**ETHICAL AND PROFESSIONAL ISSUES IN CHILD HEALTH NURSING**

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**I.INTRODUCTION**

Medical care is a combination of science and art. Utilizing the science of the most recent medical knowledge, we should make decisions regarding patients. Knowing how, when, and what to elicit from patients while also providing them with the proper aid to enable them to maintain their health is the art of medicine. The art also demonstrates the requirement for adequate communication abilities and a patient-inclusive mindset. Medical ethics is a crucial component of both the research and the practice of medicine. when we use irrational reasons for medical decisions, when we do not update our knowledge, when we are not analytically and scientifically rational, when we do not attempt to communicate effectively or adequately and discriminatory for whatever reason, we are practicing unethical medicine .Children are a particularly vulnerable group of people, so every clinical choice must be made with specific consideration for the child's needs. As a health professional, it is our responsibility to stand up for and defend the rights of children.

Clinical problems with significant ethical implications pose an ever-increasing quandary in 21st-century medical practice and rarely present a simple solution. This is especially true when it comes to moral dilemmas concerning minors and individuals incapable of making their own decisions. While the needs of the patient should always come first and any personal, cultural, and religious prejudice should be eradicated, it is also important to consider how the patient's expensive treatment may affect the available healthcare resources. It is critical to establish a morally acceptable code of behavior in order to provide a reasonable and objective management strategy for the child as well as society at large, regardless of creed or culture. While the following articles will address specific ethical issues relating to disability, the start of intensive care or "extraordinary" measures, and, finally, issues relating to care discontinuation and the dying process, this editorial will review some of the general principles that guide medical ethical problems.

**II. GENERAL ETHICAL PRINCIPLES**

If not fully realized, the ideal code of ethically acceptable practise can be approached by applying the following accepted principles in decision-making.

1. **Respect of the individual's autonomy**

Autonomy indicates that everyone has the freedom to participate actively and independently in the decision-making process. For this to occur, patients must be properly informed and comprehend the significance of their medical illness, its treatment, side effects, and outcome. In practice, however, most children lack the ability to be truly informed and must rely on others for guidance. This situation, if anything, emphasizes the doctors' responsibility to ensure true informed consent, albeit through third parties.

1. **Respect of the individual's competence**

It denotes the patient's level of comprehension, which enables him or her to weigh the ethical issues presented by a clinical situation, assimilate these, and make a rational decision. This level of comprehension is frequently a problem in young children, heightening the responsibility of parents and the medical team to act as competent advocates on their behalf.

1. **Respect beneficence**

It defines the medical principle of 'do no harm,' a tenet of the Hippocratic oath, and should be followed in all circumstances. Medical practice frequently involves a trade-off between benefit and harm, particularly in the case of interventional procedures and drug therapy, but it should always be skewed toward 'benefit.' As a result, in practice, embarking on high-risk therapy in a fully informed individual (or his/her advocate) may be perfectly acceptable, provided there is a realistic chance of reasonable benefit

1. **Respect of the truth**

Willfully lying to patients is never justified. Similarly, withholding or omitting information from patients is rarely justified.

1. **Respect of patient confidentiality**

Every patient has the right to privacy. However, in situations where failure to report could result in a greater disadvantage to the patient, disclosure of confidential information without consent may be justified (e.g. physical abuse).

**F. Avoidance of paternalism and bias**

When counseling or treating children, practitioners should strive to remain truly objective and avoid any personal, racial, cultural, religious, or other bias. Personal prejudice and preconceived notions must never be allowed to influence the provision or withholding of medical care to patients, whether they are disadvantaged, have a pre-existing disability, or otherwise. Parents' and guardians' wishes must also be respected, regardless of personal bias.

1. **Restricting any potential conflicts of interest.**

Always prioritize the needs of the child over the needs of any third party, including doctors, parents, guardians, extended family, and society.

**H.** **Respect the limitations of medical care**

Medical care should aim to support the patient and be tailored to the individual's needs, including any complications or disabilities. It is ethically appropriate to value realistic goals that medical care can achieve, rather than exaggerated or impossible expectations. As a result, 'treating at all costs' is as unacceptable as 'playing god.

**I. Informed consent**

Informed consent is a formal preauthorization for an invasive procedure or participation in research. Consent must be given voluntarily, parents as the legal custodians of minor children are requested to give informed consent on behalf of a child. When parents are divorced either may give informed consent. Both children and parents must understand that they have the right to refuse treatment at any time. In an emergency consent for treatment to preserve life or limb is not required. According to state law, children under the age of 18 or 21, as appropriate, may offer informed consent in the following situations. when they are the patient's minor parents. when they are children with legal standing (self-supporting adolescents under eighteen years of age, not subject to parental control). when they are 16 to 18-year-old teens looking for contraception, mental health counselling, or abuse therapy. In some places, mature minors (adolescents between the ages of 14 and 15 who are able to comprehend treatment risks) have the option of giving permission for treatment or declining it.

1. **Solving ethical dilemmas**

Making decisions in ethical issues may appear simple, yet the solutions may not be acceptable to everyone. A lot of organizations establish bioethics committees to help with decision-making in particular cases, educate the public, and develop policy for ethical problems. These committees are made up of a variety of experts, including clergy, nurses, doctors, and social workers. The child and family are also involved in the decision-making process. Sometimes the outcome of ethical quandaries contradicts what is legal in their field and place of practice.

**III. ETHICAL CONCERNS IN CHILD HEALTH NURSING**

1. **Cessation of treatment**

The decision to discontinue treatment is fraught with ethical quandaries, which appear to be exacerbated when the client is an infant or child. Children who would have died without life support can now have their lives extended. Parents must be involved in the decision-making process as soon as possible and informed of the available options. Parents in some states can make advance directives for their minor children under state law.

**B. Terminating life support**

* Decisions to discontinue life-sustaining systems continue to put nurses in difficult ethical and legal situations, especially when an infant or child is involved. Despite popular belief, the legal system plays an important role in this area of health care.
* Parents typically form relationships with their primary care nurses and request that the nurse be involved in the decision to withdraw a child's life support. A nurse in the neonatal critical care unit might encounter this situation while caring for a teen patient.
* A team meeting should be organized with the parents, primary nurse, physician, and a hospital staff attorney who is familiar with the applicable laws in that state in the case of a premature baby with a congenital heart. When families get together, issues can arise. Physicians and nurses have different ideas about what is best. When to first discuss the concept of cardiopulmonary resuscitation, mechanical ventilation, and do not rescuitate orders with adolescents is always a sensitive issue. Adolescents who have reached the age of majority must consent if they are of sound mind. In most states, minority status expires at the age of eighteen.

**C.Gendersensitization**

Gender and sex are some factors that affect decision making. Sex refers to the biological phenotype classified into two broad categories male and female. Gender denotes legal social and economic distinctions that follow from the biological difference of sex .The male female ratio has gradually changed through the years with an unnatural decrease in the female children. The reasons are female infanticide, pre-birth elimination of females by antenatal determination of sex.

**D.Decisionmaking**

Making ethical decisions is founded on fundamental character traits including dependability, accountability, respect, fairness, compassion, and good citizenship. Making ethical decisions leads to ethical behaviours, which serve as the cornerstone of ethical business operations.

**Steps in making ethical decisions**

**1. Collect information**

* What decisions are needed?
* Who are the key persons involved?
* What information will make the situation more clear?
* Are there any legal constraints?

**2. Identify the ethical issues or concerns of the situations**

* What are their historical roots , the religious and philosophical positions?
* What are the current societal views of each issue?

**3. Define the personal and professional moral positions on the issues?**

* What personal constraints are raised by the issues?
* What is the professional code for guidance?
* Are there any conflicting loyalties or obligations?
* What are the moral positions of the key individuals involved?

**4. Identify any value conflicts**

* What is the basis for the conflict?
* What is the basis for the resolution?

**5. Decision making**

* Who should make the decision?
* What are the possible actions and their anticipated outcome?
* What is the moral justification for each action?
* Which action fits the criteria for this situation?
* Decide on a course of action and carry out?

**6. Evaluate the results of the decision action**

* Did the expected outcome occur?
* Is a new decision needed?
* Is the decision process complete?

**IV. GENERAL ETHICAL ISSUES OF A PEDIATRIC NURSE**

Pediatric nurses must often professionally resolve conflicts involving a family's personal values, which can be difficult at times.

1. **Coping Skills.**

When a child is recently diagnosed with a serious condition, both the child and family members may feel overwhelmed. A pediatric nurse is responsible for assisting both parents and children in learning to cope with a serious illness.

**B. Restraining a Child.**

Certain procedures necessitate the use of pediatric nurses to restrain a child. In some cases, it is absolutely necessary to protect their safety; for example, if a child requires stitches but refuses to hold still, the child must be retrained for the procedure.

**C. Refusing Treatment**

Though children are minors, the parent has the ultimate right to refuse treatment for their child. As a result, it can be difficult for a nurse to have to withdraw a child from life support or refuse certain treatments that may help them recover when the nurse believes it is ethically correct to do so..

**D. Religious Beliefs**

Regardless of a paediatric nurse's spiritual or religious beliefs, she must adhere to the family's beliefs, not allowing her own emotions to get in the way.

1. **Accepting reality.**

Losing a child can be the most difficult experience a family will ever have. A paediatric nurse, on the other hand, must help family members understand when there is nothing else that can be done to save the child. In some cases, parents refuse to accept this and insist on additional treatments..

**V. SOCIO CULTURAL DIFFERENCES AND THEIR IMPLICATIONS FOR CHILD HEALTH NURSING**

The future of any society depends on its children. Culture plays a critical role in the socialization agenda of children through particular views of parenting and child development. Culture is the context of the child’s experience of health, wellness and sickness. Culture is the pattern of assumptions beliefs and practices that unconsciously frames or guides the outlook and decisions of a group of people. A culture is made up of people who share a set of values, beliefs, practices (language, dress, diet, health care), social relationships, laws, politics, economics, and behavioral norms that are learned, integrative, social, and satisfying. Culture is a worldview and a set of traditions that a specific social group uses and passes down to the next generation. Cultural values are preferred ways of acting that are based on those traditions. Understanding why people react to health care in different ways requires understanding their cultural and background values. Cultural values are frequently influenced by their surroundings. The norms are a group's typical values. Taboos are actions that are not acceptable. Values of

Respecting socio cultural values is important in child health because child rearing is a time in life surrounded by many cultural traditions. Nurses can better provide multicultural care by understanding cultural concepts and sociocultural influences on families.

**Social roles**

Children’s self-concept is derived from their ideas about their social roles . Roles are cultural creations, therefore culture prescribes patterns of behavior for persons in a variety of social positions.

**VI. CHANGING CULTURAL CONCEPTS**

Assimilation or acculturation refers to this trade of ethnic traditions for those of the dominant culture. The process of assimilation means that cultural expression is lost by taking on the concepts of the dominant culture. Ethnocentrism is the belief that one's own culture is superior to all others. Because the feelings and ways of other cultures cannot be understood or appreciated without the philosophy that the world is large enough to accommodate a diversity of ideas or behaviours, ethnocentrism can lead to prejudice.

1. **Cultural competence continuum Cultural destructiveness**

Forcing everyone to conform to the same cultural pattern and excluding those who do not- forced assimilation Emphasis on differences and their use as barriers.

1. **Cultural blindness.**

Do not see or believe in cultural differences between people. Everyone looks the same.

1. **Awareness**

Being aware that we all live and function within our own culture, and that it shapes our identity.

1. **Cultural sensitivity**

Accepting and understanding diverse cultural values, attitudes, and behaviours.

1. **Cultural competence**

The incorporation of cultural elements to improve communication and collaboration is strongly encouraged. It is critical to consider and respect people's cultural differences when planning nursing care.

1. **Socio cultural assessment**

Assessing families to determine whether socioeconomic or cultural influences exist that necessitate special care considerations .The composition of the family, as well as its functions, roles, and actions, must be investigated.

**G**. **Communication patterns**

Culture influences communication patterns, not only what people say but also how they say it. People who normally associate only with members of their own culture who speak their native language may struggle to provide a health history in English to a health care provider. Language barriers can be especially problematic if the health history is given while the child is ill, as their ability to cope and express themselves may be impaired. When under stress, people may find it difficult to recall English words for symptoms such as nausea or dizziness. Children who are embraced or fearful of speaking may simply not speak, and thus their needs may go unmet. Touch is a form of communication, whether people greet each other with it or not.

**H. Cultural shock**

The term cultural shock describes the feelings of helplessness and discomfort and a state of disorientation experienced by an outsider attempting to comprehend or effectively adapt to a different cultural group because of differences in cultural practices values and beliefs. Cultural shock is characterized by the inability to respond to or function in a new or strange situation. Nurses are challenged to overcome culture shock and develop the dynamics of cultural sensitivity an awareness of cultural similarities and differences .thus nurse is helped to practice culturally competent care.

1. **Use of conversational space**

Different cultures make use of their surroundings in various ways. Because palpation is part of the examination, examinations of children in the Western world must be conducted in a very small (intimate) space. On the other hand, the conversation is held at a distance of between 18 inches and 4 feet. Eastern cultures may not feel at ease at the same distance. Knowing that the use of space is culturally determined aids us in respecting the use of space for clients.

**VII. IMPORTANCE OF CULTURE AND RELIGION TO NURSES**

Nurses and other health care providers should be aware of their own cultural values and how those beliefs their thoughts and actions. Those who are aware of their own culturally founded behavior are more sensitive to cultural behavior in others. Cultural standards and values the family structure and function and past experiences with healthcare influence a family’s feelings and attitudes towards health, their children and health care delivery systems. Being aware of one’s own feelings and as well as respecting those of the family is essential to a helping relationship and achievement of nursing goals. It is essential to make an effort to adapt ethnic practices to the health needs of the family rather than attempt to change longstanding beliefs. Bridging cultural gaps in delivery of health care to children requires the establishment of a close relationship with families and other influential persons in the community.

**VIII. ETHICAL ISSUES OF NURSES WORKIG IN DIFFERENT SETTINGS OF PEDIATRIC UNIT**

1. **Preoperative nursing**

Pediatric perioperative nurses deal with a variety of ethical dilemmas on a regular basis. Some of these problems call for speedy decision-making. Attending ethical, legal, and clinical conferences, reading ethical papers in nursing, medical, legal, and ethical publications, and having discussions with coworkers are resources and methods that nurses can utilize to acquire the knowledge necessary for making ethical decisions. Ethics advisory committees and ethicists or people knowledgeable about ethics can provide consultation. In order to critically analyze arguments, reflect on decisions, and examine positions, nurses must be able to identify ethical issues and how ethical decisions are made. Nurses must be able to recognize and identify conflicts between personal and professional values, as well as attempt to resolve the conflict. When providing patient care, perioperative nurses must accept responsibility for their actions and make decisions based on ethical reasoning. Pediatric perioperative nurses are better prepared to provide comprehensive nursing care to all patients and families if they are aware of ethical issues and how to address them.

1. **End of life care of children**

A child's death can have a significant impact on the parents, family members, and health care providers who cared for the child. Parents of seriously ill children face unique challenges because they must serve as the legal authority for health care decisions for children under the age of 18, while the child's wishes must also be considered. Core social work values, bioethical values, and psychosocial issues presented by such situations must all be balanced by social workers. While research on ethical issues in pediatric end-of-life care settings has been conducted with physicians and nurses, little is known about how social workers deal with these conflicts. The National Association of Social Workers Standards for Palliative and End of Life Care (NASW, 2004) are used in this article to demonstrate potential ethical dilemmas in this situation and to explore solutions. These short stories offer descriptions of potential responses in this situation and can serve as a starting point for further investigation of ethical issues in the care of children who are near death from the perspective of social work.

1. **Pediatric dialysis unit**

Improvements in pediatric dialysis over the past 50 years have made the decision to proceed with dialysis straightforward for the majority of pediatric patients. For certain groups, however, such as children with multiple comorbid conditions, children and families with few social and economic resources, and neonates and infants, the decision of whether to proceed with dialysis remains much more controversial. In this review, we will examine the best available data regarding the outcomes of dialysis in these populations and analyze the important ethical considerations that should guide decisions regarding dialysis for these patients. We conclude that providers must continue to follow a nuanced and individualized approach in decision making for each child and to recognize that, regardless of the decision reached about dialysis, there is a continued duty to care for patients and families to maximize the remaining quality of their lives.

1. **Care of children with Metal health**

Ethical issues in pediatric mental health care have undergone little theoretical consideration and empirical study. In this exploratory ethnographic study, 20 Pediatric Mental Health Registered Nurses (PMHRNs) describe the ethical issues they believe arise from the care they deliver to children in school-age and adolescent age groups. Three major themes emerge from the interviews. These themes, the PMHRNs' relational roles, their role as advocate facilitator, and their view of the milieu as an extension of the family, are analyzed for ethical content using several ethical theories. These ethical theories are evaluated for adequacy, and an argument for the use of relational ethical theories in examining pediatric mental health ethical issues, as well as general pediatric nursing practice, is presented.

1. **Care of children with Cancer**

It mainly concerns about infringing on autonomy, deciding on treatment levels, and conflicting perspectives that posed a challenge to collaboration were the main ethical issues. Professionals desired teamwork and reflection to address ethical concerns, and they required resources to do so.

Experiences with ethical concerns and dealing with them in the care of children with cancer elicited strong emotions and moral perplexity among nursing staff. The study poses a difficult question: How can conflicting perspectives, a lack of interprofessional consideration, and barriers related to parental involvement be "turned around," that is, contribute to a holistic perspective of ethics in pediatric cancer care?

1. **Bed side care of children**

Every day at work, pediatric nurses face difficult ethical situations. Although several studies have shown that pediatric nurses have ethical problems, we don't believe that these problems have been thoroughly examined from their own perspective. We must create plans to handle moral dilemmas at the institutional level. It is crucial for pediatric nurses to be able to discuss ethical dilemmas with other nurses and other medical personnel. In addition, developing pediatric nurses' moral, ethical, and philosophical thought patterns necessitates the provision of immediate continuing education in nursing ethics at the location of clinical nursing, time to discuss ethical dilemmas, and other supportive measures. We should also improve the ethical climate and increase nurses' ethical sensitivity and autonomy.

1. **Pediatric Palliative care**

It investigates the hypothesis that because of the particular dynamics of palliative care in pediatrics, when a child has a life-limiting illness, the interpersonal boundaries between the patient, the patient's parents, and the health care team members differ from conventional provider, patient, and parent boundaries. A quick survey regarding working in pediatric palliative care and the difficulties maintaining professional boundaries faced by new palliative care clinicians was completed by staff members of the Journey's Palliative Care Team at Albany Medical Center. The numerous issues raised by the Journey team can be better understood by looking back at survey responses and reviewing pertinent literature. Future studies may follow the conclusions of providing comprehensive, morally upright palliative care services.

**CONCLUSION**

Management is fraught with controversy, and medicine is never a pure science. In medicine, a single, simple solution to a given ethical problem is extremely unlikely, especially in patients who are either too young or incapable of comprehending the complexities of treatment. These patients rely on third parties to make decisions, adding another layer of complication to an already complicated situation. Only by adhering to a strict code of ethics based on respect and tolerance for others, whether 'competent' or not, can decisions that are truly in the best interests of patients and society as a whole be made.

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