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

**Pranati jena,Msc tutor ,SUM Nursing college, SOA, DTU,Bhubaneswar,Odisha.**

**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 what to elicit from patients and when to do it. While 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. We are practicing unethical 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 when we are discriminatory for whatever reason. 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.

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 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 morally acceptable practice can be approximated by using the following acknowledged decision-making principles.

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

It denotes the freedom for everyone to participate actively and independently in decision-making. Patients must be appropriately informed and appreciate the significance of their medical ailment, its treatment, side effects, and outcome for this to occur. However, in actuality, most youngsters lack the ability to be really informed and must rely on others for direction.

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

It represents the patient's level of comprehension, which allows him or her to analyze the ethical considerations provided by a therapeutic setting, integrate them, and make an informed decision. This degree of comprehension is commonly an issue in young children, emphasizing the importance of parents and the medical team acting as competent advocates on their behalf.

1. **Respect beneficence**

It defines the medical principle of "do no harm," a Hippocratic Oath that must be followed in all situations. Medical practice frequently involves a trade-off between benefit and harm, particularly in the case of interventional procedures and pharmaceutical therapy, but the balance should always favour 'benefit.' As a result, initiating high-risk therapy in a fully knowing individual (or his/her advocate) may be entirely appropriate in practice, as long as there is a realistic possibility of meaningful 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 any situations where failure to report could result in a greater disadvantage to 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, regardless of their socioeconomic status or pre-existing impairment. Parent's and guardian's 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. Doctors, parents, guardians, extended family, and society are all involved.

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

Medical treatment should support the patient and be individualized to meet their needs, taking into account any difficulties or impairments. It is morally reasonable to place more weight on achievable goals for medical care than it is on unrealistic or exaggerated aspirations. As a result, "treatment at all costs" and "playing god" are both wrong.

**I. Informed consent**

Informed consent is a formal authorization for an invasive surgery or research involvement. Consent must be given voluntarily, and parents, as the legal guardians of minor children, are asked to provide informed consent on their child's behalf. When parents split, either parent may provide informed consent. Both children and parents must be aware that they have the option to refuse therapy at any moment. In an emergency, consent is not required for treatment to save a person's life or limb. Children under the age of 18 or 21, as applicable, may provide informed consent in the following instances, according to state law. 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 counseling, 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**

* 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 parents, primary nurse, physician, and a hospital staff attorney who is familiar with the applicable laws in that state in 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 resuscitate 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 age of eighteen.

**C. Gender sensitization**

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 describes legal, social, and economic disparities resulting from biological sex differences..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 situations**

* What are their historical roots , 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 decision action**

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

**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.

**A. 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 require pediatric nurses to confine a kid. In some circumstances, it is absolutely necessary to preserve their safety; for example, if a youngster requires sutures but refuses to hold still, the technique must be retrained.

 **C. Refusing Treatment**

Despite the fact that children are minors, the parent has the absolute right to decline therapy for their child. As a result, it can be difficult for a nurse to withdraw a kid from life support or deny some therapies that could aid in their recovery even when the nurse believes it is ethically proper to do so.

**D. Religious Beliefs**

Regardless of pediatric nurses spiritual or religious beliefs, she must follow the family's beliefs and not let her emotions get in the way.

**Reaccepting reality.**

Losing a child can be the most difficult experience a family will ever have. A pediatric 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**

Any society's future is dependent on its children. Through specific views of parenting and child development, culture plays a critical role in the socialization agenda of children. Culture shapes a child's perception of health, wellness, and illness. Culture is a set of assumptions, and practices that unconsciously frames or guides a group's outlook and decisions. A culture is made up of people who share a set of learned, integrative, social, and satisfying values, beliefs, practices (language, dress, diet, and health care), social relationships, laws, politics, economics, and behavioral norms. Culture is a worldview and set of traditions that a particular social group employs and passes down to future generations. Cultural values predominate.

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 formed by their perceptions of their social roles. Because roles are cultural constructs, culture prescribes patterns of behaviour for people in various 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 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.

**A. Cultural competence continuum Cultural destructiveness**

Forced assimilation is the process of forcing everyone to conform to the same cultural pattern and excluding those who do not. The emphasis is on differences and how they can be used as barriers.

**B .Cultural blindness.**

Do not see or believe in inter-cultural differences. Everyone has the same appearance.

**C.Awareness**

Being conscious of the fact that we all live and function within our own culture, and that it shapes our identity..

**C.Cultural sensitivity**

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

**D. 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.

**E.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.

**F**.**Communication patterns**

Not only what people say, but also how they say it, is influenced by culture. People who only associate with members of their own culture who speak their native language may find it difficult to provide a health history in English to a health care provider. Language barriers can be particularly difficult if the health history is given while the child is ill, as their ability to cope and express themselves may be impaired. People who are stressed may have difficulty recalling English words for symptoms such as nausea or dizziness. Children who are embraced or afraid to speak may simply not speak, and as a result, their needs may go unmet.

**G.Cultural shock**

Cultural shock refers to the feelings of helplessness and discomfort, as well as a state of disorientation that an outsider experiences when attempting to comprehend or effectively adapt to a different cultural group due to differences in cultural practices, values, and beliefs. The inability to respond to or function in a new or strange situation is characterized by cultural shock. Nurses are challenging to overcome culture shock and develop cultural sensitivity, which is an awareness of cultural similarities and differences. As a result, nurses were able to provide culturally competent care.

**H.Use of conversational space**

Different cultures make different uses of their surroundings. Examinations of children in the Western world must be conducted in a very small (intimate) space because palpation is part of the examination. The conversation, on the other hand, is held at a distance of between 18 inches and 4 feet. Eastern cultures may feel uncomfortable at the same distance. Knowing that space use is culturally determined helps us respect space use 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**

**A. Preoperative nursing**

Pediatric preoperative 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 all resources and methods that nurses can use to gain the knowledge needed to make ethical decisions. Ethics advisory committees and ethicists or people knowledgeable about ethics can offer advice. Nurses must be able to recognize ethical issues and how ethical decisions are made 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. Preoperative nurses must accept responsibility for their actions and make decisions based on ethical reasoning when providing patient care. If these nurses are aware of ethical issues and how to address them, they will be better prepared to provide comprehensive nursing care to all patients and families.

**B.End of life care of children**

The death of a child can have a significant impact on the child's parents, family members, and health care providers. 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 also considering the child's wishes. Social workers must balance core social work values, bioethical values, and psychosocial issues presented by such situations. While physicians and nurses have conducted research on ethical issues in paediatric end-of-life care settings, little is known about how social workers deal with these conflicts. The Palliative and End-of-Life Care Standards of the National Association of Social Workers (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.

**C.Pediatric dialysis unit**

Over the last 50 years, advancements in paediatric dialysis have made the decision to begin dialysis simple for the vast majority of paediatric patients. However, for certain groups, such as children with multiple chronic conditions, children and families with limited social and economic resources, and neonates and infants, the decision to proceed with dialysis is far more contentious. In this review, we will look at the best available data on dialysis outcomes in these populations, as well as the important ethical considerations that should guide dialysis decisions for these patients.

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

Ethical issues in paediatric mental health care have received little theoretical and empirical attention. Twenty Pediatric Mental Health Registered Nurses (PMHRNs) describe the ethical issues they believe arise from the care they provide to school-age and adolescent children in this exploratory ethnographic study. The interviews reveal three major themes. Several ethical theories are used to examine these themes, the PMHRNs' relational roles, their role as advocate facilitators, and their view of the milieu as an extension of the family. These ethical theories are assessed for adequacy, and an argument is presented for the use of relational ethical theories in examining paediatric mental health ethical issues as well as general paediatric nursing practice.

**E.Care of children with Cancer**

The main ethical considerations were about limiting autonomy, choosing the appropriate level of treatment, and resolving divergent viewpoints that made it difficult to work together. To address ethical issues, professionals valued collaboration and reflection, and they needed resources to do so.

Nursing staff members experienced intense emotions and moral ambiguity as a result of their encounters with ethical issues and how to deal with them when providing care for children with cancer. How many competing viewpoints, a lack of interprofessional consideration, and impediments linked to parental involvement be "turned around," that is, contribute to a holistic understanding of ethics in pediatric cancer care? is the challenging topic posed by the study.

**F. 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. Pediatric nurses must be able to discuss ethical dilemmas with other nurses and medical personnel. Furthermore, developing paediatric nurses' moral, ethical, and philosophical thought patterns necessitates immediate continuing education in nursing ethics at the site of clinical nursing, time to discuss ethical dilemmas, and other supportive measures. We should also improve the ethical climate and empower nurses by increasing their ethical sensitivity and autonomy.

**G.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 a contentious subject, and medicine is never pure science. A single, simple solution to a given ethical problem is extremely unlikely in medicine, particularly in patients who are either too young or incapable of comprehending the complexities of treatment.

 **REFERENCES**

1. Dorothy.R.Marlow and Barbara.A.Redding. text book of pediatric nursing 6theditionPhiladelphia; Elseiveir; 2005. 885-8862)
2. Whaley and Wonngs pediatric nursing 5thedition USA Mosby; 1997. 900-9113)
3. Susan Rowen James. Nursing care of children principles and pratice 2nd editionChina; Sounders; 2002; 780-7874)
4. Jane Bolt and Ruth Bindler. Pediatric nursing 2nd edition USA. Appleton andLange, 1999 .577-5805)
5. Cuttler, L, Whittaker, J.L, & Kodish, E.D. (2005). The overweight adolescent:Clinical and ethical issues in intensive treatments for pediatric obesity.
6. TheJournal of Pediatrics, 146(4), 559-564.Pellegrino AD. The metamorphosis ofmedical ethics. JAMA 1993, 269: 1158-1162.
7. Singh M. Ethical issues in perinatal medicine: Indian perspective. IndianPediatr 1995, 32: 953-958.
8. Singh M. Organization of a pediatric intensive care unit. In: Medical Emergencies in Children, 2nd edn. Ed.Singh M. New Delhi, Sagar Publications,1993, pp 1-8.
9. Tomlinson T, Brody H. Ethics and Communication in do-not-resuscitate orders. N Engl J Med 1988, 318: 43-46.
10. Barody BA. Ethical and legal issues inpediatric oncology. In: Clinical PediatricOncology, 4th edn. Eds. Fembach DJ,Vietti TJ, St. Louis, Mosby Year Book Inc,1991, pp 295-303.
11. Schneiderman L, Jecker L, Jonsen A.Medical futility: Its meaning and ethicalimplications. Ann Intern Med 1990, 112:949-954.
12. Munsat TL, Stuart WH, Cranford RE.Guidelines on the vegetative state:Comments on the American Academy ofNeurology Statement. Neurology 1989,