hence preventing the occurrence of experimental brutality [17]. However, this might complicate circumstances involving medicine rejection if the patient is unable to make independent judgments or if the patient's decisions jeopardize others. When patients refuse treatment, health care practitioners may be motivated to intervene and impose their own beliefs, but they must intervene in a way that protects patients' rights [18]. Residents in long-term care have the right to refuse drugs. Many health care institutions lack expertise in this area; most have no policies or action plans in place, causing many clinicians to conceal drugs in food or drink. 44 In the majority of refusal cases, covert drug administration is unlawful; nonetheless, 96% of clinicians see the practice as justifiable in specific circumstances. This is why every long-term care facility must implement or adhere to a medication rejection action plan [19,20].

It can be frustrating and time-consuming for caregivers in long-term care institutions to deal with medication refusal. It inhibits people from finishing medication pass, and communication among health care experts is frequently so poor that some patients will refuse prescriptions for years before the treatment team addresses the issue. Some can even conceal their rejection from the long-term care institution by spitting out or regurgitating pills and concealing them; this is a sort of passive refusal that requires further monitoring [21]. Some residents resist medication with self-destructive intent (i.e., a desire to die), and many specialists view medication refusal as a kind of self-harm. It is vital to recognize and address this behavior because people with dementia and mental impairment are at a higher risk for suicide [21].

In patients with mental illness or dementia, treatment refusal can be challenging and, regrettably, prevalent.

Numerous antipsychotic drugs effectively lower both positive and negative symptoms; nonetheless, the patient's attitude is frequently the greatest factor of whether or not medication will be taken, and therefore successful [22]. The majority of individuals with mental illness lack hope, and some will refuse therapy because they do not believe they require it. Numerous residents in long-term care homes have psychiatric diagnoses, making mental disease a particular concern for clinicians. Approximately 500,000 Americans with mental illness dwell in long-term care institutions. Numerous individuals with mental disorders assert that antipsychotics dampen their emotions, leaving them feeling numb and detached, or induce distracting extrapyramidal side effects [23].

All efforts must be taken to guarantee that patients who are able to provide permission do so. However, when patients are admitted to healthcare environments, numerous obstacles develop. This is especially the case with emergency admissions, as patients are often not able to make autonomous decisions. Because of the gravity of injuries and emergency nature of the treatment required, choices will then be taken by healthcare professionals based on the best interest theory [24]. One study argues that the concept of 'best interest' permits a doctor to act and assess what treatment would be most helpful on behalf of the patient who lacks ability. The person giving the care has to ensure that the therapy provided accords to the standard recognized as proper by a competent body of that profession experienced in that specialization this is the Bolam test [25]. This is significant according to English law; an adult patient cannot consent to an examination on behalf of another adult. Thus, clinicians are the major decision-makers for patients who lack competency [25].

CONCLUSION:

Treatment refusal remains a hard issue in health care because it involves flexibility and respect for the beliefs of a stranger, which we may not fully comprehend. Simple solutions are elusive. Refusal cases may be significantly less intimidating, however, if long-term care institutions implemented step-by-step methods and health care staff were trained to spot these scenarios. Effective efforts may prevent some individuals from causing harm to themselves or others by refusing treatment. Legal, professional, and ethical obligations of healthcare practitioners include respect for human life, protection of patients' health, and maintenance of their best interests. Every adult has the right to self-determination and to the respect of their autonomy. This ethical ideal is reflected in the law by the concept of consent. For consent to be legitimate, it

must be informed and freely provided by an adult with legal capacity. Every adult must be deemed to be legally competent unless an adequately qualified practitioner demonstrates otherwise. A person is legally competent if they can comprehend, retain, and utilize treatment information to make an educated decision. Consent is of vital importance in protecting and preserving the right of patients to decide what is to happen to them.

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