

# [Children’s training, such increase awareness of children’s individual](https://assignbuster.com/childrens-training-such-increase-awareness-of-childrens-individual/)

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Children’sparticipation in decisions could affect treatment outcome, and often childrenplay only a minor role in decision-making.

Here, paediatricians role come tooffer children opportunities for participation and to guide parents as to howtheir child could be involved (Ruhe et al., 2016).  In order to do assure adequate patientparticipation, paediatricians and other professionals caring for children withcancer need special training, such increase awareness of children’s individualneeds, capacities, and preferences and learning about strategies to involvethem according to these abilities and wishes (Ruhe et al., 2016). Theyemphasized the level of children involvement should not only depend onchildren’s maturity, but on their preferences too. Since wishes regardinginvolvement can differ from child to child. In another study, Ruhe, et al.

, 2016, said that participants children mentioned some obstacles that came out oftheir involvement or non-involvement in their care, such as confusion ofinformation provided, sense of being overlooked, and pressure in making adecision. Despite these challenges children considered their involvement asimportant because they were the ones affected by the illness and treatment. Accordingto International Society of Pediatric Oncology, Involving children incommunication about their illness and treatment decision is an ethicalobligation and demonstrates respect and value to their opinion. Children’sparticipation in decisions could affect treatment outcome, and often childrenplay only a minor role in decision-making, and her paediatricians role come tooffer children opportunities for participation and to guide parents as to howtheir child could be involved (Ruhe et al., 2016).  In order to do assure adequate patientparticipation, paediatricians and other professionals caring for children withcancer need special training, such increase awareness of children’s individualneeds, capacities, and preferences and learning about strategies to involvethem according to these abilities and wishes (Ruhe et al., 2016).

Theyemphasized also that, level of children involvement should not only depend onchildren’s maturity, but also on their preferences, since wishes regardinginvolvement can differ from child to child. Throughclinical trials progress in medical therapies for childhood cancer have beenachieved. It is known that treatment decision making in childhood cancer itselfis stressful situation for parents; then what if parents asked to enter theirchild in a clinical research trials, this will be another stress added to them. According to Shilling & Young, 2009, some parents saw trials as a threat totheir child or fear regretting their decision, whilst others saw trials asoffering hope better treatment for their child. The role of parents in trialdecision making is complex and it is a challenge for researchers in discussingpediatric trials with parents to balance the tension surrounds them.

Therefore, researchers are required to support parent’s decision making appropriately andguard against the possibility of regret (Shilling & Young, 2009). Subsequently, to conduct a trials with children it is requiredto understand the special situations of parents and their particular need forsupport to allow them to retain a sense that they have safeguarded theirchild’s interest and secure the best outcome for them (Shilling & Young, 2009). In another study, Hoberman et al.

, 2013, highlighted an importantmodifiable factors that influenced the consent process. Factors included theinvolvement of a researcher who made them feel comfortable and properunderstanding of the study, the clarity of explanation on how research risk isminimized, how participation affects standard of care, the right to withdraw atany time, and the benefits to the child and other children. Additionally, they found that, parents with high socioeconomic status and more educateddeclined consent to their child’s participation and had high level ofdecisional anxiety. Kelly& Ganong, 2006, in a unique study, presented a special findings abouttreatment decision making in single parents, and re-partnered parents suggestingthat, decision making process of single, divorced and re-partnered parentsmight differ from that of married parents. They found that both biologicalparent and step-parents assigned decision-making primacy exclusively to thebiological parent which is supporting the critical importance of treatmentdecision making of parents of children with cancer as a natural extension oftheir parental role.  As that, the parentimperative for treatment decision making compelled custodial parents to reachout to the co-parent, and the co-parent to step up to be actively involved inthe treatment decision-making process.

They elucidated also, that majority ofco-parents stepped up to decision making, this behaviour reflected a naturalpart of the parenting role, but when they did not, researchers assumed thatthis reflected their previous level of parenting. Moreover, it was noted thatmaternal gatekeeping plays a role in limiting paternal involvement however, single mothers initially attempted to engage fathers in the treatmentdecision-making process. From another perspective, Katherine & Lawrence, 2006, said that parent’s focus on the ill child created opportunities forparenting collaboration and cooperation that had not always been present priorto the child’s diagnosis. But unfortunately, normalization for parents in theirstudy which consisted returning parents’ previous patterns of interaction withtheir former partners was not effective. Study mentioned that separatedbiological parents also reported increased difficulty interacting withstep-parents than did parents who had separated years previously. Parentsare eligible to make medical decisions on behalf of their children, moreover; they also have the right to refuse or discontinue treatments, even those thatmay cause life-threatening. Hord et al., 2006, argued that, since the cure rates form any childhood malignancies are more than50% with standard therapy regimens, with holding treatment can be a dif? cultethical dilemma for the treatment providers who should seek legal recourse insuch case.

They added, it is physician’s responsibility to the patient toestablish the course of treatment that will provide the best opportunity forlong-term survival, but when dealing with patients with poor prognosis, limiting medical therapy is reasonable, ethical, and morally defensible becausethe burdens of therapy may outweigh the bene? ts, and parents must considerquality of life. However, many studies have highlighted several factors that might influence parentaltreatment decision making for children with cancer. Pyke-Grimm et al., 2006, elucidated some factors that were frequently identified to affect parent’sdecision such: parent’s relationship with physician, nature of communication, trust in the physician, parents and physician knowledge and experience. Accordingto Pyke-Grimm et al.

, 2006, most of the parents preferred collaborative rolewith physician in treatment decision making, and this reflecting the importanceof parent’s relationship with the physician in determining their role intreatment decision. Better communication between parents and physicians andother health care providers found to be associated with improved psychologicaladjustment and treatment adherence. Also, this study referred to parents trustin physician as an important factor in the situation of treatment decisionmaking process. It is pointed that parent’s decision about their child’s cancertreatment was influenced by trust in physician. At last, study listedphysician’s superior knowledge as an important factor in parents’ decisionprocess.

Parents’ participation in decisions making was influenced by theirawareness of doctor’s level of knowledge, and experience, believing thatphysician having knowledge, and experience were expert at dealing with cancer(Pyke-Grimm et al., 2006. According to Miller & Nelson 2012, parents’demographic characteristics such as education, income, race, gender; andprevious experience with a similar decision treatment decisions for theirchildren are factors affecting parents’ decision-making. They found that, low participationof parents in treatment process was associated with lower education, malegender, minority status, and not having previous experience with a similardecision.             Accordingto previous view, parents are considered the key part in childhood cancermedical decision making. Many strategiesand policies have been developed to facilitate parental decision making processsuch as informed consent. It is legally allowed for parents to provide informedpermission for their children.

Several literatures showed that making treatmentdecision is one of the most major challenges faced children’s parents withcancer.  Definitely, it is a difficultresponsibility for parents to make decision that will affect their child healthand life span. According to Stewart, Pyke-Gerimm, & Kelly 2012, making the rightdecision is a nature extension of the parental role, of acting in one’s child’sbest interest and ensuring the best possible results. They found that uncertaintywas characterized as one of the most stressful aspects of parenting a seriouslyill child. Whereas uncertainty related to limited knowledge and experience canoften be improve. It is possible to say that, the nature of parents’relationships with the physician responsible for child’s care, was central tothe decision making process.

Therefore, physician attributes that conveytrustworthiness found to ameliorate the parents emotional stress associatedwith uncertainty and decision responsibility (Stewart, Pyke-Gerimm, & Kelly, 2012). Furthermore, McKenna et al., 2009, identifiedparental perceptions of their own involvement in the decision to enrol theirchild on to a speci? c cancer treatment protocol. They found that, parents werehappier with their decision when they felt that they had made an informedchoice and received the right amount of information regarding treatmentoptions, while decision-making process was more dif? cult when parents wereunsure what to do.

Accordingly, information and support tailored to parents’speci? c needs may therefore enhance satisfaction with clinical decision makingand reassure parents about decisions made in the long-term interest of theirchild’s health. Another important finding was that, parent’s satisfaction withboth the decision-making process, and their con? dence in the decision wasimpacted with accessibility of treating physician, information provided anddegree of support afforded to them. (McKenna, et al., 2012. On another study, Mack, et al.

, 2011, evaluated the extent to which parents’ roles in decision makingin the ? rst year of their child’s cancer treatment matched their preferences. Theyfound that, the majority of the studied parents were able to have their desiredlevel of involvement in decision making for their child’s cancer, but nearly aquarter were less involved in decision making than they wished, a circumstancethat was associated with decreased trust of the child’s physician. Treatmentdecision is a critical and complex task especially when providing care forpediatric oncology patients. Physicians are facing many challenges whenidentifying and selecting from available treatment options. Ethical practice ofmedicine involves a set of responsibilities, namely providing maximum benefitand avoiding harm, relief of symptoms, and saving and/or prolonging life(Friebert & Kodish, 1999). Many ethical theories argued that physicians mustprovide information for patients and their families to enable them to taketheir own decision rather than making decisions for patients (Simons et al., 2006).

Whitney et al., (2006), integrated the ethical theory with the concreterealities of clinical medicine as physicians strive to ? nd the right treatmentchoice for oncology child, and they suggested that physicians have decisionalpriority when there is one clear best medical option, whether the chance ofcure is signi? cant or vanishingly small. Empirically and ethically, physicianrole is to assume decisional priority because of his or her knowledge, based onthe best available evidence as applied to the child’s circumstance, indicatesthat this is the most effective treatment approach priority, and then comes the role of the parents to exercisedecisional and legal authority (Whitney et al., 2006). In my point of view, Ibelieve this is an ethically appropriate division of the work of decisionmaking. Childhoodcancer is the cancers that occurs in children younger than 18 years.

Althoughcancer is uncommon in children, it is has been classified the leading cause ofdeath in children under 15 years, despite many medical interventions available. There are no known causes of childhood cancer, and it occurs across all ethnicgroups; moreover, some children are even born with cancer. A child’s cancerdiagnosis creates major emotional distress, and affects personal and familyequilibrium.

After the diagnosis of cancer it begins the most critical anddifficult step; it is a treatment decision making of a life-threatening illnessand risks associated with treatment. For children with serious illness such ascancer, the clinical decision making is a significant challenge for physicians, parents, and patients. It is accompanied with unique ethical issues (Whitney etal., 2006). Therefore, ethics practice is necessary during clinical decisionmaking in pediatric oncology.

Accordingly, this paper will be focused on anumber of key themes: decision making in pediatric oncology by physicians; parents’participation in treatment decisions; factors that might affect parent’sdecisions; participation of child in clinical trials and refuse of treatment byparents. I will then turn my attention to another ethical dilemmas such as involvingpediatric patient in decision making; preservation of fertility; end of lifepreference and choosing a do not resuscitate. (DNR). Finally, I will offer myown thoughts and hypothesis.