

Ethical dilemma during community nursing



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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 also felt that his family were taking away his freedom to make an informed choice about his forthcoming care.

Analysis

Evaluation

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 whichever action he or she chooses will be an ethically wrong one'.

Kuupelomaki and Lauri (1998) and Roy and MacDonald (1998) agree that health professionals are faced with many ethical dilemmas when caring for terminally ill cancer patients and communicating the diagnosis and subsequently prognosis is one of the most common dilemmas experienced.

Alexander et al (2001) state that it is not unusual for relatives to ask a Consultant to withhold information. Kenworthy et al (2002) say that these

requests are made out of compassion and love. However, Rumbold (2002) disagrees and suggests it is often the relatives who are unable to cope and have difficulty in coming to terms with the impending prognosis. Dimond (2005) agrees and adds that 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. Buckman (1988) also appears to agree pointing out receiving 'bad news' can have a negative and drastic effect on a patient's view of their future.

The mentor acted in the correct manner speaking to Bob's consultant and agreeing with him to withhold the diagnosis from the patient. Dimond (2005) states that Nurses have a duty to adhere to the Consultants decision even when they are in disagreement. The Consultant made a professional decision to discuss the diagnosis and prognosis with Bob's partner. Rumbold (2002) identifies it is the correct decision to give information to family members when it is deemed that it is not medically advisable to inform the patient. Although patients may insist on being told of their diagnosis Consultants have the power to withhold information, there is no clear right in law even if the patient is exercising their right under the Data Protection Act 1998 (Dimond 2005). However, Harris (1994) argues that for Consultants to act in such a way is paternalistic.

Paternalism is when others believe they are acting in the individuals own best interests, whilst not affording them individual control over their own life, although concern for the individuals welfare is paramount, it omits respect for the individuals autonomy (Harris, 1994). However, Tingle and Cribb (2005), argue that there are two types of paternalism. Hard paternalism is <https://assignbuster.com/ethical-dilemma-during-community-nursing/>

acting on an individual's behalf because they feel qualified to do so, whereas soft paternalism is about making decisions on behalf of the individual whilst they are unable to exercise their own autonomy and feel they are doing so in the best interests of the patient. My feelings were that Robert had a right to know the truth about his diagnosis, this is identified by Tingle and Cribb (2005) as a deontological position, whereby obligations and duties to tell the truth overrides the justification of behavior, even when that action can be justified to be in the best interests of the patient's.

The principles of beneficence (promote goodness) and non-malifience (cause no harm) are fundamental ethical principles surrounding the decision to tell or not to tell a patient the truth regarding their diagnosis (Alexander, Fawcett, & Runciman, 2001). Rumbold (2002) identifies that health professionals should act according to the principles of beneficence and non-malifience, and states that withholding information or telling a lie is unethical and denies the individual autonomy. Rumbold (2002) argues that autonomy enables the individual to think, decide, and make decisions freely and independently based on information given. Nevertheless I felt that Bob could not be autonomous when he did not know the truth regarding his diagnosis and thus denying him the right to make informed decisions surrounding his death.

Although my values and beliefs differed from the Consultants, I was aware that I had to uphold his decision. Essentially, the consultant has clinical responsibility for patients Rumbold (2002). However, Kenworthy, Snowley and Gilling (2002) state that professionals who override an individual's autonomy for 'doing good' a dilemma exists.

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A dilemma can be described as a variance between personal beliefs, feelings and principles where different answers to a situation exists, although several courses of action may be taken each can be morally justified (Royal College of Nursing, 2000). Essentially the courses of action that could have been taken for Bob were to tell the truth or not, both positions could be morally justified, to tell the truth would enable Robert to be autonomous, however withholding the truth prevents Robert losing hope. Saunders (1991) however argues that healthcare professionals need to question whose needs they are seeking to meet. This is supported by McCarthy (1996) who states that healthcare professionals have a tendency to assume they know what there patients needs are. This made me feel that the Consultant and my mentor were colluding with Robert's wife and subsequently they were meeting her needs by withholding information thus ignoring Roberts's right to be autonomous. I therefore found that I was involved in a personal ethical dilemma related to veracity (truth telling) honesty and withholding information (Begley and Blackwood, 2000). Fry and Johnstone (2002) believe the principle of veracity lies with the individual not to deceive or tell a lie therefore tell the truth to others.

Research in to truth telling and patient diagnosis carried out by Sullivan (2001) suggests that ninety-nine per cent of patients want to be informed of their diagnosis and felt that Doctors had an obligation to tell them the truth.

However, ten Have and Clark (2002) argue that when diagnosis is imparted abruptly it can provoke denial, impair adaptation and psychologically harm the patient. McGuigan (1999) states that it is difficult to predict how patients

will react to ‘ bad news’, she suggests that the procedure for news should be slow, this then enables the patient time to absorb information given.

I believed that Robert had a right to know and felt that we would not be unduly harming him by informing him of his diagnosis. Anxiety, fear of death are all obvious signs when patients face life threatening illness Mason (2002). This is supported by Golds (2004) research who identifies that patients rarely suffer greater anxiety, depression, sadness, or despair on being informed of their diagnosis. Open honesty is encouraged by McGuigan (1999) who believes that as a result of being informed patients have a greater trust in the healthcare professionals treating them and are able to communicate more effectively with relatives and healthcare professionals as a result. This is agreed by Seale (1997) who advocates that an open awareness of diagnosis affords the individual to have control over circumstances surrounding their death.

I had been reflecting over the situation and realised it was too complex for me to handle therefore I sought guidance from my mentor. Although she would normally take a deontological position, she informed me that she was taking a utilitarian position in this case therefore acting within the principle of beneficence (do good) and acting in the best interests of Robert. Tingle and Cribb (2005) state that individuals who act on the principle of utilitarianism are acting in a way which yields the greatest happiness to all parties concerned regardless of the motives for taking these actions. My mentor and I also reflected on the conversation she had with Robert’s wife prior to his test results. It was felt that Robert was currently in denial and telling him of his diagnosis could potentially harm him, he may lose all hope

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therefore she was adhering to the principle of non-malificence (prevent harm).

Research carried out by Kubler-Ross (1969) (although an old reference it is still used today in Kenworthy, Snowley, & Gilling, 2002), identified denial as being the first stage of adjustment to the prospect of death by patients, she believes that individuals deny the reality of the situation and are unable to face up to the prospect of death. She also argues that it is the retreat in to denial that isolates the individual and as a consequence, communication is compromised between patients and healthcare professionals. Kubler-Ross's research has been endorsed by Buckman (1988) research however he suggests that patients go through reactions as opposed to stages.

Nonetheless, Evans and Walsh (2002) identify that it is often the healthcare professional's feelings of helplessness with the situation that leads them to believe that patients who hope for a cure are in denial of their disease.

Nevertheless, Kenworthy, Snowley, & Gilling (2002) argue that it would be unethical and damaging to force a patient in to facing the truth about their diagnosis.

I therefore realised that it would be unethical and be detrimental to force Robert to face the truth about his diagnosis, if we took away his hope of a cure we would only leave him with fear. Mason (2002) believes that in terminal illness hope and fear are synonymous to each other if hope is taken away patients are only left with fear. She also states that a patient's hope is fundamental and something to be protected. This is supported by Buckley and Herth (2004) who identify that hope of a cure in terminal illness is

immeasurable. In addition, Mason (2002) argues that hope is an individual's right and even in the final stages of death patients hold on to hope.

Conclusion

Reflecting back we had not actually lied to Robert as I had once presumed, although he was aware that further tests had been carried out he had never enquired about the results.

I believe that if I were ever faced with this type of situation again I would be more conscious of my patient feelings, listening and hearing what they are saying, thereby my approach would be more holistic rather than clinical.

By analysing my decisions I realise that I was blinkered and had stuck rigidly to the NMC (2004), not fully appreciating that the NMC (2004) has policies and parameters for which a registered nurse can work within, which enables a nurse to be proactive and use their professional judgement (Seedhouse, 1998).

Next time I would not be judgemental but look at the surrounding issues related to decision making. I had condemned the Consultant and my mentor for their decision and believed they were acting paternalistic, however I realise their decisions were based on their knowledge of Robert in addition to their experience and expertise. Benner (1984) suggests that an expert has the expertise and principles from which to make informed decisions based on their experience, training and practice which enables the expert to be holistic in their approach to patient care of which the novice has yet to gain and develop.

Reflecting over my decisions and feelings made me realise that I was a complete novice. This is supported by Benner (1984) (in Baillie 2001), who states that novices have no basis from which to apply their principles it is only in a clinical setting that experience can be gained, however novice can also be applied to nurses working in unfamiliar surroundings.

I now believe that I was guilty of paternalism believing my own beliefs and values were right. I had assumed that Robert needed to know of his diagnosis if he was to be autonomous.

To conclude I now realise that in terminal illness it can be question of when to inform the patient of ‘ bad news’. I believe that Robert was clearly not ready to accept the truth at that time therefore withholding information had been the right decision. Arguably Robert was autonomous, it was his decision to hope for a cure therefore it would have been unethical and morally wrong to take that away. However, the circumstances surrounding this decision could only be applied to Robert’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.

By using the Gibbs (1988) reflective framework cycle it has enabled me to analyse, question, move forward, learn and make sense of my actions. I am now aware that reflection is a continual learning process in nursing. Rather than condemn myself where I think I have failed I have been able to turn it in to a positive learning experience and apply this newly gained knowledge in to my future practices

Action Plan