

## **Module Eight**

### **Competency 8**

#### **Professional Issues and Advocacy**

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## Competency 8

### Professional Issues and Advocacy

#### Objectives:

1. To be able to collaborate with the person, family and the interdisciplinary team when addressing ethical issues related to end-of-life care.
2. Be able to apply an ethical decision-making framework to end-of-life issues.
3. Identify appropriate strategies for addressing ethical end-of-life issues.
4. Support informed choices that the person and family make regarding ethical end-of-life concerns.
5. Demonstrate knowledge of the historical evolution of the modern hospice palliative care movement in Canada.
6. Be knowledgeable about the Canadian Hospice Palliative Care Association Norms of Practice.
7. To be able to assist the person and family when addressing relevant legal issues.
8. Recognize stressors unique to hospice palliative care nursing and identify coping strategies that maintain self-care and well-being.
9. Apply knowledge gained from hospice palliative care research.
10. Demonstrate an understanding of the barriers to hospice palliative care nursing research.
11. Advocate for the rights of the person and family while supporting autonomous decision making.
12. Be aware of quality improvement processes related to hospice palliative care nursing.

#### Definitions

##### **Abandonment**

Abandonment can be subtle. When a patient/family chooses a course of care that is discomforting or deemed useless by health care team, health care professionals may withdraw from the relationship and therefore abandoning the patient/family.

##### **Advanced Care Planning**

The process of dialogue, knowledge sharing, and informed decision-making that needs to occur at any time when future or potential end-of-life treatment options and preferences are being considered or revisited. The primary goal of Advance Care Planning is to seek consensus on care plans that reflect the best interest of the person.

##### **Advanced Care Plan**

The form used to record clinical management decisions reached through the Advance Care Planning discussions. It can be completed in appropriate clinical situations, generally where persons, substitute decision-makers or the health care teams wish to define end-of-life care, often, but not exclusively, in anticipation of deterioration. While an Advance Care Plan must be consistent with any existing

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|---|--|
|   | Health Care Directive, it does not replace it. Health Care Directives must, by definition, be self-directed, and are usually self-initiated, while an Advance Care Plan is generally health care team initiated and defines the formal care/treatment plan.  |
| <b>DNAR order</b>                                   | Do-not-ATTEMPT- resuscitation order; same as a DNR Order but this term has gained popularity to emphasize the fact that resuscitation is unlikely to be successful.  |
| <b>DNR order</b>                                    | Do-not-resuscitate order; a physician's order to not attempt cardiopulmonary resuscitation should a patient experience a respiratory or cardiac arrest; sometimes called a no code or code blue.   |
| <b>Health Care Directive</b>                        | A self-initiated document that allows individuals to make health care preferences known in the event that they are unable to express them. In Manitoba, a Health Care Directive may indicate the type and degree of health care interventions the person prefers and/or may indicated the name(s) of a person (s) who has been delegated to make decisions (i.e. a "Proxy"). In the absence of evidence to the contrary, a person who is 16 years of age or older is presumed to have the capacity to make a Health Care Directive. Generally speaking, a Health Care Directive is binding on health care professionals, unless the request for intervention is illegal or inconsistent with accepted standards of practice. |
| <b>Substitute Decision-Maker</b>                    | A third party identified to participate in decision-making on behalf of a person who lacks decision-making capacity concerning end-of-life issues. The task of a Substitute Decision Makers is to faithfully represent the known preferences and/or the interests of the incapable person.   |
| <b>Artificially-Provided Nutrition or Hydration</b> | An artificial means to convey food into the body such as an intravenous infusion, nasogastric (NG) or Percutaneous Enteral gastrostomy (PEG) tube. In contrast, a special feeding spoon, bottle, or diet designed to reduce the risk of choking are not considered artificial means.   |
| <b>Assisted Suicide</b>                             | To assist another to take his or her life by providing the means to accomplish his or her death; e.g., a loaded gun or a type and quantity of prescription medications that will result in death.  |
| <b>Autonomy</b>                                     | An ethical principle that affirms the right of the individual to self-determination, in particular over what happens to his or her physical body.  |
| <b>Beneficence</b>                                  | An ethical principle to do no harm   |
| <b>Double Effect</b>                                | Derives from Catholic theology and distinguishes between intent and consequences. It holds that when an act has two foreseeable effects (such as pain relief and suppression of  |

|                                   |  |
|-----------------------------------|--|
|                                   | respirations) it is ethical to provide the act if one's intent is the good effect not the bad.   |
| <b>Euthanasia</b>                 | A general term derived from the Greek eu, well + thanatos, death, or good death. Currently used broadly to refer to the act of causing a painless death for a person or animal   |
| <b>Emancipated Minor</b>          | A person under the age of 18 or 21 (but usually at least 16) who is legally considered to be an adult due to circumstances that are defined by law. For example, marriage usually leads to a minor being considered emancipated  |
| <b>Guardian</b>                   | A person who has been appointed, usually by the court, to ensure an incompetent person's rights are respected; Similar to a surrogate or proxy in terms of healthcare decision-making but generally also has the power to make decisions about housing, financial matters etc.   |
| <b>Involuntary Euthanasia</b>     | The act of painlessly killing another person without the person's expressed permission or even without their prior knowledge.  |
| <b>Killing</b>                    | An action, whether intentional, or accidental, that results in another person's death.   |
| <b>Mechanical Ventilation</b>     | The use of a machine to support a patient's pulmonary status by ensuring adequate lung inflation via an endotracheal or tracheostomy tube. (Note the correct term for these machines is ventilators, not respirators: ventilation is the expansion of the lungs with air while respiration is the exchange of O <sub>2</sub> and CO <sub>2</sub> at the membrane level). |
| <b>Mercy Killing</b>              | Lay term used to describe cases where someone kills another person out of compassion or mercy such as when the person is in unremitting pain.  |
| <b>Minor</b>                      | A person under the age of 18 or 21 (depending on province) who cannot legally make healthcare decisions for himself independently.   |
| <b>Physician-Assisted Suicide</b> | Patient requests assistance from his or her doctor to commit suicide.  |
| <b>Terminal Sedation</b>          | Sedation for intractable distress in the dying.  |
| <b>Truth-telling</b>              | Delivering bad news in palliative care is a reality and truth-telling can sometimes be troublesome in a multitude of situations.   |
| <b>Voluntary Euthanasia</b>       | The act of painlessly killing another person at that person's request or with the person's informed consent.   |
| <b>Withdrawing Therapy</b>        | To withdraw therapy means that the therapy has already been initiated in the care of a patient, regardless of whether the therapy is continuously administered (such as mechanical ventilation) or intermittently utilized (such as antibiotics, hemodialysis, or blood transfusions).   |
| <b>Withholding</b>                | To withhold therapy implies that the therapy will not be   |

**Therapy**

initiated, (e.g. examples include not attempting CPR in the event of an arrest or not initiating hemodialysis in spite of increasing renal failure).

**Myths**

1. Anything that is not specifically permitted by law is prohibited.
2. Termination of life support is murder or suicide.
3. A patient must be terminally ill for life support to be stopped.
4. It is permissible to terminate extraordinary treatments, but not ordinary ones.
5. It is permissible to withhold treatment, but once started, it must be continued.
6. Stopping tube feeding is legally different from stopping other treatments.
7. Termination of life support requires going to court.
8. Living wills are not legal.
9. Morphine drip will hasten death in terminal patients.
10. It is illegal to provide terminal sedation to dying patients.
11. Allowing a dying person to just stop eating and drinking when they are still able constitutes helping them commit suicide.
12. Physician assisted suicide would help obtunded and comatose patients in critical care units on life support to be able to legally die peacefully.
13. Voluntary active euthanasia would not be an issue if physician assisted suicide was legal.
14. A child's death is always unanticipated and unwelcome.
15. Children cannot participate in healthcare decision making.
16. Most patients who die in the hospital have CPR attempted at the time of their death.
17. If you are not able to make your own healthcare decisions, your physician will end up deciding what is best for you.
18. Living Wills are usually worthless because they are ignored by physicians and families when decisions actually have to be made.
19. All ethical problems encountered by nurses in palliative care can be resolved by the nurse adhering to the principle of autonomy (the right of the individual to self-determination)
20. The primary role of the nurse in ethics is to be the patient's advocate.

**Ethics/Legal**

When a person is approaching the end of his or her life, decisions may need to be made about the types and extent of healthcare. Competent persons who are capable of making healthcare decisions have a legal and ethical right to participate in healthcare decision making. This right to participate is based on the ethical principle of respect for autonomy; the right of the individual to self-determination, in particular over what happens to one's body. This ethical right is protected by laws mandating informed consent for medical treatment. Incompetent persons who are not capable of making healthcare decisions have several mechanisms for ensuring that someone close to them speaks for them or that their previously stated wishes are honored. This right is protected

by laws covering surrogate decision making and advance healthcare directives. Most deaths are preceded by an active decision to stop or not start something. In many cases, the ill person is unable to participate in decision making when life and death choices are needed. When that situation occurs, family members and other significant persons will be called upon to make these difficult choices. Few proxy decision-makers will have written evidence, such as a living will, of the patient's preference for end-of-life care, but many will have verbal evidence (prior conversations). These decision-makers may turn to nurses for support and guidance in making these difficult choices.

### **Informed Consent**

Five elements must exist:

- person must be competent
- relevant facts must be disclosed
- the person must understand what is disclosed
- the decision must be voluntary (rather than coerced or forced)
- the person must give consent

### **Life Support**

Withholding and withdrawing life-sustaining therapy means to stop or not start any medical therapy that sustains the life of a specific patient. Specific therapies depend on the patient's underlying medical condition but might include cardiopulmonary resuscitation, mechanical ventilation, artificially provided nutrition or hydration, antibiotics, surgery, blood products, bronchodilators, insulin or any other therapy. Medical therapies may be stopped or not started because they are not working (ineffective) or because they are not wanted (either by the patient or their legal surrogate). Problematic areas tend to be artificially provided nutrition and hydration, and situations of permanent unconsciousness (such as persistent vegetative state). We consider life support to include many types of therapy depending on the situation. All therapies can legally and ethically be stopped or not started to allow death to occur. For example, insulin, antibiotics, and aggressive pulmonary suctioning can be withheld in addition to the more commonly recognized therapies such as mechanical ventilation, hemodialysis, or inotropes. Withholding and withdrawing medical therapy does not imply that palliative care will also be foregone. Medical therapy that promotes comfort should be continued even as curative therapies are discontinued.

Historically, a distinction was made between ordinary versus extraordinary care, but this distinction has proven to be meaningless. What is ordinary in one situation may be extraordinary in another due to the circumstances of the case (e.g., providing mechanical ventilation and antibiotics for an acute infection versus for end-stage lung disease). Legally and Ethically, withholding life support is not better or worse than withdrawing life support, yet many clinicians report that it is much harder emotionally to withdraw life support than to withhold it. Part of the reason for this clinical difference may be that withdrawing requires an action while withholding does not. It is important to note however while these feel "different" emotionally, legally and ethically withholding a therapy is not better or less risky than withdrawing that same therapy. However, often a short clinical trial is useful or even necessary to determine whether therapy will be effective or achieve the desired benefits. For example, it takes approximately 48 hours to

accurately assess neurological damage from anoxic insult following resuscitation. Hence, it is more appropriate clinically to treat a patient aggressively for several days following a successful resuscitation attempt until neurological function can be assessed than to assume that significant damage may have occurred and withdraw therapy immediately. The important clinical issue is to always approach life-sustaining therapies with a timeline for when the therapy will be evaluated for effectiveness and benefit to the patient.

### **Nutrition and Hydration**

Is nutrition and hydration different from other forms of life support? The distinction between artificially provided nutrition and hydration, such as nasogastric or gastrostomy tube feedings, and oral ingestion of food has been problematic for several reasons:

- 1) Food is not “medicine” the way it is provided is what is medical.
- 2) We facilitate feeding many individuals in our society who cannot effectively eat by themselves (e.g., infants, disabled, elderly).
- 3) Food is a social convention and is a reflection of extending caring and hospitality to another.
- 4) We have all experienced hunger and thirst at some time so that the experience of having nutrition and hydration withdrawn is imaginable for most of us and tends to evoke empathy.

This subject tends to be an emotional subject for many people. It is useful to reflect on our emotional and cultural biases that make it hard for us to consider “food” not as a medical therapy. Contrasting that to the real situation in which nutrition and hydration are withdrawn is helpful. Stopping nutrition and hydration may actually promote comfort in actively dying persons. Many dying persons lose a sense of hunger or thirst as death nears. Therefore many if not most people will stop eating and drinking in the acute dying phase. Furthermore, in spite of the emotional issues, artificially provided nutrition and hydration is considered a medical therapy that can ethically and legally be withdrawn.

### **Terminal Sedation**

The definition of what constitutes terminal sedation does not have universal agreement. Most people consider it to be providing sedation that achieves a state of unconsciousness while maintaining a respiratory drive for a period prior to the patient’s death. Most people agree that terminal sedation is “sedation for intractable distress in the dying”. Terminal sedation is distinct from euthanasia in that it is viewed as a tool for the management of intractable symptoms of suffering rather than as a tool to elicit death. One argument in favor of terminal sedation is that intractable suffering, particularly suffering that cannot be easily treated with medication such as existential suffering deserves to be treated as aggressively as physical pain would be treated. Hence, since we tolerate a diminished consciousness to achieve relief of physical pain, we ought to tolerate a diminished level of consciousness to treat other kinds of suffering. Using terminal sedation reassures the public that people will not be forced to die in pain even if it means that the person is sedated to unconsciousness. It is also important to stress to

patients and families that morphine does not speed the dying process through a physiological mechanism unless a rapid increase in the dose causes respiratory depression. Due to opioid tolerance, respiratory depression is relatively uncommon for most dying patients. In addition, the normal process of dying involves decreasing respiratory rate. Hence, opioids should not be reduced solely due to a low respiratory rate in the dying patient. In fact, if a patient's respiratory rate increases after a decrease in morphine it is likely to mean that pain is stimulating the patient to breathe more frequently suggesting the pain management is inadequate.

### **Professional Development/Advocacy**

In 1974, the first program in Canada was started in Montreal at the Royal Victoria Hospital under Dr. Balfour Mount, followed a few months later at St. Boniface Hospital in Winnipeg by Dr. Paul Henteleff. The Palliative Care Foundation of Canada was formed in the early 1980s to foster the development of palliative care throughout Canada. It was in 1991 followed by the emergence of the Canadian Palliative Care Association (CPCA) in the same year. Today the CPCA has now included Hospice in their title. The Canadian Hospice Palliative Care Association have developed a model to guide Hospice Palliative Care: based on National Principles and Norms of Practice. This document is available at <http://www.cPCA.net>. Nurses are encouraged to use this model to guide all activities related to their practice and begin to implement the hospice palliative care nursing standards of practice that were based on these norms.

### **Nurses as Advocates**

Traditionally, nurses have been seen as “patient advocates.” This perception may be too limited and narrow when confronted with decisions at the end of life. The role of the nurse is one that capitalizes on the “in-between” position to facilitate collaboration and coordination of care. Patient advocacy is based on the principle of respect for autonomy. Most of the time, a nurse will experience no ethical conflict or question in supporting a patient's expressed interests. But what about cases where the conflict has to do with:

- Autonomy versus justice such as a person practicing IV drug use yet wanting a third heart valve replacement secondary to continued re-infection?
- Autonomy versus beneficence such as when a patient is refusing clearly beneficial surgery due to an unfounded fear of anesthesia?

In these cases merely advocating for the patient's right to autonomy does not resolve the ethical dilemma. Moral distress for nurses is often presented as an unavoidable part of being involved in ethical issues. It is characterized by signs of anger, powerlessness, frustration, cynicism, distrust, burnout or combinations of these feelings. The cure for moral distress is moral dialogue, meaning discussion about the ethical issues by the participants in the situation. When a nurse moves beyond the role of being the patient's advocate, he/she can use strategies to promote ethical decision making regarding end-of-life choices and encourage dialogue between people involved in the patient's care. It is important for the nurse to follow three strategies; knowing, facilitating and guiding.

*Knowing*- the context of the ethical decision and by understanding all the perspectives of the people involved.

*Facilitating*- communication between people by bringing them together, informing, preparing, and supporting all input.

*Guiding*- the context of ethical decision to help others fulfill their social or professional roles.

### **Self-Care**

Empathy is the tool that caregivers use most often to establish a healing therapeutic relationship, especially in palliative care situations. Over time, working in emotionally charged situations continuously, this empathy can become overtaxed and exhausted even when the caregiver is diligently maintaining self-care skills. Secondary traumatization and burnout, the two components of Compassion Fatigue, affect mostly every caregiver at some point in their professional cycle leaving them challenged to reach out for help. Fear of judgment, reprisal or ridicule; fear of exposing one self; often prevent us from reaching out for the help we need. Compassionate fatigue is a reality and may result in diminished capacity to function at work, home and within personal relationships.

### **Gentry & Baranowsky Model of Compassion Fatigue**

Primary Traumatic Stress

X/+

Secondary Traumatic Stress

X/+

Burnout

=

Compassion Fatigue

### **Target Symptoms of Compassion Fatigue**

- increased negative thoughts
- intrusive thoughts/images of personal trauma situation
- difficulty separating work from personal life
- lowered frustration tolerance. Increased outbursts of anger or rage
- dread of working with certain clients
- increased transference/countertransference in work
- depression
- ineffective and/or self-destructive behaviors
- hypervigilance
- decreased feelings of work competence
- diminished sense of purpose/enjoyment with career
- reduced ego-functioning (time, identity, volition)
- lowered functioning in nonprofessional situations
- loss of hope

**Resolution and Resiliency from Compassion Fatigue**

- acknowledgement and acceptance of symptoms
- decision to resolve symptoms
- meaning of symptoms-pathology vs evolution
- professional development
- personal development (self-of-the-therapist)
- systemic self-care
- balance

## CRITICAL INCIDENT STRESS INFORMATION SHEET

You may feel like you have experienced a traumatic event or a critical incident (any incident that causes health care professionals to experience unusually strong emotional reactions which have the potential to interfere with their ability to function either at the scene or later). Even though the event may be over, you may be experiencing new or may experience later, some strong emotional or physical reactions. It is very common, in fact quite normal, for people to experience emotional aftershocks when they have passed through a horrible event. Sometimes the emotional aftershocks (or stress reactions) appear immediately after the traumatic event. Sometimes they may appear a few hours or a few days later. And, in some cases, weeks, or months may pass before the stress reaction appears. If the response happens quite a bit after the incident, it is often harder for you to make the connection of the event.

The signs and symptoms of a stress reaction may last a few days, a few weeks or a few months and occasionally longer depending on the severity of the traumatic event. With understanding and the support of loved ones, the stress reactions usually pass more quickly. Occasionally the traumatic event is so painful that professional's assistance from a counselor may be necessary. This does not imply craziness or weakness. It simply indicates that the particular event was just too powerful for the persons to manage by themselves. The counselor's role is to assist you to regain your sense of control. Here are some very common signs and signals of stress reaction:

| <b>Physical</b>         | <b>Cognitive</b>            | <b>Emotional</b>       | <b>Behavioral</b>      |
|-------------------------|-----------------------------|------------------------|------------------------|
| Fatigue                 | blaming someone             | anxiety                | change in activity     |
| Nausea                  | confusion                   | guilt                  | change speech pattern  |
| Muscle tremors          | poor attention              | grief                  | social withdrawal      |
| Twitches                | poor decision               | denial                 | emotional outbursts    |
| Chest Pain*             | heightened or lowered alert | severe panic           | suspiciousness         |
| Difficult breathing*    | poor concentration          | emotional shock        | alter communication    |
| Elevated BP             | memory problems             | fear                   | loss/increase appetite |
| Rapid Heart Rate        | hyper vigilance             | uncertainty            | alcohol consumption    |
| Thirst                  | identify familiar objects   | inappropriate behavior | drug use               |
| Headaches               | disturbed thinking          | agitation              | antisocial acts        |
| Visual Difficulties     | poor problem solving        | loss of control        | inability to rest      |
| Fainting                | poor abstract thinking      | depression             | nonspecific complaint  |
| Vomiting                | loss of orientation         | apprehension           | hyper alert            |
| Grinding teeth          | nightmares                  | overwhelmed            | pacing                 |
| Weakness                | intrusive images            | intense anger          | erratic movements      |
| Dizziness               |                             | irritability           | alter sexual function  |
| Profuse sweating/chills |                             |                        |                        |

- Definite indication of the need for medical evaluation also if experiencing shock symptoms.

## **Research**

### Goals of Palliative Care Nursing Research

Nursing research serves multiple functions such as:

- quantification of information
- discovery
- description of phenomenon
- quality of life improvement
- problem solving

### Barriers to Nursing Research in Palliative Care

- Overall limitations in funding for nursing research and in the limited number of nurse researchers in the area of palliative care
- Research establishment and associated funding bodies have been focused on rehabilitation and cure
- Limited focus on palliative care in graduate nursing education to promote end of life care
- Ethical considerations of conducting research with vulnerable populations, including issues to ability to provide consent.
- Rapidly declining status limits subject accrual and opportunity for longitudinal measures
- Lack of conceptual frameworks appropriate for palliative care research
- Late referral to hospice palliative care programs severely restricts opportunities for accrual to studies.
- Lack of research instruments and methods appropriate for this population.
- Challenges of conducting research in a sensitive area.

## **Continuous Quality Improvement**

The concept of quality improvement as a management approach is a way of doing business; a way to stimulate employees to become part of the solution by improving the way care is delivered; whereby evaluation is a continuous process. The quality improvement process begins and ends with the customer, determining their needs and creating products that meet or exceed their expectations. Quality care begins in clinical settings with well-defined standards of care that are accepted by professionals such as the Canadian Hospice Palliative Nursing Standards of Practice. These standards articulate what palliative care nurses do, who they serve and define what clinical services and resources are needed to provide high quality end of life care. These standards also provide a framework against which quality of care can be measured and constantly improved. Clinical care pathways form a structured, multidisciplinary action plan that defines the key events, activities and expected outcomes of care for each discipline during each day of care. The goal of pathways is to reduce the variation in services and practices thus reducing cost.

## Goals of the Palliative Care for Advanced Disease Pathway

1. Respect patient autonomy, values, decisions
2. Continually clarify goals of care
3. Minimize symptom distress at end of life
4. Optimize appropriate supportive interventions and consultations
5. Reduce unnecessary interventions
6. Support families by coordinating services
7. Eliminate unnecessary regulations
8. Provide bereavement services for families and staff
9. Facilitate the transition to alternate care settings, such as hospice, when appropriate.

## Study Questions

Case Study 1. Mr. Delman was diagnosed with prostate cancer 3 years ago at the age of 74. He received radiation therapy and did well until about a year ago when he saw his doctor for back and leg pain. At that time it was discovered that his cancer had spread to his bones, bladder and liver. Mr. Delman chose to forgo further curative therapy and enrolled in a hospice program. After a few weeks of relative comfort, Mr. Delman has become increasingly unresponsive and uncommunicative and appears to be extremely uncomfortable. Most of the time he moans loudly and moves restlessly in bed. Mr. Delman is the acknowledged patriarch of his family. He and his wife have attended an Orthodox Jewish temple since their marriage 52 years ago and have raised two sons and one daughter. Their three grown children are married and live nearby. All three children continue to attend the same synagogue as their parents but are more lenient in their religious observation. The nurse who had been assigned to Mr. Delman recently left her position to move to another province. You volunteered to pick up this case and are making your second home visit. At the first visit, you were concerned about Mr. Delman's level of pain but Mrs. Delman assured you that it was a transient change. Now, just four days later, you are alarmed to see that Mr. Delman appears to be in even greater pain. You also realize, after talking with Mrs. Delman, that the pain management regimen ordered by the physician is insufficient and that even this is being further reduced by the wife.

### **1. Considering Mr. Delman's religious and cultural background, what might be behind the apparent inattention to relieving Mr. Delman's suffering with pain medication?**

- a. There is no cultural or religious explanation for allowing a person to be in pain.
- b. The family needs to be informed about the doctrine of double effect from the Catholic tradition that allows pain to be relieved even if it results in hastening death.

- c. The family may be following the father's wishes by carefully insuring that his death is not hastened by the use of pain medications in accordance with orthodox Jewish teachings.
- d. The family appears to be hateful towards the father by allowing him to be in pain. Adult Protective Services should be notified and Mr. Delman should be removed from the home.

**2. By refusing further curative therapy was Mr. Delman...?**

- a. Requesting assistance with suicide?
- b. Requesting voluntary active euthanasia?
- c. Requesting that curative therapy be withheld?
- d. Asking the healthcare providers to participate in an illegal act?

**Answers**

- 1. **C.** For some religions and cultures, pain at the time of dying has meaning including redemption, self-awareness, punishment, or enlightenment. In addition, while the majority of cultures accept the doctrine of double effect, it is derived from Catholicism. This belief is not shared by all Orthodox Jewish persons. Another helpful way to think about this issue is to consider whether pain should always be relieved regardless of the patient's or family's wishes. If yes, what about labor pain during childbirth? Are some types of pain "better" than others?
- 2. **C**

Case Study 2. Mrs. Freeman has end-stage cardiomyopathy and has just been discharged for the third time this year following hospitalization for shortness of breath, fluid overload, and cardiac arrhythmias. Following this discharge her primary physician made a referral for visiting nurse services. Mrs. Freeman is assigned to your caseload. Your mother died of heart failure several years ago. Mrs. Freeman's favorite food is Campbell's chicken noodle soup. You explain that this is not an option on her low salt diet, to which Mrs. Freeman replies, "Honey, that is the only thing I get to enjoy any more and you're not taking it away from me!" A few minutes later while you are measuring her ankles and listening to her lungs, she asks you if the salt in the soup really could kill her. Then she says, "I might need to have something like that handy if things continue like they are going." You find this comment distressing and decide you do not want to care for Mrs. Freeman.

**1. Should you have to remain as Mrs. Freeman's nurse?**

- a. No, if patients refuse to be compliant with care and this is distressing to the nurse, the nurse should be able to discontinue care.
- b. No, why bother? There is nothing that can be done for her anyway so she should be discharged from homecare.
- c. Yes, while consuming salt will make her disease more unstable, that does not mean that Mrs. Freeman should be abandoned and the nurse needs to engage in moral dialogue to understand her own issues.

- d. No, Mrs. Freeman is clearly suicidal and needs to be admitted to a mental healthcare facility since she is a clear danger to herself.

**2. How should you respond to Mrs. Freeman's last comment respectfully?  
(Choose all that apply).**

- a. Call the crisis hot line and tell them that Mrs. Freeman is suicidal.
- b. Ask what she means by "the way things are going?"
- c. Tell her that your mother died of heart failure and you do not want her to bring statements up like that again.
- d. Ask her is she is saying that she wants to hasten her death.

**Answers**

- 1. C Yes. While consuming salt will make her disease more unstable she should not be abandoned at the end of her life.
- 2. B & D. Explore her feelings about dying and death.

**Questions**

- 1. A competent patient cannot refuse life-sustaining treatments that his or her physicians believe would be of benefit to the patient?
  - a. T
  - b. F
- 2. Legally and ethically, it is always better to withhold a therapy, (such as blood transfusion), rather than try to withdraw it later because it is illegal to stop a therapy that is medically beneficial once it has been started.
  - a. T
  - b. F
- 3. To have a valid advanced healthcare directive a lawyer must be consulted.
  - a. T
  - b. F
- 4. Physicians who prescribe excessive doses of morphine for comatose patients in the ICU are guilty of physician-assisted suicide.
  - a. T
  - b. F
- 5. Terminal sedation is illegal?
  - a. T
  - b. F
- 6. If a dying patient voluntarily stops eating and drinking, the nurse must report their suicidal behavior to the appropriate resources or risk losing their license?
  - a. T
  - b. F

**Answers**

All answers 1-6 are False

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