

Reflective account: ethical dilemma treating cancer



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This reflective account will discuss an ethical dilemma which arose during a placement within a community setting. To assist the reflection process, the Gibbs (1988) Reflective Cycle which encompasses 6 stages; description, thoughts and feelings, evaluation, analysis, conclusion and action plan will be used which will improve and strengthen my nursing skills by continuously learning from both good and bad experiences, and develop my self confidence in relation to caring for others (Siviter 2008). To comply with the Nursing and Midwifery Code of Conduct (NMC) (2008) and maintain confidentiality all names have been changed and therefore for the purpose of this reflection the patient will be referred to as Bob.

Bob is a forty four year old man who has been receiving aggressive and invasive treatment for several months in the form of chemotherapy in an attempt to cure his Hodgkinson's lymphoma cancer. Throughout the treatment Bob remained positive that he would be able to put the worries behind him and live a 'normal' life with his partner and teenage daughter. However, Bob was unable to control his body temperature, which was a possible sign the chemotherapy had not been successful and was offered further investigations to establish his prognosis.

Whilst my mentor who is a Community Matron, was talking to Bob, his partner Sue took me to one side and asked me if the investigations revealed bad news would it be possible to withhold this information from Bob because she felt he would not be able to deal with a poor prognosis and would give up hope. Prior to Bob's original admission the possibility of the chemotherapy failing was discussed but he refused to consider this was an option and was convinced the condition could be treated successfully. I

explained to Sue that this situation was outside of my area of expertise but with her permission would discuss it with my mentor and ask her to contact Sue at a mutually convenient time to discuss further.

My mentor contacted Sue and advised her that she would discuss the situation with Bob's Consultant once they had received the results of his tests. However, my mentor diplomatically informed Sue that she has no legal right to insist that information be kept from Robert (Dimond 2005). As expected Bob's test results concluded the chemotherapy treatment was unsuccessful. Considering what he knew of Bob, the consultant agreed it would be advantageous to withhold the diagnosis from him. Therefore it was agreed to discuss Bob's test results with his partner.

Thoughts and feelings

In the first instance I felt that the Consultant was ethically wrong to withhold the results of the investigations from Bob and not necessarily acting in his best interests. I felt that in order to ensure Bob's rights were protected and to give him the opportunity to be involved in his own plan of care he should be informed of the outcome of the tests. Bob had the capacity to consent and as during my placement would be acting as an advocate for him. I felt that if I was in Bob's position, I would want to know what the outcome of any investigations were and it did not seem right that the diagnosis would be documented in his records and his family and possibly friends around him would be aware of his diagnosis whilst he was kept in the dark. I felt that if we were to visit on a regular basis that I would feel very uncomfortable knowing something that had been kept from him and possibly have to lie to him or avoid answering directly when asked difficult questions. I felt that I

would be able to have a better relationship and understand the care he wanted if he was told the truth about his condition. I also felt that his family were taking denying him the right to autonomy and th right to make informed choices in his end of life care.

Analysis

The situation was complex in terms of ethical principles. It was not just a matter of clinical practices but providing the best holistic care to Bob during his forthcoming terminal illness. This situation gave rise to multi-disciplinary team discussions to assess whether the diagnosis should have been delivered to Bob. Standing back from the situation, I realize that my own feelings were perhaps judgmental and that I should have taken a more holistic approach rather than just clinical. It also made me aware of the importance of promoting advance directives to patients in situations where an illness may lead to terminal care

Evaluation

Today patient autonomy is a highly regarded principle that healthcare professionals promote at all times and is fundamental for all patient interactions of which telling the truth to a patient about their diagnosis and prognosis is part (Dimond 2005).

Lo (2009) says to be totally autonomous competent patients have to be told the nature of their illness, recovery prospects, how their illness will develop, treatments available and the consequences of any such treatments to enable them to make an informed choice in order to grant consent to treatment of their choice or refuse treatment they do not want.

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However this has not always been the case, traditionally, paternalism, where the doctor alone would make a decision about whether or not to inform their patient of the diagnosis used to be the preferred method of treating and caring for patients (Lo B 2009). It is only over the past 20 years or so where it is the norm to share decision making with the patient to enable them to make informed choices in their preferred care and treatment (Boyle 1995).

However not all patients want to know their prognosis or take part in their end of terminal treatment and care. A study which took place in 1995 concluded that some ethnic groups were less likely to approve of truth telling in respect of diagnosis than others (Blackwell 1995).

The UK is culturally diverse and not all patients and families want or accept autonomy. When a person is sick in some cultures, the family prefers to take responsibility for the medical decisions and often wish to receive the diagnosis and nursing plan before the patient. Although this is often the case within Chinese and Japanese cultures, it does not automatically mean that the request to withhold diagnosis from the patient will be upheld. To add to this complex issue, there may be differences within these cultures, such as recent immigrants and older family members wishing to adhere to cultural traditions and younger family members wishing to practice autonomy (Lo B 2009).

Advanced care directives - definition are used to enable a person to have autonomy.

These ethical Barbosa da Silva (2002) defines an ethical dilemma as:

' A situation where a person experiences a conflict where he or she is obliged to perform two or more duties, but realizes that whoever action he or she chooses will be an ethically wrong one'.

Many experts agree healthcare professionals are faced with many ethical dilemmas when caring for terminally ill cancer patients. Communicating the diagnosis and subsequent prognosis is one of the most common (Kuupelomaki and Lauri 1998)(Roy and MacDonald 1998). It is not unusual for relatives to ask a Consultant to withhold information (Alexander et al 2006) which Kenworthy et al (2002) says family members request out of compassion and love. However, (2006) disagrees and suggests it is often the relatives who are unable to cope and have difficulty coming to terms with the impending prognosis. Dimond (2005) suggests withholding the truth can be harmful or lead to a conspiracy of silence but may be justifiable if it is in the patient's best interest not to know. In agreement, Lo (2009) points out receiving ' bad news' can have a negative and drastic effect on a patient's view of their future.

Nurses have a duty in accordance with their professional code of conduct to act as a patient's advocate. Whatever their personal thoughts are in relation to withholding diagnosis from a patient, if the Consultant deems it in the best interest of the patient then a nurse has a duty to adhere to the Consultant's decision (Dimond 2005). However Georges and Grypdonk 2002 suggest this can lead to nurses feeling powerless, frustrated and concern when involved in palliative care.

Evidence suggests that if a Consultant establishes it is not advisable to inform the patient of the diagnosis or prognosis then it is right to give information to the family (Rumbold 2006). Dimond (2005) states patients have no legal rights to information and therefore if a Consultant's believes it is in the best interest of the patient they can refuse to give a diagnosis to them. However, some would argue to withhold information would be considered paternalism (Lo B 2009).

Paternalism is when an individual, in this case the Consultant, believes they are in a position to act in the best interest of another individual. Although Bob's welfare is key, the consultant has taken away his right to his autonomy to make future healthcare choices including important end of life decisions by making the decision not to inform him of his diagnosis (Sandman and Munthe 2010). Tingle and Cribb (2005) define this as 'hard paternalism' as opposed to 'soft paternalism' in which Bob would not have the capacity to make an informed decision regarding treatment and care following his diagnosis. The may be in beneficence to the patient but conflicts with autonomy.

While considering the decision to not tell Bob the truth regarding his diagnosis, the consultant would have taken into account the ethical principles of beneficence (to do good) and non-malifience (to cause no harm) (Dimond 2005). In Rumbold's (2006) opinion it is wrong to not tell the truth or withhold information from a patient as it denies the patient autonomy and is in conflict with the ethical principles of beneficence and non-malifience.

Research carried out by Sullivan (2001) suggests patients believe that Doctor's should tell them the truth with a staggering ninety nine per cent of patients wanting to be informed of their diagnosis. However there is evidence to suggest the consultant was right to withhold diagnosis as it can initiate denial, and cause the patient psychological damage (Kenworthy et al 2002). Patients react differently to bad news and Elliott and Oliver (2007) suggests information should given slowly enabling the patient to have enough time to absorb the information given.

Sadness, despair, anxiety and depression are feelings patients suffer when faced with life threatening illness. ??> believes that if healthcare professionals have an open and honest relationship with their patients it enables greater trust (Elliott and Oliver 2007). Bowers and Arnold (2010) agrees with this and adds that an open relationship based on trust enables healthcare professionals to support patients to be in control and make preferred choices with issues relating to their end of life care. However, Kenworthy, Snowley, & Gilling (2002) are in disagreement with these statement say to force a patient into to face the trust regarding their diagnosis is both unethical wrong and damaging. Millard and Florin (2006) (nursingtimes) says that patients have different needs which can often be complex and it is important to recognise that some patients choose not be involved, that some individuals do not want to be part of their care but put their trust in health care professionals who are trained in what they do.

Elliott and Oliver (2007) states that a hope is fundamental to a terminally ill person's wellbeing and as such is something to be protected. She adds that hope of a cure whilst facing a terminal illness is an individual's right and

helps them to face the final stages of life and points out that if hope is taken away it leaves a patient with only fear.

Conclusion

This experience has made me aware that good listening, hearing and communication skills are vital to gain a holistic view when dealing with patients and close ones in end of life care. It is also important to liaise with other members of the multi-disciplinary team to ensure that the best possible approach and care is delivered to the patient. It is important not to be judgemental but to incorporate all issues when taking a holistic view in order to make the right decision. As this was my first experience of end of life care in the community, I was in unfamiliar surroundings and as such not experienced enough to make the right decision in Bob's case.

The consultant was correct in determining that Bob was not in a position to accept a poor diagnosis and therefore withholding the information was the correct decision.

Action Plan.

My action plan is to promote advanced decision and power of attorney

Assess holistically and taken into account

I also feel that advance directives may have cleared some of these issues and will read about their importance in order to have resolved some of these issues and read about their importance and promote their importance when the opportunity arises

However, the circumstances surrounding this decision could only be applied to Bob's situation. I believe that as a Nurse I will be involved in ethical dilemmas again however I feel that now I my decisions will be based on each unique patient recognising their own individual needs and wants.

Delegation

This essay is a reflection of a situation I came across whilst on Community Placement. To assist with this process, Driscoll's model of reflection will be used to focus my thought processes whilst learning. Driscoll's is a straight forward model which encourages one to return to a situation to understand it better and improve future experiences (Driscoll 2000). To comply with the Nursing and Midwifery Code of Conduct (NMC) (2008) and protect the confidentiality of patients pseudonyms have been used throughout.

As required by the first stage of Driscoll's model I will describe the event s which took place whilst my mentor was on annual leave and I was assigned to Dianne, another district nurse within the community team. The reason I have decided to return to this situation is because registered nurses should ensure their practice does not compromise duty of care to individuals and at the time I felt that Dianne was delegating duties inappropriately and therefore may have been in breach of NMC requirements (NMC 2004).

Whilst assigning the day's work Dianne said that it would be a good opportunity for my personal development to go out unsupervised to visit patients within the area to carry out their care and treatment. I was asked to visit a 92 year old patient called Rose who the team visited on two or three times a week to treat a couple of problems. Firstly, she had ulcerated legs

which the team were treating with four layer compression bandaging which evidence suggests is the best way to encourage venous return in order to maximise the healing process (O'Meara et al 2009). Secondly she had a small sacrum sinus which was packed and redressed. Dianne's request put me in an awkward position as I had visited Rose on a number of occasions with my mentor and with her supervision had been able to assess, treat and care for Rose's problems appropriately with the exception of applying compression bandages as my mentor had explained to me were only to be applied by staff who had received appropriate training. I am keen to take advantage of any professional development opportunities and improve my clinical skills. However I felt that although I was able to manage most of the delivery of care to Rose as required by the NMC Code of Conduct (2008) applying the compression bandaging was outside my remit and would have been unsafe practice. My feelings were that Dianne was not doing this for my personal development but for her own personal reasons resulting in her abdicating her responsibilities. She did not ask me how I felt about attending patients without supervision or check I had the necessary clinical skills.

With this in mind I agreed I would visit Rose, take down her dressings, assess and debride the wound, apply appropriate dressings and the first two layers of bandages. However I requested that Dianne called in after me to apply the compression bandages. Dianne did not appear to be very happy with my request but reluctantly agreed.

When I arrived at Rose's I introduced myself and explained the purpose of my visit and that Dianne would follow me to apply the compression bandages. I explained at each stage what I was doing, to put Rose at ease,

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remembering look up and face Rose, so that she could hear clearly what I was saying or read my lips and facial expression as she was partially deaf. As agreed with Dianne I took down the existing dressings, debrided and assessed the wound against the current wound care plan. The wound bed had reduced considerably and although an Iodine dressing had been applied previously, the wound had dried considerably and in my opinion did not require replacing. Therefore I telephone Dianne to let her know of my assessment and it was agreed to dress the wound with a simple NA dressing before bandaging. Whilst at Rose's I took the opportunity to update the wound care plan and therefore documented the size of the wound, exudate, smell etc etc and documented all my findings and actions in the care plan.

Whilst at Rose's I also required to redress the sacral sinus in accordance with her care plan. When assessing the wound I noticed that although her skin was not broken, her sacrum was very red. I had also previously noticed that although she had a pressure cushion sitting on another chair I had never actually seen her sat on it. Therefore I took the opportunity to encourage her to become involved in promoting her own health and explained that her sacrum was very red and that as she sat for long periods of time, it was possibly that her skin would break down, which was why she had been issued with a pressure cushion. We discussed why she did not use the pressure cushion, she said that she did not find it very comfortable in her favourite chair, I explained the benefits of the pressure cushion and we agreed that she would sit in another chair with the pressure cushion in situ for a least part of the day and that we would discuss how she got on next

time I visited. Before leaving Rose's I documented my assessments, nursing interventions, evaluation and actions in her care plan.

The second stage of Driscoll's entitled now what will look at the chain of events which has led me to reflect on when it is appropriate to delegate care.

Delegation involves entrusting and transferring a task or responsibility to another person who is able to accept responsibility for the task, typically one who is less senior than oneself (Sullivan and Decker 2005, Oxford dictionary 2011). However Wheeler (2004) argues that delegation and abdication amount to the same thing. On the other hand MacKenzie (1998) states that abdication is giving up either by abandonment or resignation and says that whilst delegation can offer potential benefits to both individuals and organisations, many nurses practice abdication which can be attributable to the current economic climate of underpaid and overstretched employees.

Whilst I did appreciate that Dianne thought I was capable to deliver appropriate care to Rose I also suspected that she thought it she would have an easier day if she asked me to carry out the more routine and mundane tasks. The NMC standards of proficiency (2004) state whilst nurses should delegate care to others they should also accept responsibility and accountability for such delegation. As a registered nurse under the NMC Code of Conduct (2008) nurses have a duty of care to ensure that patients receive care in a safe and skilled manner. Dianne was not aware if I was competent or not to carry out compression bandaging as she had neither previously worked with me or questioned me about my clinical skills. In line

with the NMC Code of Conduct (2008) I understand that I must work within the scope of my professional competence and it is for this reason I refused to apply the compression layer.

It is important for organisations and individuals to delegate in order for them to develop and function resourcefully and successfully (Ellis and Hartley 2004). Effective Delegation requires skills in planning, analysis and self-confidence. The tasks to be delegated should be assessed, planned, communicated, implemented, monitored and evaluated (Royal College of Nursing 2006).

In the UK, the rate of change is accelerating and the delivery of services are regularly restructured in an attempt to provide the most effective and efficient care to patients (Shepherd 2008). This environment has led to the evolution of work from junior doctors to nursing staff such as giving intravenous therapy and with the evolution of nursing practitioners many agree that the role of the nurse is increasingly difficult to define as the boundaries are constantly changing (Shepherd 2008, Spilbury and Meyer 2005, McKenna et al 2006). A study conducted by Ulster University concludes that there is much ambiguity amongst the nursing role. It concluded that although nurses are happy with role extensions they have less patient contact as they would like. Some nurses like the role extension of technical jobs, however others see it as menial tasks Doctors do not want to do (Allen 2002). However this was only a small survey of 26 nurses and therefore may not be a true representation of all RGN's (McKenna et al 2006). It can be assumed therefore that demands on nursing care at times are greater than RGN's can cope with, and therefore increasing expected to

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to delegate some tasks routinely, traditionally carried out by RGN's, such as personal care (Curtis and Nicholl 2004). Effective delegation can give RGN's more time for other activities which enables them to focus on doing fewer tasks well rather than many tasks poorly and offer HCA's the opportunity to become competent and improved confidence (Kourdi 1999).

Shepherd (2008) articulates that it is important for these tasks to be defined and when devolved it should not be at the detriment to the patient. As a result health care assistant (HCA) roles have increased in both numbers and scope of activity undertaken and it is therefore important that all health care staff understand their roles and accountability in the delegation process. Health care staff need to work together in order for patients to receive safe and effective care from the most appropriate personnel (Pearcey 2007). However some nurses find it difficult to relinquish any part of their role and find it difficult to delegate (Wheeler 2004) Zimmerman (1996) suggests this might be because some nurses were trained before delegation skills were required. However Nicholl and Curtis (2004) state that delegation is not an art and but a nursing skill which can be learned and is becoming increasingly important in changing times.

Delegation also enables health care professionals to train in new skills and broaden their skill range. However Wheeler argues that some could abuse their power of delegation for example to provide themselves with extra breaks while their subordinates may have to forfeit theirs to complete additional tasks. Or one nurse could favour a subordinate resulting in some always receiving more appealing tasks than others. Delegation is a complex

process and to successfully delegate consideration should be given to both existing workload and skill mix of staff should be known.

Delegation of too many tasks may result in loss of control, but failing to delegate may lead to one member of staff being overwhelmed, overworked and can lead to incompleteness of duties and de-motivated and un-cooperative team.

Most HCA's give personal care due to the fact they are usually more available than RGN'S. Many studies have indicated that RGN'S favour the employment of HCA's (McKenna and Hansson 2002). However the MIDRIS (2001) study suggests that care provided by HCA'S is task based and fragmented.

There are many pros and cons for delegating tasks. Detailed Job Descriptions (JD) may result in staff being reluctant to take on new responsibilities that are not specified on their JD. Others will be reluctant and believe if you want a job done properly do it yourself. This can inhibit delegation leading to nurses being overworked stressed with little job satisfaction (Kourdi 1999). On the other hand Wheeler (2001) suggests effective delegation encourages staff to have a better understanding and be able to influence the way in which work is carried out. She also says that by participating in decision-making it will increase motivation, morale and ultimately job performance enabling the organisation to become more flexible and responsive to change.

Effective delegation will enable a business to move forward as new ideas and viewpoints will be encouraged and it will better prepare nurses to be able to cope when career opportunities arise (Wheeler 2001). Delegation frees up

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time to enable a nurse to carry out other duties which cannot be delegated. Although at first the time saved might be minimal once the HCA becomes proficient more time will become available. Fewer tasks are better than many that are inefficient (Kourdi 1999).

In order to delegate effectively it is important to decide which task to delegate, select the best person to carry out that task, assessing the task in detail and offer clearly the level of authority associated with it, check the skills and experience of the delegates, follow the task process and assess and discuss the progress (Curtis and Nicholl 2004).

Cohen suggests it is right to delegate in order to carry out an organisation's needs as long as certain criteria are met such as right task, right circumstance, right person, right communication and right supervision.

The third stage, of the Driscoll's reflection model requires what can be done differently in the future and what actions to be taken.

Dianne was right to delegate the more junior tasks in order to ensure the fewer tasks she had were carried out more effectively. However, she should have verified my competence prior to delegating. If she had communicated with me effectively to assess my competence I would not have felt awkward having to point out that I did not have the skills to carry out compression bandaging and only practice within my capabilities (NMC 2008).

In the future in such a situation I would not do anything differently as I believe I have a responsibility for practicing within my own capabilities in line with the NMC Code of Conduct (2008). Had I been a permanent member of

staff I would have asked for compression training, however this would have been impractical as I was on placement for only a short period of time. When I qualify this situation I will be aware that I am ultimately responsible for the care of patients even when tasks are delegated to HCA's. I will also ensure that I do not delegate anything that involves critical thinking skills such as nursing assessments, planning and evaluation of patient care and nursing judgement.

(take off 90 for references)