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

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**I.INTRODUCTION**

Medical treatment is both a science and an art. We should make patient-related judgments using the science of the most recent medical information. The art of medicine lies in knowing how, when and what to elicit from patients and offer appropriate assistance to enable them to stay healthy. The art also determines a need for adequate skills of communication and a non-discriminatory attitude towards patients. Medical ethics is an important part of both science and art 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 dilemma in everyday medical practice in the 21st century 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. In order to provide a reasonable and objective management strategy for the child as well as society at large, regardless of creed or culture, it is crucial to establish a morally acceptable code of behavior. While the upcoming series of articles will address specific ethical issues relating to disability, the beginning of intensive care or "extraordinary" measures, and, finally, issues relating to the discontinuation of care and the dying process, this editorial will review some of the general principles that guide medical ethical problems.

**II. GENERAL ETHICAL PRINCIPLES**

The ideal code of ethically acceptable practice may be approached, if not fully achieved, by applying the following accepted principles in the decision-making process.

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

Autonomy indicates that everyone has the freedom to participate actively and independently in the decision-making process. Patients must be properly informed and comprehend the significance of their medical illness, its treatment, side effects, and outcome for this to happen. In practice, however, the majority of children do not have the ability to be truly informed, and rely on others for guidance. If anything, this situation heightens the doctors’ responsibility to ensure true informed consent, albeit through third parties.

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

It implies the patient's level of understanding that allows him or her to weigh up the ethical issues posed by a clinical situation, assimilate these and reach a rational decision. This degree of comprehension is often a problem with young children, thereby increasing the responsibility of parents and the medical team to assume the role of competent advocates on their behalf.

1. **Respect beneficence**

It defines the medical principle of ‘do no harm’, a hallmark of the Hippocratic oath, and should apply in all cases. Medical practice frequently entails a compromise between benefit and harm, especially with regard to interventional procedures and drug therapy, but should always be biased toward ‘benefit’. Hence, in practice, it may be perfectly acceptable to embark on high-risk therapy in a fully informed individual (or his/her advocate), provided there is a realistic chance of reasonable benefit.

1. **Respect of the truth**

There is never a case for willfully lying to patients. Similarly, there is rarely any justification in withholding or omitting information from patients.

1. **Respect of patient confidentiality**

All patients have a right to confidentiality. However, disclosure of confidential information without consent may be justified in situations where failure to report may lead to greater disadvantage to the patient (e.g. physical abuse).

1. **Avoidance of paternalism and bias**

Practitioners should strive to remain truly objective and avoid all personal, racial, cultural, religious or other bias when counseling or treating children. Personal prejudice and preconceived ideas must never influence the provision or withholding of medical care to patients, regardless of whether they are disadvantaged, have a pre-existing disability or otherwise. The wishes of parents and guardians must also be respected, again regardless of any personal bias.

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

Always put the child's needs ahead of those of any third party, including doctors, parents, guardians, extended family, and society.

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

Medical care should strive to support the patient, and should be tailored to the needs of the individual including any complications or disabilities. It is ethically appropriate to appreciate realistic goals which medical care can achieve, and wrong to aim toward exaggerated or impossible expectations. Hence, it is equally unacceptable to ‘treat at all costs’, as it is to ‘play god’.

1. **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. Children under 18 or 21 years of age depending on state law, can legally give informed consent in following circumstances. When they are minor parents of the child patient. When they are emancipated minors (self-supporting adolescents under eighteen years of age, not subject to parental control). When they are adolescents between 16 and 18 years of age seeking birth control , mental health counselling or abuse treatment. Mature minors (14 and 15 year old adolescents who are able to understand treatment risks) can give consent for treatment or refuse treatment in some states.

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 the family also participate in decision making process .sometimes the result of ethical dilemmas may be in conflict with 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 an ethical quandary that appears to be exacerbated when the client is an infant or child. Children who would have died otherwise can now have their lives extended by using life support. Parents must be immediately involved in the decision-making process and informed about the available options. Some states' laws allow parents to make advance directives for their minor children.

1. **Terminating life support**

* Decisions to discontinue life support systems continue to present nurses with difficult ethical and legal situations, particularly when an infant or child is involved. Despite popular belief that such decisions should be based on quality of life, the legal system plays a significant role in this area of health care.
* Parents typically develop relationships with their primary care nurses and ask the nurse to be included in the decision to remove a child's life support. An instance of this might arise for a nurse in the neonatal critical care unit with a teenager patient.
* Of a premature baby with a congenital heart 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. When families come together, problems can arise.. Physicians and nurses differ in their opinion of what is best. The issue of when first to discuss with the adolescents the idea of cardiopulmonary resuscitation, mechanical ventilation, and do not rescuitate orders is always sensitive. Adolescents who have reached majority age must give consent if they are of sound mind. In most states minority status ends at the age of eighteen years.

**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**

Ethical decision-making is based on core character values like trustworthiness, respect, responsibility, fairness, caring, and good citizenship. Ethical decisions generate ethical behaviors and provide a foundation for good business practices.

In practice, many of the above ideals do not fully apply to a specific case. It can be difficult, for example, to completely separate disinterest and dispassion from patients with whom an attending physician has developed a close, professional relationship. As a result of these factors, forming independent ethics committees to oversee particularly difficult decisions is not only desirable, but also required (both with regard to clinical medicine and research). Medical, nursing, paramedical, and legal experts, as well as laypeople and representatives from various support groups, should be included.

**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. GEERAL ETHICAL ISSUES OF A PEDIATRIC NURSE**

The ethical issues pediatric nurses face can be quite challenging at times, as they must often professionally solve conflicts involving a family’s personal values.

1. **Coping Skills.**

If a child is recently diagnosed with a serious condition, it can be quite over whelming for both the child and family members. A pediatric nurse has the responsibility of helping both the parents and child learn to cope with a serious illness

1. **Restraining a Child.**

There are certain procedures that require pediatric nurses to restrain a child. In some situations it’s absolutely necessary in order to protect their safety; for example, if a child is in need of stitches but refuses to hold still, the child would need to be retrained for the procedure.

1. **Refusing Treatment**

.The parent ultimately has the right to refuse treatment for their child, as children are minors. Therefore, it can be quite challenging for a nurse to have to pull a child from life-support or not give a child certain treatments that may help them recover, when the nurse feels that it’s ethically right to do so.

1. **Religious Beliefs**

Despite a pediatric nurse’s spiritual or religious beliefs, she must comply with the family’s beliefs, not allowing her own feelings to personally get in the way.

1. **Accepting reality.**

Losing a child can be the most difficult thing a family will ever go through. However, a pediatric nurse must help family members understand when there is nothing else that can be done in order to save the child. In some cases, parents refuse to accept this, and want to perform more 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 composed of individuals who shares a set of values , beliefs, practices (language , dress , diet , health care) social relationships , laws ,politics , economics and norms of behavior that are learned ,integrative , social and satisfying. Culture is a view of the world and a set of traditions that a specific social group use and transmit to the next generation. Cultural values are preferred ways of acting based on those traditions to understand why people react to health care in different ways it is important to understand their cultural and background values. Cultural values often arise from their environmental conditions. the usual values of a group are called norms . Actions that are not acceptable are called taboos. Cultural values influence the manner in which people carry out child rearing and respond to health and illness. Cultural differences occur across not only different ethnic back grounds but also different lifestyles. Adolescents, urban city youth .nursing care that is guided by cultural aspects and respects individual differences is termed transcultural nursing.

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. The belief that one’s own culture is superior to all others is referred to as ethnocentrism. Ethnocentrism can lead to prejudice 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.

1. **Cultural competence continuum Cultural destructiveness**

Making every one fit the same cultural pattern and exclusion of those who don’t fit- forced assimilation. Emphasis on differences and using differences as barriers.

1. **Cultural blindness**

Do not see or believe there are cultural differences among people . Everyone is the same .

1. **Awareness**

Being aware that we all live and function within a culture of our own and that our identity is shaped by it.

1. **Cultural sensitivity**

Understanding and accepting different cultural values, attitudes and behaviors

1. **Cultural competence**

The integration of cultural elements to enhance communication and work effectively with people is being strongly encouraged. When planning nursing care , it is important not only to respect people’s cultural differences but also to help people share their cultural beliefs with health care providers so their beliefs can be considered and respected.

1. **Socio cultural assessment**

Assessing families as to whether socio economic or cultural influences are present that special considerations of care necessary will make The composition of the family , and functions , the roles and actions of the family need to be examined.

1. **Communication patterns**

Communication patterns not only what people say, but how they say it are determined by culture . People who ordinarily associate only with members of their own culture speaking their native language may have great difficulty detailing a health history in English to a health care provider .Language barriers can be particularly significant if the health history is given at a time when the child is ill because their ability to cope and express may be low when they are ill. Sometimes people may not be able to recall English words for symptoms such as nausea or dizziness when under stress. Children who are embraced or bashful about speaking may simply not talk , therefore their needs may go unmet .Touch is a form of communication ,whether people greet one another with hugs and kisses or omit touching one another is culturally determined . Some people don’t like to touch or shake hands.Eg; some Vietnamese Americans feel that palpating the fontanels is an intrusive gesture because they believe that head is the seat of the body’s spirit and should not be touched. whether people look at one another while talking is also culturally determined .Eg . Chinese Americans may not make eye contact during conversation, asocial concept that shows respect to the health care professional.

1. **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 use their surroundings in different ways. Examinations of children in the Western world must be conducted in a very small (intimate) space because palpation is part of the examination. Conversation on other hand is held at a distance between 18 inches and 4 feet. People from eastern culture may not be comfortable at the same distance .Being aware that use of space is culturally determined helps use to respect 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**

Medicine is never a pure science, and management is fraught with controversy. A single, simple solution to a given ethical problem in medicine 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, which adds another layer of complexity to an already complex situation. Only by adhering to a strict code of ethics based on respect and tolerance of other people, whether 'competent' or not, can decisions be made that are truly in the best interests of patients and society as a whole.

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