



# Cases in Health Care Ethics

4th Edition

Edited by Robert Pepper-Smith

August 2014



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## Introduction

Without personal engagement, health care ethics can become a technical and impersonal activity, at worst the application of theories to widely publicized and discussed cases that, however gripping, are remote from one's own experience. Conversely, nothing advances the dialogue of health care ethics more effectively than the discussion of circumstances that matter to one, the discussion of concerns that have arisen in one's own immediate community. Thus the motivation for the publication of this small collection of cases. All have been written by students of Vancouver Island University's philosophy courses in biomedical ethics. Many contributors are (or were) student nurses; others are health care practitioners from many different fields. The cases reflect, in my experience, recurring issues in our region: the moral status of D.N.R. orders and substitute decision-making; the ethics of pain control and of care for seniors at home and in facilities.

Some of the cases are gripping in their own right; others may leave the reader with a feeling of, "So what?". The latter are of particular interest for they demonstrate that health care ethics very often includes decisions that are not likely to make news: whether to order a hospital bed for a client who lives at home and needs the bed but doesn't want it; whether to tell a physician that one doesn't intend to accept any treatment, no matter what the results of one's tests.

A second source of discomfort may be the brevity and incompleteness of some of the cases. Many read like anecdotes rather than complete case presentations. One wonders in many instances, What happened? A student nurse may care for a patient only for a brief time; she may never learn how the patient fares once she moves on. These cases reflect an important aspect of the student's own moral experience: she may never get to know what happened.

Details in each case have been altered to ensure confidentiality. I would like to thank Zain Raza for his assistance in preparing this document for publication.

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## Section I: Informed Consent

## **Abortion Question**

I had a patient who was a 37 year-old Indo-Canadian woman who had immigrated to Canada with her husband within the last ten years. She was the mother of one child, a daughter. She was admitted to hospital for hyperemesis and depression. She had been depressed with her first pregnancy as well, but with this one, she said she wanted to kill herself.

She stated her hyperemesis was ongoing, yet I could find no evidence of any emesis. It seemed that she was spitting saliva into tissues and telling us it was vomit. I consulted with the RN, who agreed that there was no emesis.

In talking with the roommates of this woman, it was suggested that her husband would be very angry if she gave birth to another girl. Upon talking with my patient, she revealed that her husband had not been happy, although not angry either, about their first-born female child. I enquired about the sex of the fetus and whether she had been told, knew, or even suspected what the sex of the child would be, and she suggested that since the pregnancies were so similar, this child would probably be female as well.

That morning, the doctor was in to consult with the patient and her husband. The decision was made to terminate the pregnancy as soon as possible. An abortion was booked for later that day. Then my instructor approached and suggested I go to observe the abortion. She felt it would be a rare and valuable learning experience to see the procedure. I was amazed to see that she was surprised when I refused to go.

## **Pain Control: Patient vs. RN**

Mr. S. was recovering very well from a total knee replacement. He was on his fourth day post-op when I cared for him and was most likely going home the following day. Mr.S. had a PNR order for Tylenol 3. He was able to have one or two tablets every four hours for pain. When four hours had passed since his last Tylenol, I asked him if he wanted anything for pain. Since he had been moving and working with physio all morning, I wanted to make sure that he wasn't in pain. Mr. S. told me that he didn't want any more pain medication. His wife was there at this time and told me that the two of them don't take a lot of medication at home, especially if they don't need it.

I respected Mr.S.'s right to refuse treatment, but at the time, I wanted to make sure he knew the therapeutic effects of Tylenol 3. I explained that he couldn't get addicted to any pain medication if he was really in pain. I also told him that taking a pain medication before mobilising could help him recover faster. Mr.S. appreciated the information that I gave him, but he thought that he would be just fine on his own.

When the RN from my team came back onto the floor, she asked me if I had given Mr. S. his Tylenol 3s at the appropriate time. I explained that he had refused the Tylenol, and that I had told him the risks and benefits of his choice. She was extremely mad that I hadn't forced him to have it, for she believed that analgesics were the only way for him to recover quickly.

She came into Mr. S.'s room with me and told him that he had to take two Tylenol 3s. He told her there was no way he was going to take them, for he felt he didn't need them. The nurse insisted that Mr. S. take the medication. He was quite angry, but he felt he had no choice but to do as she said.

## **Angry Doctor**

During the first trimester of my second pregnancy I was once again admitted to the hospital with hyperemesis. I had experienced hyperemesis during my first pregnancy as well, and was hospitalized for one week. In this case, the hyperemesis persisted for approximately two months and was very severe.

Due to the severity of my illness over the two months, I was continuously hooked up to an IV so I did not become dehydrated, receiving a steady stream of gravol shots in an effort to control the severe nausea and vomiting. After a month had passed, I primarily subsisted on my IV and, at my suggestion, a liquid vitamin solution, as I was now down to 93 lbs. Concerned for my health and that of my unborn child, I suggested to my doctor that perhaps it would be a good idea to begin feeding me intravenously; I was becoming very weak due to my extreme loss of weight, and the cycles of hyperemesis were showing no signs of abating. The doctor agreed with my suggestion, but once again I wondered why I, the patient, found it necessary to make these suggestions instead of the doctor.

It was shortly after this that my doctor approached me and tried to convince me to take a relatively new drug that was currently being used by cancer patients to help relieve nausea as they underwent chemotherapy treatment. Interested, I asked the doctor if the drug had been tested and approved for the use of pregnant women. Hesitating, he replied no, it had not yet been tested or approved for pregnant women. However, he felt quite confident that the drug would help me with the nausea and hyperemesis and that it would not harm the baby. The doctor continued to pressure me to make my decision to use the drug, but I told him I wanted to think about it first. He left, looking rather displeased that he had not been successful in his attempt to persuade me to use the drug and to follow his recommendation.

As soon as the doctor left, I explained my situation to one of the nurses on duty and asked her if she would bring me a medical book with information on this particular drug. The nurse agreed that I had every right to learn as much information as I could regarding this drug in order to make an informed decision, as the drug would not only affect me, but my unborn child. Looking at the information in the medical book, I came to the conclusion that the possible risks to the baby outweighed the benefits to me and so decided against taking the drug. At that moment the doctor walked back into the room and when he saw me with the medical book he became very angry. I informed him of my decision not to take the drug. He told me that because I was not a doctor I could not understand everything I was reading regarding the drug, so how could I possibly make the correct decision. He said that's why I should listen to him and take his professional advice. He then told me that 'I was trying to be too responsible for my unborn child' and that I was 'being overprotective'. At this point he walked out of the room and proceeded to yell at the nurse who had brought me the book, telling her that she had no right to give one of his patients a medical book without his express permission.

### **Nurse Interference**

Jennifer was a 23 year-old woman who was pregnant for the first time. As it was her first pregnancy, she and her husband were very interested in every detail of childbirth and pregnancy. With her doctor's encouragement she devoured knowledge from every pregnancy book that she could get her hands on. As a result, Jennifer thought herself very capable of making decisions about her upcoming labour and delivery. On her birthing plan (a copy of which was forwarded to the hospital) Jennifer distinctly stated that she wanted to have access to pain medication while she was in labour. She decided that she would have an epidural and shots of Demerol as well. Jennifer was not interested in experiencing a natural child birth. If she did not have to feel any pain, she was not going to. As far as Jennifer was concerned, as long as her baby was delivered safely into her arms it would be a 'natural' delivery.

Jennifer went into labour and was subsequently registered into the hospital. A nurse was assigned to her, as her doctor had not arrived yet. When Jennifer requested some relief for her pain the nurse stated that she had not been in labour long enough to warrant a shot of Demerol. The nurse also

stated in a business-like fashion that the pain could not be 'that bad yet'. After a while, Jennifer stated that she had made a birthing plan, that she was in terrible pain, and that she wanted the epidural she had planned on as soon as possible. The nurse told her that she would have to wait, and then launched into a speech about how she could not believe how all the new mothers these days opted for drugs. Jennifer told the nurse (having gotten very worked up and upset as time had gone by) that it was very nice that she had an opinion on the matter, but that she was in pain and wanted to speak to her doctor immediately. The nurse gave her a look of exasperation and coldly left the room.

When Jennifer's doctor arrived she was told that she had missed her 'window' for the epidural to be administered. Shortly after, Jennifer gave birth to a little girl without the aid of any drugs. Thinking back, Jennifer states that her labour was probably the worst moment of her life; not only had she endured needless pain, she felt as though her wishes had been ignored completely.

### **Cancer Treatment**

Doug was a happy, socially active individual of 45 years of age. He enjoyed a close relationship with his wife of twenty-one years and his two teenage daughters. In January of 1994, after four months of ongoing treatment for pneumonia and varying degrees of coughs and colds, he was diagnosed with advanced lung cancer.

Little information was readily available. Further discussion was dependent on the results of a tissue biopsy. Two days later, Doug was informed that the biopsy revealed a small cell cancer that, while aggressive in nature, was known to be relatively responsive to conventional chemotherapy. The physician advised him that he would be admitted to a cancer ward in a nearby city hospital for further evaluation. Testing would be undertaken to determine the extent of the cancer, thereby enabling them to give Doug a clear picture of his options. Subsequently, Doug was admitted and tests ensued.

A meeting was scheduled between an oncologist and the patient. The patient's spouse attended this first meeting. At this time, information was disclosed regarding the metastasis of the cancer to the liver and kidney. There were suspicious spots evident in the bones and in the brain that were too small to allow any conclusions. The oncologist was very professional in delivering the information and her approach to the patient. She appeared to be particularly careful not to engage in any form of moral persuasion and discussed only health related issues. Doug was told that, while surgery or radiation therapy were not an option, clinical intervention was available to him if he so chose. He was advised that in addition to conventional chemotherapy, there was an experimental treatment that involved a screening process, based upon medical criteria, to determine candidate eligibility. He would automatically be screened as part of the normal process involved in determining the best treatment. The oncologist instructed Doug to consider his options and told him that he would be asked to make a decision when results of the screening were available the following day.

Doug questioned the oncologist on a number of points and finally asked, "With your medical knowledge, if this was you, would you take treatment?" The oncologist replied, "Absolutely! I would go for it!"

Doug decides to proceed with conventional chemotherapy. The normal treatment protocol is followed. Doug suffers no severe side effects from the drugs. The results are favourable and there is much optimism.

The final meeting with the oncologist is scheduled for mid-June. In marked contrast to the initial meeting, the physician's attitude is now much lighter. Her approach to the patient appears more personal. The news is good. Tumours that were present in the lungs, liver and kidney are virtually gone. When questioned regarding the inconclusive and suspicious spots found during the original examination, the physician shrugs this off. When asked if further tests will be conducted to determine

whether these also have disappeared, she replies that it's not something they plan to do at this time. She advises Doug to return home, relax, and regain some of his strength.

Within two weeks of his final treatment, Doug begins to experience severe headaches, nausea and mild disorientation. He sees his family physician. For the first time, the terms "metastases to the brain" and "palliative measures" are being used. The focus has shifted. He is having great difficulty eating and has become weak and despondent. Most days he is too ill to leave his bed. Considering the speed at which this has occurred, there has been no discussion regarding his imminent death. His wishes have yet to be articulated. He is afraid to upset his family. His family is afraid to upset him. No one is prepared for this situation.

At this time, Doug suffers what is thought to be a stroke which is later revealed to be a tumour that has bled in his brain. This results in loss of speech and memory. He no longer recognizes family members. His wife and children are strangers to him. He becomes highly agitated and begins to exhibit behaviours that could be considered potentially harmful to himself and others.

### **Withholding Information from the Patient**

While working on floor three at the hospital last spring I was responsible for the care of an elderly woman, approximately eighty years old. Due to bowel cancer, half her colon had been removed, a procedure known as a hemicolectomy. During the surgical procedure the physician identified clinical signs causing him to believe the cancer had metastasized. He sent tissue samples to pathology to confirm his speculations. The surgeon was so confident of his suspicions that he discussed his findings with the patient's husband. It was also noted on the Kardex that the patient was terminal, that she was unaware of her prognosis and that she wasn't to be told until the pathology report was returned. The rationale for not informing the patient at this time was that she had a very anxious/nervous personality type: the physician didn't want to cause her any undue anxiety by telling her she may be terminal until he was 100% certain.

It's true she was very nervous and anxious and telling her she wasn't going to recover could have caused her a great deal of stress. It's also true that she already suspected something was wrong.

More than once she spoke of it being too late, that she went to the doctor too late. Her apparent anxiety and nervousness could have stemmed from believing she had the surgery too late, that cancer had already spread.

### **Informed Consent - Med Student**

I was observing surgeries in the OR for one of my clinical days and met a third year medical student who was doing her residency at NRGH. While preparing for surgery, I realized that the resident would be performing the surgery; this seemed perfectly normal.

Dr. Stewart made the initial incision along with a few other procedures, and then the resident took over. I couldn't help but notice that Dr. Stewart was talking to the patient as though *he* was the one performing the surgery – not the resident. There was a sheet up between the patient and the staff so the patient could not see who was doing the surgery.

Later that day, I observed the same doctor and medical student do the same thing again in the OR. Once more, Dr. Stewart spoke to the patient as though he was the one actually doing the surgery. This time I was confused because I could see a pattern unfolding and decided to look into it. I soon discovered exactly what I had been suspicious of: the patient(s) had given consent to the experienced doctor to perform the surgeries, not the medical student.

I looked in one of the charts, and on the consent sheet it stated that the patient gave permission to Dr. Stewart to perform the surgery - there was no mention of the student. I asked a nurse why the

patient(s) had not been made aware of the fact that the student would be performing the surgeries, and she replied 'It would have just made the patients nervous'.

### **Refusing Care**

This week my patient, Mr. Craig, clearly wanted nothing to do with me. He had no trouble telling me to go away and leave him alone. Mr. Craig was recently deemed palliative and was very visibly dying. He was extremely thin and jaundiced – like no other patient I have seen. I think it was because of this that he was very short with nurses and primarily wanted to be left alone. As an eager-to-learn student and with him as my only patient, I was not about to do as he asked and simply leave him alone. Instead, I proceeded to enthusiastically go into his room and see if he was ready to eat breakfast (“no”), get washed up for the day (“no”), or have his blood sugars tested (“you better do it quickly”).

I was fairly discouraged after hearing the words “go away” so many times in one morning, and yet I hadn't really stopped and thought about actually doing what he asked. That is, until a pivotal moment in my morning. As I listened to his respirations, he suddenly got quite agitated and told me to “get out”. I was quite taken aback since he hadn't argued with me about doing a head-to-toe assessment initially, so I asked him if there was something wrong and if I had done something to upset him. His exact response was, “I just shit myself, now go away”. This was shocking to me. I tried to stay and told him that it was fine and I could just help him get cleaned up and get a new brief on. Again, he told me to go away. At this point, I had to try really hard not to take this personally. Why on earth would someone want to just lie in their own feces? I did not understand why this man was choosing to not eat, not bathe, and not change after a bowel movement. From a medical point of view, I knew that it was extremely unhealthy for him to be in a soiled brief for long because of possible skin breakdown and the festering of bacteria. I felt that I needed to change his brief, but he was uncooperative. In the end, I talked with my instructor and the RN I was working with that day and we decided that, although Mr. Craig was resistant at first, if we went in with a different approach he may be more willing to let us clean him up. Rather than making it a question, I went in and said, “Okay, it's time to get you changed and cleaned up Mr. Craig.” After that, he agreed and simply told me to hurry up as I washed him.

### **Birth Control Controversy**

A young woman, Kira, lived near Dawson Creek, BC. She had a less than perfect childhood. Her parents were very religious and lived their lives accordingly. A family friend raped Kira at the tender age of fourteen. Kira's parents decided to ignore the whole episode and even led Kira to believe that she was the one at fault. They refused to talk about it and denied Kira the counselling that could have helped her to reconcile and deal with the issue.

After a fairly troubled youth, spending time in and out of the psychiatric ward for periods of severe depression, Kira grew up to be a loving and caring person. Because Kira's parents neglected to provide any sex education, her menses came as a surprise. She had only a vague idea of how her body worked, and had no information on birth control.

When she was 19 years old she met a man who she thought cared for her. They had a son together but he left her shortly after. Kira was left to manage raising her son alone with no financial or emotional support from the father. She received financial help from the state which helped, but had to endure her parent's condemnation in order to have some help in raising her son. There were many difficult times.

At 23 years old she met a man three years her junior, they fell in love and got married. The couple lived in poverty and, although they often fought over finances, they were happy for the most

part. When they found out they were going to be the proud parents of twins, they had no idea how they were going to manage to take care of three children.

Near the end of the pregnancy, they learned that the babies would have to be delivered via caesarian section. Her doctor agreed that after performing the C-section, Kira's fallopian tubes would be cut and cauterized before she was sewn up. Kira and her husband signed the necessary papers prior to her being wheeled into the operating room. Kira and her husband decided to employ a permanent birth-control method.

When she awoke, Kira was told that the babies were both healthy and that the doctor had decided to just clamp her tubes instead of cut them. The doctor's rationale was that she was too young to make such a permanent decision about whether she would want more children or not and that the clamps were removable. She was also informed that the clamps were only 60 – 70% effective, and that she should also use another method of birth control.

### **Patient Advocate**

It was my second evening shift with Mr. G. he was six days post-op from having had a right hemicolectomy to remove some malignant bowel cancer. His intravenous site was the same one he'd had for seven days, and it had become sore and reddened. When this happens, it means that the site is beginning to be infected and could have many complications, some very serious.

I told the RN about my observation. She checked it out and decided that the site was okay. She said that Mr. G shouldn't have to be poked unnecessarily because the doctor was planning to put in a central line the very next morning.

I was in the room when she came in and educated Mr. G on her point of view. He agreed not to have his I.V. site changed that evening, but was not fully aware of the total implications because she did not completely inform him. Not one of the complications that I knew about were 100 percent guaranteed to happen, but he was very vulnerable to them.

I knew the nurse had many years of experience, and maybe many times she had taken these same chances and they had turned out okay. I also knew about the dangers of a red streak at an I.V. site that's sore, so I would never take that chance with my life or anybody else's. I felt very scared because I knew that he could be in great danger, and I also knew that the nurse might be very angry with me if I did not agree with her. Because I believe it's better to err on the side of safety, I had to get someone to be my advocate for his sake and his family's.

I immediately went to the other RN and my instructor to voice my concern. The other RN said she would change the I.V. site for me. I had to first explain the reasons to Mr. G, and that was all it took to change his mind. This did make the other RN very angry, and she stated that the patient did not want to have his I.V. changed. I did not want a confrontation, but knew that he was not aware of all the problems not changing the I.V. could cause. He was not making an informed decision because he did not know all the facts, and I can only assume that he trusted the more experienced nurse because I was "just a student." I could see that he was also very vulnerable emotionally.

I think that this problem was resolved in the best interest of Mr. G and, even though I don't know what's become of him, I know in my heart that I did the right thing at that moment, which felt good! It was a very emotional experience.

### **Informed Consent**

I was caring for John, a young man of 32 years, who had been admitted with an ulcer on his lower right leg. This ulcer had been present for some time and was getting larger and more painful. John, who was friendly and outgoing, was married with three children.

In 1986 John was in a serious car accident. Following a coma lasting several weeks, along with multiple broken bones, he woke up brain damaged. John has severe short-term memory deficit. I had to remind him what my name was each day. When asked, he was able to talk about the car accident that had caused his problems but had very poor recall of anything since then. He had no memory of how long he had been suffering with the ulcer or even of how it had manifested. John was questioned as to whether he was diabetic, to which John confirmed that he was. John's wife later informed us that he was not. She further advised us that the ulcer had started as a small injury that kept getting worse over the course of a few weeks.

I read in his chart that he was scheduled as an add-on for surgery to have a skin graft and debridement on his leg later that day. I was asked to take the consent form in for him to sign. When I met with him, I had expected him to be aware of what the doctor was going to do, as it is the doctor's responsibility to discuss any surgery with his patient. John remembered that the doctor had been in to see him and had examined his leg, but had no recollection of being advised of the surgery. My suggestion to John was to await his wife's visit, following which the procedure could be explained to both of them and the consent form could be signed. John agreed with this idea.

Approximately an hour later, I saw one of the nurses coming out of his room with the consent form signed. I advised the nurse that we were awaiting his wife's arrival so that he could have someone present to be sure that he understood what the surgery was entailed. The nurse assured me that John had signed the consent and was aware of what the surgery entailed.

### **Blood Transfusion**

Emily was a 20 year-old young lady diagnosed with mild autism and Tourette's syndrome which causes her to have obsessive compulsive behaviors. She was admitted to the hospital with severe abdominal pain manifested by several days of constipation. After a thorough examination and an array of x-rays and tests, she was diagnosed with a perforated bowel due to the obstruction. She would need surgery to correct it immediately in order to prevent sepsis.

Emily's first doctor placed her on TPN therapy to rest her bowel and to build up the nutrients in her body so she could withstand surgery.

While in my care she took a turn for the worse, developing a fever of over 40 degrees. Emily needed surgery immediately; an OR was booked and she was taken away. However, Emily returned from the OR without surgery taking place. The doctor made the decision not to operate on her because she was at risk of losing a moderate amount of blood during the surgery, and he did not want to be held responsible if anything should go wrong. Emily could not have blood transfusions since she was raised as a Jehovah's Witness. For this particular surgery, patients tend to lose enough blood to warrant a blood transfusion.

After she arrived back on the floor, her condition declined considerably and her level of pain was considerable. The following morning a different doctor came for a consult at the request of the parents. He advised them of the seriousness of the situation, but they would not give consent for a blood transfusion.

The second doctor operated on Emily that afternoon and found pus throughout her entire abdominal cavity – she had developed peritonitis due to the perforated bowel. Prior to surgery the doctor informed the RN in charge he would give Emily a blood transfusion if it was needed to prevent her death. He said he would deal with the legalities later.

## Section II: Patient Capability

## **Conflicting Interests**

It was the second week of my psychiatric rotation, and I was really enjoying it. There was more time to focus on my interpersonal relationships with the clients, and I really missed that on the other floors.

One of my patients named Jeff was recovering on the psychiatric ward from toe amputation. He was admitted to the ward because he was a well known drug addict who lived on the street for a long time. One night while high, he walked in the snow with bare feet for a few hours and lost a couple of frost-bitten toes. He had stayed on the surgical floor until he was stable and then transferred to psychiatry.

When I started my shift, I quickly went to introduce myself to my patients and check in with them before I did anything else. I went to Jeff's room first and had a chat with him. I found him to be very agitated and distressed. He told me that he had been waiting for his government check to come to the hospital for almost a month, and no one seemed to be working on it. I assured him that I would talk to the social worker and the RN in charge. He thanked me for doing this and hoped that he would finally get his money.

The social worker told me that she had been on holidays and just got back. She was going to make a few phone calls and get back to me. I made sure that Jeff was aware of the process and informed him of what was happening. The next day when I was back at the hospital, the social worker gave me his cheque and asked me to give it to him or, with his permission, deposit it into his account so he could take some and save the rest. He agreed to the second option, and I was about to leave the ward to deposit his cheque when the nurse in charge of the team asked me what I was doing. I explained the situation to her and she totally disagreed with Jeff's decision. She was sure that Jeff was not financially competent and would spend his money on drugs. She asked me not to cash his cheque and to wait for her to talk to him. Jeff became furious when he heard that he couldn't have the money and started acting out. The nurse told me to set punishments for his actions.

# Section III: Substitute Decision-Making

## **Pain Control and Substitute Decision-Making**

This is an ethical dilemma I encountered about one year ago. As a student doing practical experience in the hospital, I had just begun my second year of nursing. I had chosen to work with a woman who'd had a fairly recent stroke. This was only about one week afterward. The stroke was quite severe and the woman was left unable to speak and could barely eat. She also had Parkinson's Disease and was on medication for tremors. At the beginning of my shift I went in to set her up and to help her eat breakfast before doing her A.M. care. The woman was in severe pain and could hardly tolerate being positioned in bed to eat, so I decided to see if she was due for any pain medication. I found that she was only on Tylenol Extra-Strength and that she was not due for any for at least two hours. I questioned my RN as to why she was not receiving anything stronger, because the Tylenol was not coming close to reducing her pain.

The answer astounded me. Since this woman was unable to communicate, her family had decided for her not to give her anything stronger than the Tylenol. They thought that if she was given anything stronger, she would lose her will to rehabilitate herself. Yet the woman was in too much pain even to be turned in her bed.

Although I never had the opportunity to meet the family, it seemed that they may have needed to know the facts regarding their mother's condition, including how pain affects rehabilitation and her rehabilitative prognosis, the myths regarding analgesics and stronger pain medications, addiction and de-motivation.

## **D.N.R. Orders**

Two weeks ago I found myself in a situation which I have never been in before. I was caring for a 74 year old woman who had suffered a cerebral vascular accident ten days prior. I had done her a.m. care and completed my assessments on her. My findings were that she was often sleeping, yet easy to arouse. She could not speak as a result of her right hemiplegia and did not always follow me with her eyes. I did not know whether she comprehended totally what I said. She did, however, open her eyes when you called her name, so this indicated to me that she could hear and comprehend something. She was moving her unaffected limbs in bed but did not seem to have controlled movement. Her pulses were strong in all extremities, her colour pink, bowel sounds present in all four quadrants and her chest was clear.

As the morning progressed the R.N. in charge asked me to replace the s/c butterfly so that this client could have her morphine. The morphine order was P.R.N. and this client, after her a.m. care and my moving her about in bed, did not appear to be in pain. My decision was not to give her the morphine. I checked in the chart to establish why she was being given this morphine and could not find an answer. I checked with my instructor who would not determine the reason for the morphine either. The order had been written the day she was brought into emergency after the C.V.A. The doctor had prescribed the morphine for pain. She was rubbing the side of her head; her daughter thought she had a headache. The scan showed a significant bleed, which indicated that she probably did have a headache. But for some reason the nursing staff continued to give her morphine every two hours as ordered P.R.N. up until the day that I looked after her. I should also explain at this point that when I checked the order for the morphine it had been written incorrectly from the doctor's order to the M.A.R. Her order was for 2 mg and the M.A.R. said 2 ml. This was a very large difference. This error was corrected on the M.A.R. but I did not check back on the narcotic records at the time to see what previous amounts were given. I had thought of checking later that day after our six hour shift was over.

By noon that day this client was more alert and moving in bed. The R.N. had suggested giving her Ativan to calm her but I refused; I did not see her as agitated, only moving. She had not had any morphine since the night before.

I feel that she was snowed and could not have woken up on her own. This client was on thickened fluids and was not being offered sufficient fluids. Her urine output over six hours was only 100 cc. We are taught that anything less than 30 cc an hour is cause for great concern. I was concerned this client was not getting the fluids she needed and that she was being given morphine that she did not seem to need.

There was a D.N.R. order on her chart, signed by the doctor. His comment in his notes was that I do not think that this patient would want to be resuscitated. No assessments had been noted in her chart, other than the scan on the day of admission.

My instructor and I took this case to the care coordinator. The care coordinator agreed to arrange to have a swallowing assessment done and physio was called to see if they could get the patient up. By noon physio had come up and the patient, weight bearing on her good leg with assistance, was able to pivot and sit in a recliner.

### **D.N.R. Order**

It was during my summer mentorship at W.C.G.H. I was following a very competent nurse through the routines on our floor. One of my patients was a gentleman in his late sixties. A diabetic, he was in the hospital for a below-the-knee amputation of his right leg.

Mr. T. was on his second day post-op, and we were doing dressing changes two times per day. Over the course of the week, we noticed the incision was getting worse; more and more exudates were coming out of the wound, and parts of it were even necrotic. On our days off, Mr. T. was taken back into surgery and received an above-the-knee amputation.

After the operation, he went downhill. Although he was on I.V. antibiotics three times a day, his condition did not improve; the stump got more and more infected. A short time after, it became evident that Mr. T. was not going to make it. For about two weeks, he was asking us to let him die.

At the start of his last week, I requested that the doctor check with the family on the code status of the patient. The doctor finished writing the orders and left the floor. It wasn't until I processed the orders that I realized he had written a D.N.R order for the patient. In the chart, the order read, "Discussed with patient D.N.R. Signature." I know that he did not discuss this with the patient or any member of his family, because I was sitting there doing my charting for the morning. Even if the doctor had gone into the room, the patient would have been unable to understand the conversation.

### **Family Intervention**

On my first day on floor five I was caring for Cathy, a 92 year-old woman who had been admitted with severe depression and failure to thrive. She was a 'full care' patient due to the fact that she had given up the will to live, would no longer feed herself, or perform any other basic care for herself. One of the nurses on the floor informed me that this patient had voiced her wish to just be left alone, and to be allowed to die peacefully.

Cathy's daughter was adamant that her mother receive the best care and treatment possible. Her daughter believed that if her mother's depression was cured then she would get better and would not wish to die. Cathy had been on the floor for quite some time, and had trialed several different anti-depressants in an attempt to correct her depression. So far, however, none had been effective.

The next treatment the medical team tried was ECT, or electroconvulsive therapy. She received her first ECT on the first day I cared for her. I was allowed to go and observe the procedure.

They begin by putting the patient to sleep and then send electrical currents into the patient's brain. Cathy's whole body jumped on the table with each set of electrical currents. The ECT technician informed me that this procedure is used for severely depressed individuals and that it has a very high success rate in correcting depression in younger people. He also told me that it is not common practice to perform this procedure on people over 65 years of age since the success rate is extremely low in the elderly.

I continued to provide care for Cathy over the next while and noticed no improvement with the continuing ECT treatments. She was eventually transferred to the palliative unit where she received comfort measures and passed away one month after our first meeting.

# Section IV: Advance Directives

## **Refusal to Allow Death**

Gloria, an 86 year-old woman, had been living in a complex care facility for the last five years of her life due to a loss of control of her diabetes. She had lived with diabetes for most of her adult life when, unexpectedly, her disease became unpredictable and needed constant professional monitoring. Thus, she had to give up her home and move into an extended care facility. She had been widowed for almost two decades and had lived independently throughout that whole time. Gloria had an extensive support system, including two sisters, five children, and over twenty grandchildren. Because of her career history as a nurse, she was very aware of the complications of her disease and had always been very health conscious. As a devout Christian, she found peace in believing that she would be with God when she passed on.

In the four months prior to her death her health took a serious turn for the worse. She had recurring seizures, uncontrollable insulin and glucose levels, and intermittent delirium during which she would say things like “I haven’t been good enough; God won’t take me and let me be with Chris (her son who was killed in a horrible accident at age 15) because I haven’t been good.”

Gloria had been under the medical care of the same physician for many years and together they had discussed and agreed upon an informal advanced directive stating that if her condition worsened significantly, her life would not be prolonged with new medical interventions or treatments. Her eldest daughter and son (power of attorney) were cognizant of her wishes and her agreement with her physician. They were prepared to respect the wishes of their mother and expected the physician to follow through with the agreement.

When her condition rapidly deteriorated, the expectation was that the physician would proceed as per their agreement. Unfortunately, her physician of many years was on sabbatical when this happened and the replacing physician proceeded quite differently. The new physician ordered new medications for her seizures and anxiety. He also ordered IV fluids to ensure hydration and encouraged the nurses to feed her as much as she would take. These new medications and interventions would never cure Gloria, but would only prolong her life for a short (but unknown) period of time. Gloria’s family was very upset by this and on a number of different occasions voiced their opposition to the new medications. The new physician was adamant, however, and stuck to his decision to treat Gloria with a number of new interventions. The physician’s argument was that the agreement between Gloria and her family physician was not legal and, in his medical opinion, he felt it was better to move forward with the new interventions.

After three months of watching their mother die a slow, painful, and frightening death, Gloria’s son and daughter pleaded with the attending physician to relent and withdraw treatment. He agreed and she died three days later.

## Section V: Confidentiality

## Confidentiality

It started out like any other first day at clinical. The usual feelings of tentative confidence in my abilities to manage groups of patients and usual disorganization were present as we started our only day of clinical practice that week. Usually, the first day of clinical is a write-off, but by the second day you are back into the groove and feeling more comfortable and confident in dealing with multiple patients. Unfortunately, this week we would only have one day.

I was working with a group of six patients. Dr. X was recovering from major surgery two days previously, and was not progressing as quickly as other patients I had with similar surgery. He was very anxious and agitated, and would not talk to staff. Whenever questions were directed to him, he would look over at his wife and let her answer for him. Although he had his surgery two days previously, he was very reluctant to get up and move around. As a result, his chest was filling up with fluid and he was at risk of developing pneumonia. When I checked his orders that morning, it was listed on his Medical Administration Record that he could receive up to 2 mg of Ativan as needed to help him settle or to relieve anxiety. I was concerned that if I gave this patient a sedative, it would further depress his respirations, increasing the fluid in his lungs. Also, if he was sedated, he would be less likely to want to get up and move around which was imperative for his recovery. I didn't have keys for the med cart, so went to the nursing desk to request them from the RN in charge of the team.

When I arrived at the nurses' desk, several physicians were completing their morning rounds and charting on their patients. I spoke to the RN and told her why I wanted the keys. The patient's physician was sitting at the desk, and started joking with the nurses about this patient self-prescribing the wrong antibiotic, causing his condition to worsen and resulting in surgery. Supposedly the patient didn't take any sedatives when at home, but "wasn't it curious" that he was requesting 2 mg of Ativan pm? These comments were made with snickers, laughter and facial gestures and preceded comments about the patient self-prescribing more than antibiotics for himself. The doctor seemed to be aware of the drug use, but only cancelled his order for Ativan for the duration of the patient's hospital stay.

I returned to Dr. X's room and relayed to him that he would not be receiving any Ativan as the sedatives were causing him to become too sedated and his lungs were filling up. I further explained that we needed to get him up and moving or he would suffer further complications. At this point both Dr. X and his wife became angry and agitated and insisted that I give him something to help calm him down. I again explained that I could not give him something unless it was ordered by his doctor and that I would ask his doctor to come in and talk to them about his decision. At this point, I relayed the patient's concerns to the RN and the doctor and left for my coffee break.

Upon my return, I entered the patient's room and inadvertently overheard a conversation between the patient and his wife. The patient was asking his wife to go to his office to get his prescription pad so he could "order it for myself". Did this mean the patient was going to order Ativan for himself because the doctor had cancelled his order? What should I do? Was this a private conversation I should not pay any attention to, or should I repeat what I heard to the RN or physician?

There wasn't any concrete evidence that Dr. X was writing himself prescriptions for sedatives. Was it drug abuse to take 2 mg of Ativan every four hours? Who is to say whether the amount of Ativan on person needs over what an average person needs constitutes abuse? The only "facts" I had were based on conjecture, hearsay and circumstantial evidence, but did this mean I should do nothing? What about patient safety? While in hospital, patient safety is the responsibility of hospital staff. What would happen and who would be responsible if Dr. X did take medication unbeknownst to his physician and suffered from medical complications related to the drug interaction?

## Section VI: Restraints

## **Chemical Restraints**

I was doing my mentorship in hospital in May of this year. During my first week on the floor I took care of a patient, age seventy-five, who was a resident at Madrona Lodge (an extended care facility). He was admitted to the hospital for a broken hip, which was replaced. The duration of his stay was over a month, at which point he lost his placement at the Lodge (he couldn't be readmitted because he no longer fit their criteria). During the month that I cared for him, this patient was verbally and physically abusive to the female nursing staff (he also suffered from dementia). His outbursts of foul language and his striking the staff would occur during any sort of intervention with him; anything from hygiene care to helping him take his medications.

During the month that the patient was in the hospital, it was noticed that his abusive behaviour was not subsiding. Therefore, approximately two weeks after his admission, my mentor insisted that when I did my medication round I was to give this patient some loxapine, an antipsychotic medication. This drug was ordered by the physician P.R.N. (as needed basis). One of the side effects of loxapine is sedation. This side effect was quite prevalent in this patient. When this drug was in his system he was completely unresponsive to stimulus. My mentor was aware of this fact, but she found that the results were beneficial because the patient was no longer able to abuse staff.

I was worried about the quality of the patient's life while he was taking the drug. I wondered how a person could live a full life while he was constantly sedated. My second concern was for the nursing staff. They had become fearful of caring for the patient.

## **Right to Refuse Medication**

Each day a new resident is admitted with some form of dementia. One particular gentleman, Mr. L, is aware enough to know that our facility is not his home. He spends much of the day pounding on the door, calling out, and continually asking the way home. Although he is usually a very quiet man, his frustration can escalate causing him to become quite agitated. This can lead to other residents becoming restless as well. Soon there are four other residents acting out and the nurses must deal with all of them.

Redirecting Mr. L becomes routine and ongoing throughout the shift, which is very tiring. At what point do you give him medication? When he is agitated enough that the medication does not work, or at the beginning of the shift to keep him manageable?

More times than not I have seen a nurse give an agitated resident something to calm him or her down and the medication does not work at all. Many times the medication is crushed and added to a sandwich or pudding so that the resident is unaware of what they are eating.

## **Mechanical Restraints**

Maureen is a 40 year old, mentally challenged woman who has lived for the past five years in a large psychiatric hospital. Maureen's brain damage results from illness in infancy and has left her functioning at the approximate level of a two-year-old. Maureen has always had regular outbursts on average two to three a week, in which she runs around shouting angrily and tearing her clothing. These incidents generally last for 30-45 minutes. In recent weeks, Maureen's behaviour has begun to deteriorate to include self-aggression such as striking herself in the face with sufficient force to cause bruising, biting her arms and throwing herself onto the floor.

Subsequent to the first such incident, the nursing staff on Ward 8 have been using a Posey jacket to restrain Maureen when she begins to show signs of agitation. While this has the desired effect of subduing Maureen, it leaves her weeping and distraught for up to a day afterward. Maureen's mother, Mrs. B, is opposed to having her daughter restrained and has repeatedly asked that it be discontinued. She feels that the restraint causes Maureen more pain than it prevents. Nursing staff have expressed their concern that left unrestrained during an outburst, Maureen may seriously injure herself, or perhaps

strike out at another resident or staff member. On several visits to Maureen, Mrs. B has found her either in the Posey jacket, or in the state of emotional distress that suggests she has recently been restrained.

The bite marks and bruises which Maureen leaves on her body are testimony to the extent of her distress during the moments in which she inflicts them upon herself. However, the incidents of angry running and shouting which preceded this more violent behaviour have always subsided as suddenly as they arose, with no apparent lingering ill effects. In contrast to this is the profound sadness Maureen suffers for as long as a day following each incident of restraint. This strongly indicates restraint as the cause of her weeping and sadness.

There are twenty residents of Ward 8. Do her outbursts create an unacceptable level of stress or anxiety for the other residents? Is Maureen's behaviour putting others at risk? There is so far no evidence of Maureen's attacking another resident or staff member. The question remains, however, if other residents may be at risk because an inordinate amount of staff time and attention needs to be allocated to monitoring Maureen during her episodes of self-aggression.

### **Medication Refused**

On the first day of my second year CPE, I was shadowing an RN who requested that I assist her with an elderly client, Elaine. Elaine was an 82 year-old woman who had fallen at home and was admitted into hospital with a broken hip. That morning I had had a chance to talk with Elaine. She was in obvious pain and she was distressed that her husband had not been in to visit her. She was not clear as to where she was or why, but she did understand that the medication she was receiving was pain medication along with other cardiac medications including the PRN anti-anxiety drug, Ativan. Later that day Elaine began refusing her medications. She was also becoming more confused and agitated, stating that we were 'trying to kill her with the drugs'. She refused to open her mouth and hit the medications out of the RN's hand. Elaine was also trying to climb out of the bed. The RN left the room and I followed. She requested my help; I would have to hold Elaine down while she injected the diluted Ativan into her mouth via a syringe.

I immediately felt uncomfortable with this request and told the RN about my reservations (I was afraid that I may hurt this frail woman). She explained that due to Elaine's cardiac condition, if her anxiety was not addressed, she would be at risk for developing dysrhythmias and possible cardiac arrest. In addition, she may hurt herself by trying to climb out of bed (a pineal restraint was ordered the next day). I decided to assist the RN by gently but firmly holding the woman's arms across her chest while the RN administered the Ativan. Thirty minutes later Elaine was sleeping comfortably.

# Section VII: Maternity Care

## **Adoption**

I was caring for a patient who was on the floor because she had had a caesarian section. She was on the first floor instead of maternity because she was planning to give the baby up for adoption. I noticed that the nurses seemed to be leaving her alone, and that she felt she was being ignored. A lot of nurses did not approve of her giving the baby up for adoption. She had had children previously, so they did not understand why she had decided to give this one up.

I went in to talk to her with an open mind, and she told me that she had been raped, and that was why she was giving the baby up. She stated to me that she did not feel comfortable because of the way the child was conceived. She told me that it was up to me if I wanted to tell the nurses about the rape or not. I did not feel that it was really my place, but I wanted her to receive the care that she deserved as a patient and as a human being, so I decided to tell the staff.

She ended up receiving amazing care. Even though she had not felt comfortable telling all the nurses, she was glad I had done it for her.

She had not told anyone that she was pregnant, so she was very concerned about what to tell her kids and their father about why she was in the hospital. And what should she tell them if she did decide to take the baby home? The social worker kept trying to convince her to keep the baby and raise it herself. Every time the social worker came to talk to her, she got more and more confused. This was a problem for me as well, because every time the social worker left, she would ask me if I felt she was doing the right thing by the baby and the rest of her family. I did not know what to tell her other than to say she would have to live with any decision she made for the rest of her life.

## **Premature Twins**

I am a mother of three-and-a-half year-old twins who were born extremely prematurely (27-28 weeks gestation).

I had a normal pregnancy, other than it being a twin pregnancy, and had no reason to expect an early delivery. As I approached my 26<sup>th</sup> week, I began experiencing some sporadic, mild to moderate cramping sensations, but within a day or two the cramping had stopped. I was a little concerned but waited until my next check-up to talk to my doctor about it. At my check-up, without an examination, my doctor told me that the cramping was only the 'stretching of the uterus' and I had nothing to worry about. I felt that I should have had an exam, but was too embarrassed to ask for one.

A few days later, the cramping started again. I didn't want to return to the doctor because I thought he might think I was obsessing. The cramping was still sporadic, but it was worsening. I finally returned to the doctor and told him I thought I was having labour pains. He again explained that my uterus was being stretched from a twin pregnancy and that the pain was normal. It was only upon my absolute insistence for a physical examination that he discovered, to my horror, that I was already 4 cm dilated.

Off I went to the hospital in complete shock and fear of what was happening. Everything happened very quickly. I was hooked up to numerous tubes and was given injections of steroids in an effort to stop the labour. I had never heard of a person giving birth three months early and didn't even know that survival at that point was possible. I kept asking question after question - What happens if the labour doesn't stop? Were they going to survive? How much would they weigh? If they survived would they be disabled? My mind was whirling. The only response I could get was that we would have to "wait and see".

With a complete lack of information at what could happen to my children, I basically went hysterical. After two hours of desperation, my sobbing turned to anger – nobody was going to brush off my questions anymore. I wasn't going to let anyone touch me until I could speak to someone who

would give me some answers. Reluctantly, the on-duty pediatrician who attended to the emergency care of premature babies was summoned to my room. This man saved my sanity. He patiently explained my entire situation, what my babies' chances of survival were, and what kind of health complications they might face. He even brought up pictures from the special care nursery of babies that had recently been born at the same gestation. His news wasn't all good, but at least it was honest and I could finally stop being afraid of the unknown. He told me that my doctor didn't want to say too much because he didn't want to worry me with outcomes that he could not predict.

With many of my questions answered, I could now face the rest of what was to follow. By this time, I had reached 5 cm dilation. My doctor informed me that he had never personally seen labour cease at this point and that it was time to go forward with the delivery, which would be by caesarean section. I wanted to wait a little longer and give the labour a chance to stop but the doctor insisted that waiting could put my babies at risk; they would need to be delivered right away.

My children were born that night (only five hours after I insisted that my doctor give me an examination). They were 2 lbs 12 oz. and 2 lbs 14 oz., a good size for their gestation, which is probably why they survived. However, I had two very sick children; they could not breathe by themselves and we had several close calls throughout the first few days of their lives. It is now three years later and I find myself blessed every day with healthy, happy three year olds that have, so far, beaten all the odds.

I am extremely grateful for the way things have turned out, but their road to recovery was long and agonizing, so I can't help but feel resentful for the confusion and stress surrounding their birth; the lack of communication from my caregivers amplified my anxiety.

### **Language Barrier**

A young immigrant couple, Camilla and Augusta, were on their fourth pregnancy after having experienced three miscarriages. During the third pregnancy, fetal tissue testing showed chromosomal abnormalities; therefore, the fourth pregnancy was monitored very closely.

At 32 weeks gestation of the fourth pregnancy, testing revealed problems with the baby's development related to the inadequate size of the placenta; the baby was not receiving adequate nutrients to develop normally. Unpredictably, the baby continued to thrive but showed evidence of developing asymmetrically, increasing the chance of cognitive impairment due to irregular nutrient distribution. In these situations, the nutrients are either provided in a greater proportion to the brain and the baby is born with a small body which makes her asymmetrical, or nutrients are supplied to the body leading to cognitive impairment due to inadequate nutrients and blood to the brain.

During the delivery, the baby's vitals dropped and an emergency C-section was performed. The baby's APGAR score was 0 at 1 minute, 0 at 5 minutes, and 3 at 10 minutes when the heart beat started with continuous resuscitation. At 45 minutes the baby gasped and took her first breath.

The baby, Carissa, is now five months old and is in and out of NRGH and Vancouver Children's on a regular basis. She has a feeding tube in because she is still unable to swallow. Carissa requires frequent suctioning to clear her mucous secretions, and she chokes on them if too much time has passed between suctionings.

Due to the language barrier between Carissa's parents and the staff, it is unclear as to whether or not the parents are aware of how poor their child's prognosis is, or if they are just in denial. Staff have found formula in the infant's throat indicating that Camilla and Augusta have tried to bottle feed her. Do they think that as she grows, she may begin to swallow?

Carissa has seizures approximately every two hours, and a brain function test revealed that no normal activity was present.

The nurses are concerned for Camilla who rarely sleeps or eats and keeps a constant vigil at her daughter's side. She has lost over 30 lbs on her already petite frame and says things like 'caring for my baby is the most rewarding thing for me'.

To make matters worse, the family's collective income per month is less than \$2,000, but the government has determined that they make too much money for financial assistance. Therefore their formula and medical supplies are paid for out of their pockets.

### **Maternity Care**

Approximately one year ago I was assigned to a childbearing family. There were some objectives that were laid out by my instructor for this experience. I was expected to visit this family a minimum of two times before the birth of the baby. I was also encouraged to be a part of the childbirth experience, and then work on the maternity floor while my family was staying there. After this I was to make at least one visit to see how the family was managing at home and to see how this new addition to the family altered the family dynamics. Throughout this time I was supposed to discuss the concepts covered in class with my family. I could also try to answer any questions that they might have or suggest any resources that could benefit them.

Before I met this family I was given a sheet of paper that had some brief information about them. I learned that the mother, Sarah, was a forty year old woman with a career as an RCMP dispatcher. Sarah was married to Bill – he was approximately the same age as her. He had two grown children from a previous marriage. Bill and Sarah have a five-year-old daughter together.

On my first meeting with this family they welcomed me with open arms. Sarah tried to do everything she could to help facilitate my learning. My education on the whole concept of childbirth was very limited and the family was aware of this. This family was very knowledgeable about childbirth because they had experienced it before. They basically took me under their wing and taught me all that they could.

This relationship continued to grow more into a friendship than a professional relationship. I was unsure of my role, so this friendship seemed to meet everyone's needs at the time. Because I was not clear about my role, obviously my childbearing family did not understand it either.

When Sarah was ready to give birth, the family called me so that I could be part of this experience. This is where our relationship changed. I was unsure if I was there as a support system for the family or if I was there as a student nurse learning about childbirth. I knew that I was expected to take on the role of the student nurse, but because of the friendship that had blossomed between the family and me, this made me feel awkward.

I was relieved when I learned that Sarah's labour was false and she was discharged. When she was discharged I decided to go home. About one hour after I left the hospital she had a baby girl. They decided to do a caesarean section because she was already overdue. When I heard of this news I was very happy for the family. I was also happy that I did not have to decide which role I should take. Unfortunately, I was informed that I had to work on the maternity floor the next day.

Being very naïve, I thought that working with my family on the maternity floor would be a new and exciting experience. It turned out to be a nightmare. The maternity floor was very busy and extremely understaffed. The nurse that was in charge of my client did not have the time or energy to listen to what I wanted to gain from this experience. She basically handed me Sarah's chart and told me to take care of her. I tried to explain that I had never worked on a maternity floor before, but she did not care. I felt so lost and vulnerable that I didn't know what to do.

I looked in Sarah's chart to find out what her needs were for the day. I saw that she had a few medications, she needed help with her peri-care, her catheter needed to be removed, and her I.V.

needed to be capped. I felt comfortable with the medications and the I.V., but I felt that doing her pericare and removing her catheter were crossing the boundaries of a friendship. Knowing that this experience would be uncomfortable for me, I couldn't even imagine how embarrassing this experience would be for Sarah.

Once again, I tried to explain my concerns to the nurse, but she did not understand. This made me feel very alone and useless; I went ahead with the procedures.

### **Maternity Nightmare**

Approximately five years ago, I gave birth to my first child, a beautiful little girl, Kaitlyn. I had been in labour for nearly thirty hours when I decided, with help from my family, that it was time to go to the hospital. The nurse took me into a room and put a monitor on my tummy to test the strength of the contractions. The nurse stated, "The contractions don't look big enough, and you're not in enough pain to be in labour."

Being a naïve young mother with a high pain threshold, I thought the nurse knew best. I went home, only to be brought back an hour later. The same nurse admitted me to a room and got me to fill out all the paperwork. She still stated, "There'll be no baby today, but we'll keep you here anyway." I was very upset by this time, because the pain was unbearable, and I was concerned that I was becoming a nuisance.

Hours later, there was a shift change, and a new nurse came into my room to introduce herself. She assessed that I was scared, confused, and in a great deal of pain. She discussed the stages of labour with me, confirmed that I was indeed in labour, showed me how to breathe properly, and then gave me a needle for the pain. The needle was full of Demerol, which helped take the edge off immediately. However, I had stated on my admission form that I did not want any drugs or procedures done to alter a natural childbirth. After many hours had passed, and the actual delivery came closer, I received another shot of Demerol. My thoughts were that I had already had one, and that I was in a lot of pain, so I didn't care.

The nurses were fearful that I was becoming too tired to go through the actual labour and brought me some consent forms for an epidural. I was so tired and in so much pain that I just wanted the baby out, so I signed the forms without even reading them. Fortunately, my water broke minutes later, and I gave birth.

Once I returned to my room, I stated that I did not want to breast-feed. This upset the nurses greatly, and they tried to persuade me to change my mind. In the middle of the night, they brought Kaitlyn in to me and tried to get me to breast-feed again. This really upset me, because I felt they had tried to take advantage of my sleepy state. The next morning, my doctor arrived to check Kaitlyn and me out. He then proceeded to try to persuade me to breast-feed to the point that I almost felt like I would be harming my child if I did not. Needless to say, I was very upset again and discharged myself from the hospital so I wouldn't be judged anymore.

The tragedy of this was that no one informed me that if you're not breast-feeding, you should not drink a lot of liquid, because your breasts become engorged, which is very painful.

# Section VIII: Home Care

## **Home Care**

Julie has massive ascities due to cirrhosis of the liver, hepatitis C, congestive heart failure, aortic murmur, osteoporosis, osteoarthritis and several other medical conditions. Julie is 85 years old, and needs live-in care to stay at home. I have been helping Julie since mid-June so she can live at home. During the past month I have watched Julie's condition deteriorate quickly. In a short period of time Julie has had a lot of changes – a hospital bed, Hoyer Lift, using a wheelchair over her walker, not being able to stand and using the lift, and being told she needs to use the commode as it is no longer safe for her to use the toilet.

Julie is not very happy with these changes and still feels she is able to do things as before. She does not understand why staff need to use the lift. One staff member has already hurt her back transferring Julie. Julie can be very uncooperative when transferring – she doesn't always listen to what you tell her to do.

One day while I was helping Julie, all hell broke loose. I implemented the Hoyer Lift and found that it was not set up for Julie's house. The Hoyer Lift did not raise Julie enough to clear her bed, so we had to transfer the 'old' way. Also, it was written in our communication book that if we hurt our back transferring Julie without the lift, we would not be covered by workers' compensation. Julie was fairly cooperative in transferring to her wheelchair this time.

Also, a medical equipment company came in and blocked Julie's sofa eight inches off the ground. I had checked to ensure the sofa's safety, and it seemed sturdy enough. I was told the lift was suitable for transferring from the wheelchair to the sofa, but again I found that the Hoyer Lift did not lift Julie high enough to clear the sofa. I would have had to lift her approximately two inches, and I know I am not strong enough to lift Julie by myself.

While transferring Julie from the wheelchair to the sofa the 'old' way, the sofa fell backwards off the blocks. Fortunately, some furniture was placed behind the sofa to stop it from completely falling over backwards. Needless to say, this really shook me up; Julie was just trying to figure out what happened.

I phoned the office to get some help, and a meeting was set with my supervisor and boss for early afternoon. During this meeting, it was decided that a hospital bed needed to be delivered Monday for the safety of the client and caregivers. Because of her medical condition, Julie needs to sleep at an angle to help her breathe easier.

What right do I have to tell someone they need a hospital bed? For Julie, the choices were either a hospital bed or admission to a hospital. I also know with Julie that the hospital is not an option; she will do almost anything to stay at home. I was raised to respect my elders, so now I'm trying to find the fine line between professionalism and the client's dignity.

As a caregiver, I am placed to help someone stay at home with their freedom and dignity intact. In this situation, I'm not sure I can say that I have accomplished this. On the other hand, I also know that I would be putting both of us at physical risk without using the lift and hospital bed.

## **A Moral Issue**

I had been Mrs. and Mr. M's main home-support worker for a year-and-a-half, and had developed a close relationship with them. Mrs. M was a 77 year-old blind woman, and Mr. M was an 88 year-old man who suffered from unpredictable dementia. They spoke many times about how they wished that they could die in their own home without having a medical institution involved or having to die alone in the hospital. If something happened at home, they did not want the paramedics involved. I respected their wishes and hoped that nothing would happen to them.

I noticed that Mr. M's health had been declining rapidly. He had tremendous difficulty in getting out of bed, so he was getting more back pain medication. He also suffered from dementia more often and for longer periods. Further, he started to become incontinent, which made the situation much harder. Mr. M had always done everything for himself and would not accept help, especially when it came to toileting or bathing.

One morning as I helped him to the bathroom, we made it only halfway before he fell. He complained that his back was in great pain. I tried to help him, to no avail. I recommended that we call an ambulance. Mrs. M refused and did not want me to do anything. I then suggested that we call the neighbour for assistance. However, another home-support worker dropped by and assisted me.

Mr. M was clearly in pain and needed medical assistance. Mrs. M could not fully appreciate his condition because of her blindness. The other home support worker and I tried to explain the severity of the situation, that it was cruel to leave him that way. After some time, she agreed. An ambulance came to take him to the hospital, where he died no more than half a week later.

# Section IX: Professional Standards

### **Intoxicated Nurse**

I was working as an Employed Student Nurse (ESN) in a facility that had an urgent care center and a long term care home. As an ESN, I was always assigned to work with another Registered Nurse (RN) and share half of her duties for that shift.

One evening, the RN that I was working with came on shift intoxicated. I could smell the alcohol on her breath and she was acting very sociable and giggly. The other staff members could also smell alcohol on the RN's breath. This RN's mental ability was definitely altered by the alcohol – she nearly gave out two wrong antibiotics to two different patients. When confronted about this, she replied, “Oh they are both the same thing!” The two antibiotics were definitely not the same. What if one of the patients had an allergy to the antibiotic that was meant for the other patient?

# Section X: Cross Cultural Issues

## **Disclosure of Prognosis**

During this past summer I was given the opportunity to do my practice hours in Bangkok, Thailand. On the third week of my experience I spent a day on a women's surgical ward in the government hospital.

Upon my arrival on the floor there was an awful odour, and when I inquired as to what it was I was shown something that will stay with me for a long time. There was a woman lying in a bed, with her gangrenous intestines exposed except for a cloth that covered them. She was on a respirator, was in considerable pain, and yet remained somewhat coherent.

When I inquired about her, the staff told me that the patient had been brought in from a small nearby province because they did not have the resources to care for her. They did an exploratory surgery because of the abdominal pain and vomiting, which revealed the intestines riddled with gangrene. Due to the language barrier, I never fully understood why they didn't close the incision and instead just covered it with a cloth.

As to the possible cause of the gangrene, the staff believed she had had a stillbirth and that it was somehow linked to her mesenteric artery becoming occluded, blocking blood-flow. The nurse also explained that the patient was a nurse herself, which suggested to me that she would understand, or at least question, what her fate was. She was being taken to surgery to remove the gangrenous intestine, and if possible, they were going to put in a colostomy. The truth was that her prognosis was very poor due to the extent of the gangrene and her deteriorating condition.

I asked her if she understood what was going on, and if her family was aware of her poor condition. I was making the assumption that the staff would want to help her settle any unfinished business, and say her good-byes, but the nurse explained to me that it would be unethical to tell her she was dying because it would take away any hope that she may have. The nurse went on further to explain their strong belief in reincarnation - they did not fear death or dying because it was always for a reason. If she lived a hard life, and died this way, she would have a better life next time. She explained that their faith in Buddha would see them through anything and that, in their culture, telling the patient the truth about her prognosis would be unethical.

## **Simon's Story**

In 1975, my father, David Daniel Walkus, died in a plane crash, leaving my mother to single-parent five children. Danny was the highest ranking chief in our tribe, and as such, held the duty of role-model and visionary.

Every time there was a new resource to be harvested, his first harvest was to feed his community. During cold winters, when boat access to the only store was not possible, our stocks would be plentiful enough to disperse as required.

Food is a very important part of traditional lifestyles, and a good host would always share a meal or snacks. Consequently, my mother would bake twelve to fifteen loaves of bread weekly, prepare extra at meals, and have a supply of baked goods. She would also knit socks and mittens for many children.

Our home was a gathering centre for everything from socialising to politics. Community drunks, hearing the laughter at our house, would drift in. Mom would give them plenty of black coffee. They would often play games or chatter themselves sober. Not once did I ever hear my parents turn away a community member in need.

Even the children benefited beyond warm fingers and clean cuts. In the winter season, my father would drive all the children in the village to school. During spring, he would gather up the village and take us all up to our picnic spot. We would get out at the top end of the road and berry pick our way down. He would organise Easter, Halloween, Christmas, and other events to let us know we were

important. My three older brothers and my one sister would have weekend dances and pizza nights when they were home from Vancouver.

Dignitaries, pilots, nurses, doctors, etc. who came to town would come to our home for meals and relaxation. When they were stranded, they stayed with us.

My father received \$40 per month for his leadership as Band Council Chief. My mother was the Community Health Representative. My father had a second job with the Department of Fisheries because my mother's salary was not sufficient; she was eligible under medical services to be paid for only a few hours of pay per week.

There was no TV, and, in the beginning, no plumbing. Yet despite the lack of television, I found many things to fill my endless curiosity and imagination. I often played close by as my parents prepared foods; I questioned non-stop and hacked many fish. I was never forced to help prepare food, but when I got the urge, I would dive in with much vigour. I was asked to stay away from homes when people were drinking and was urged to see how alcohol was affecting my people.

My ideas were never wrong, but my parents did punish me when required. I don't recall being aware of labels that categorised people. I was never forced to subscribe to my parents' whims, but often would find myself fitting into their lifestyle.

When my father was building my older brother's room, I sat at the end of the board to keep his saw from being pinched. I remember him saying, "What am I going to do when you're gone? Who is going to help me?" By that time, my siblings were at high school in boarding home programs, and the only times we were all together were Christmas and summer.

In the early seventies, the Department of Indian Affairs was still pushing to make Indians into farmers. We were given free seedlings, which my parents made good use of. We had a large garden that had a variety of hearty vegetables. My parents would send my mother's siblings big sacks of potatoes, and they would send us traditional foods that we had no access to.

In traditional societies, when a spouse dies, it is up to the woman's siblings to undertake the responsibilities of supporting the children. When my father's mother died, he took this role upon himself, because a lot of my father's family died of TB. My mother told me of the times they would buy school clothes and gifts and give her brothers-in-law spending money.

When my father died, my uncles would send my mom food, money, and presents. My uncles would send my sister big bags of wieners in with the doctor. My Uncle Marshall would go to the store to get me a whole box of Double Bubble every time he heard I was coming to town. As my siblings are much older than I, I benefited from their support as well. Even after her marriage, my sister was like my mother, and my oldest brother often helped by buying me treats on special occasions.

Before I was born, my parents were foster parents. They accepted two little community children who were from a mixed marriage. At my mother's funeral, a former foster child told us about everyone's rejecting him and his sister because they were "half-breeds." Fortunately, my father told the community that as long as they had Oweekela blood, they were Oweekela. If they were Oweekela, they were welcomed.

My parents further supported change by encouraging local drunks to sober up. One man began walking behind our house, but my mom soon discovered his ploy and began poling her head out back. The man is now sober and is a leader in the community.

Unfortunately, my parents did not want us to know our history. They thought we would have an easier life if we were more "white." They were both products of residential school and thought that we would be better off if we were raised to be white. At age twelve or thirteen, we were all placed into boarding home programs. Because I had the grounding of this traditional relationship, I can appreciate the lifestyle, even if I was not formally trained in our history.

In June of 1991, my mother called me in Bella Bella. It was time for me to travel back to Vancouver to be at my brother's side. My brother had AIDS. Two months earlier when I left him, I told him to call me when he needed me. For the five out of the eight months that we had known of Simon's AIDS, I watched him suffer horribly. When I got the call, I was afraid. I was afraid of death and afraid of losing him. Simon was my surrogate father, hero, and a life-long best friend.

When I got to my aunt's house, he was in much discomfort. We decided to call an ambulance. The staff at the hospital re-hydrated him and ran tests. The doctor came by and told us the following: my brother had a virus that was causing something like a tumour. It was an aggressive virus and had probably damaged his mobility permanently. If we chose not to give Simon antibiotics, he probably would never wake up again. We were told that we could choose to treat him, but his KS would soon be so advanced that he would be facing death yet again. Even after treatment, it was probable that he would be permanently hospitalised. We could choose not to treat him and let him die. I chose death, and my mother supported me.

Despite the fact that we had not told many people about his hospitalisation, many people came. Within a few days, we were hosting up to twenty guests per day. The staff decided that it would be less stressful to other patients if we were moved to a private room.

Two days after the move, Simon woke up. He was very hungry and thirsty. The doctor came by the next day. He wanted to ask Simon to make his choice. I was devastated. I felt he shouldn't be asked, because as much as we tried to communicate, I could never understand him. Apparently, they showed him the forms and asked him if he was ready to die. They wrote a "yes" and a "no" on a piece of paper and asked him to point. Then they gave him a pen and asked him to "X" his signature. When he couldn't decide, they came back to us. We talked amongst each other and decided to let him die.

Eventually, he was totally bedridden, and by about the third week, he could no longer eat. His tongue and his lips had deep cracks, and there was a brown film in his mouth. Everything about him was skeletal except his swollen, black feet. What I recall most, though, is how much I wanted to kill him. It would have been so easy. His friend would remind me that I could not take his choice away from him. "When Simon is ready, he'll go."

At 3:30 pm, two days after my two other brothers came, on July 31, Simon died. The nurse told us that we could take as long as we needed and told us to call when we were ready to let him go. After about half-an-hour, my older brother convinced me to leave the room. We went to a private room, where he told me not to let them take Simon away. Fortunately, my half-sister came and was also not ready. About two hours later, almost everyone had left. My sister, a cousin, and I stayed with him.

At sunset, I told the nurses I was ready to let him go. Three people came and kicked us out. I went outside and began arguing with the head nurse. I told her that I did not want my brother to be alone when he was being bagged. Finally, after reassurances that I would stay in the corner and not interfere with their process, I was allowed in the room. My cousin and sister, on the other hand, had to wait outside.

We were not allowed to follow him to the morgue, no matter how much I argued, so I settled for being in the room. I went back and told my family the conditions. To my recollection, I asked my sister to go to the waiting room so that she could make sure our ancestors knew where to come.

As they bagged him, I prayed and sang him prayers and love songs. After he was bagged, my cousin stormed into the room, unzipped the bag, looked directly into his face, touched him, and told him he was not alone. When they rolled him out of the room, I stopped at the nurses' station. I saw my cousin following him to the elevator. My sister and I left the hospital and waited for her to come. Eventually, she came out. When she sat in the car, she proudly announced that she had walked him to the morgue.

“There was no way I was going to let him take his last journey on this earth alone! When the elevator came, I stepped in! I just came from the morgue.” We were elated and had a grand time giggling at our tenacity.

# Section XI: Health Care Justice

## **Equal Treatment**

I was doing my practical experience on a surgical floor at the hospital and was assigned to care for a forty-five year-old female patient, Leanne. She had a history of IV heroine use and has been admitted to the hospital many times over the past couple of years for large wounds on her forearms directly related to her drug use. The wounds required constant care; this was very time consuming and required a meticulous approach. Leanne required IV antibiotic therapy every four hours due to infection in the wounds. In addition to this, the doctor had ordered morphine “as needed” for the pain related to the large open cuts.

The other nurses on the floor labelled Leanne as “drug seeking” and would often refuse to medicate her. I noticed that the dressings on her arms were not done properly; they were too tight and were cutting off circulation to her hands. When I took the dressings off, it was evident that the wounds had not been cleaned in quite some time and were in fact getting worse.

Several of the nurses would make remarks such as, “She will just be back in to see us again in another month of two, so why even bother” or “She’s inflicting this on herself so why should we be helping her so much.”

## **Ethics of Transfusion**

Mrs. A was an 85-year-old resident living in an extended care facility. She had been a resident there for three years because of a stroke. Over the last year, she had deteriorated to the point where she was a bed patient, since she couldn’t tolerate sitting up in any type of chair for any length of time. She was mentally alert and capable of carrying on a conversation. She was also able to feed herself. Her loyal husband and friends came to visit daily, and she enjoyed these visits immensely.

Over a few months, staff noted that her urine was quite sanguineous and that her energy level had decreased. The physician stated the symptoms were caused by the cancer of the adrenal glands she had had for quite some time and had opted not to be treated for. He decided to order some blood work, which indicated very low haemoglobin.

Mrs. A and her husband knew that her time was limited, so they called their daughter in Ontario, who would come for one last visit. They discussed it with the physician, who decided Mrs. A should have a transfusion of two units of blood to help prolong her life for her daughter’s visit. The staff was appalled at such an order, stating it was “a waste of blood, time, and money.” Many staff members also commented that they no longer donated blood because of the way it is wasted on patients who don’t stand a chance of recovery. Since Mrs. A would also have to be transferred to the hospital via ambulance for the transfusion – this would be an additional cost to the facility.

# Section XII: End-of-Life Decision Making

## **Letting the Patient Go**

In 1988, Mrs. R began to experience the early symptoms of dementia at 56 years of age. She was admitted to a long term care facility in 1991 and by 1995 she was transferred to the Shady Pines Alzheimer unit.

By the time she was 64 years old, Mrs. R was severely demented. Weighing 46 kilograms, she had a strong appetite, drank as much liquid as was offered, and walked well on her own. She also spoke a few words, smiled at the staff at times and seemed to be in no pain. However, her dementia caused her to often grab at other residents, sit on tables and occasionally fall down. While she was not considered dangerous to other residents, the staff, or herself, her spastic and non-stop movements required a lot of staff attention. An additional problem was that she was incontinent and it took three care aides to change her.

There was concern by the administration of Shady Pines that Mrs. R required too much staff attention: they wanted to reduce the number of care aides on a shift. An application was made to transfer Mrs. R to Riverview Psychiatric Hospital. However, it was rejected as Riverview was not taking on any more permanent patients. After discussions with her physician and a person from Mental Health, Shady Pines administration felt that there was nothing more they could do for Mrs. R. Her family was approached and informed that Mrs. R was in the last stage of Alzheimer disease and in pain and that they could either have her transferred to Riverview Hospital to sustain her as she was or she could remain at Shady Pines where she could be medicated to a vegetative state and administered analgesic morphine to suppress her immune system to “let her go”. They compared her state to someone with terminal cancer, with no quality of life or dignity left. Since the family was very uncomfortable with having Mrs. R go to Riverview, they agreed to the proposed treatment.

When the staff of Shady Pines were informed of the decision regarding Mrs. R’s treatment, they strongly objected. Some of the RNs and the care aides who worked with Mrs. R felt that the decision was a purely cost-effective measure. They argued that when a patient is in the last state of Alzheimers they go into a natural vegetative state, curled into fetal position. They will clamp their mouth shut when offered food or drink and eventually die on their own. In Mrs. R’s case, the care aides did not note any symptoms of pain and said that she loved her food and drank as much as she was offered. They proposed that she be kept on the Alzheimer unit in a room of her own with a sink chair and low bed without side rails so she could get up without falling and manoeuvre in and out of her chair without assistance. If Mrs. R were to become ill, then antibiotics could be withheld and she could be let go naturally that way.

Their suggestion was not adhered to and the proposed treatment was started. Within a few weeks Mrs. R was down to 30 kilograms. She became unable to swallow food or liquid due to the massive doses of drugs and morphine.

## **Allowing Death**

I was working on a surgical floor in a small island hospital. It was 4:00 on a Friday afternoon when we received a patient back from the post-anaesthetic room (PAR). She was 48 years old, in what appeared to be good physical shape. She had undergone a laparoscopic diagnostic surgery to determine the cause of her unbearable pain. What they found was that she was full of cancer. This cancer grows on various mucosal tissues and tends to compress the blood vessels. This results in ischemic areas and tissue necrosis.

The processes of ischemia and necrosis are very painful. Mrs. J had been in the hospital for about a week, doing everything the nursing staff asked. On one evening shift, the night nurse found

Mrs. J crying into her pillow, and they talked for about an hour, going through the process of dealing with issues that had come up after finding out she had terminal cancer.

Approximately two days later, Mrs. J started to refuse treatment; she stopped taking chemotherapy and would not go for any of the tests or procedures that were planned. She refused her meals and pulled out the I.V. When I asked her about refusing meals, she told me that she wanted to die, and that she knew nobody would be able to help her. I asked if it was her intent to starve herself to death, and she said yes. I could see that she was in a lot of pain and asked if she wanted something for it; she said no. When I asked her why, she said that she just wanted to be left alone so she could die. We ended up controlling the pain with morphine and allowing her to die. It took about two weeks.

### **Comfort Measures**

The daughter of Dana, a patient on the floor who I was not looking after, came to the nursing station and told us that her mother felt warm and was breathing a little funny, asking if we could please come down and take her temperature. The other nurse at the station was busy with something else so I said I would go and do it – she said she would let the patient’s nurse know what was happening. When I grabbed the thermometer I also picked up the oximeter so I could assess the patient’s O<sub>2</sub> saturation (amount of oxygen in the blood) because the daughter had said she was also having difficulty breathing. This was something I never even thought twice about doing since it is a natural first step in an assessment for a patient of this description.

As I was finishing these two assessments, Dana’s nurse entered the room. I immediately gave her the report on the situation including the fact that the patient’s O<sub>2</sub> SATs were 87% on room air, (normal is in the 94-100% range) a factor that would immediately indicate giving the patient oxygen. The nurse told me she would take care of it so I left Dana in her care.

Approximately five minutes later the nurse returned to the desk and proceeded to tell me that I should not have taken Dana’s O<sub>2</sub> readings because if her family had known what I was doing and questioned me on the results they may have insisted that we give her oxygen. When I questioned the nurse as to why she had not given Dana oxygen, she stated that it would have only prolonged Dana’s life for no good reason, and that Dana was dying, and was going to be dead within the next few hours anyway.

### **End of Life Decision-Making**

I was taking care of Patricia, a woman in her late eighties who had had multiple strokes. She had lots of family members constantly gathered around her night and day. She was well loved and very important to the whole family. When Patricia first came into the hospital her family wanted everything to be done in order to keep her alive. However, Patricia just wanted to be left alone - she was ready to die. Further complicating this situation is the fact that Patricia had a mild form of dementia, so there was some uncertainty as to whether or not she was mentally well enough to make decisions for herself.

Patricia’s family was afraid of making a wrong decision that they would have to live with the rest of their lives. On the other hand, Patricia and her health care professionals felt that she was no longer living her life comfortably and that she would be happier “in another place.” There was no joy or happiness for Patricia anymore – she was merely alive, not living. She had lost all function on the right side of her body, was having difficulty swallowing, and was not able to stand, feed herself, or perform other normal daily activities that she was before very capable of doing. She was previously a very independent woman, so being unable to take care of herself depressed her.

## **Degrees of Intervention and Family Involvement in Decision-Making**

Ms. P was a sixty-five year old woman who had Multiple Sclerosis for ten years. She had lived at Eaton Lodge for two years. Her husband was alive and lived in northern B.C. He was unable to look after her because of poor health. Four of her five children (two being girls) lived in Duncan. The girls decided that it would be easier for the children to care for their mother in Duncan. So with the consent of their father they had her transferred to the extended care ward at Eaton Lodge.

On admission it is customary for residents to sign a degree of intervention form. When she was admitted I talked about the form and its meaning to the family and to Ms. P. They said they would like to talk about it together and get back to me. After two weeks and several reminders, no form was returned.

I talked to Ms. P about the form, its meaning and the reasons for making a decision. I reviewed the options with her and questioned her to make sure the communication was clear. I was satisfied that the communication was clear. She said she would sign the form and had agreed to no code, therapeutic measures and not to be sent to the hospital. A note was left on the chart to tell the family that she had signed the form and what she had decided. They seemed to be interested in helping with the decision-making.

Several months later Ms.P developed a high fever with accompanying symptoms. I left a message on the family answering machine about the situation and that a call was out to the doctor to prescribe treatment. A short while later, the daughter phoned and asked if her mother was on the way to the hospital. I told her no, that her mother had signed the degree of intervention form and requested not to go to the hospital. The daughter came right over and went in to talk to her mother. She came out quickly, told me her mother did not know what she was talking about and that she wanted her to go to the hospital. At this point Ms. P was semiconscious because of her high fever. The doctor was informed of the situation and agreed to the transfer of Ms. P to the hospital.

## **Comfort Care**

I have worked as a licensed practical nurse for the past four and a half years, and have encountered many ethical dilemmas. The one that stands out for me is one that caused me 'moral distress' and is something I still think about occasionally when working with palliative care clients. It began when I arrived on shift to do an evening, and was given a report that one of our clients had returned from the hospital after being treated there for almost four weeks due to a pleural effusion and shortness of breath. Mrs. Smith was diagnosed with end-stage heart failure, and was sent back to us to receive end of life care. It was reported that the nurses on the unit had started a subcutaneous butterfly for the purpose of administering morphine for comfort measures, and had tried to contact her family physician for palliative care orders. Mrs. Smith was alert, and although cognitively impaired with a diagnosis of dementia, was refusing to eat but was cooperative and pleasant, and would express her pain and concerns. A fax was sent to her family doctor with the information we received from the hospital requesting him to get back to us as soon as possible with an order, if he would so choose, as well as palliative care medication orders, such as scopolamine and morphine which are usually the standard medications for used for comfort care at the end of life. An oxygen concentrator was set up in her room prior to discharge as per hospital instructions due to her occasional severe shortness of breath, which were always accompanied by severe anxiety and panic. Late in the evening after having settled her for bed, Mrs. Smith began to have an attack of shortness of breath accompanied by anxiety. She could not remember to use her call bell, and would yell, "Help! Help!" down the hall. It became apparent that lying down and changing positions from side to side were causing the fluid in her lungs to move around and cause episodes of shortness of breath. A care aide and I sat Mrs. Smith at the edge of

the bed and rubbed her back, reassured her and increased her oxygen to help relieve her symptoms. She appeared afraid and worried and would make comments such as “I’m too old. I should just fly away.” This was the first of many of these episodes throughout the night as reported by the night nurse. Almost 24 hours had passed, and we had still not heard from the GP, so the nurse on staff called the office and confirmed that he was working and was not taking calls because he was in with patients. The physician’s nurse assured us that she had received the fax and that she would put this in front of him so that he would respond. Later in the evening, we still had not received any reply. We sent another fax labeled urgent this time that explained these episodes of shortness of breath, and after two more days and numerous calls from the nurses and having the family attempt to contact him, the physician did not respond.

We had our resident doctor see her because we were giving up on trying to contact her own doctor. He suggested that we get her file sent to his office as soon as possible, and that he would take over her care but until then he did not feel comfortable ordering morphine and discounting her oral medication until he knew the full extent of her situation. That night I was working the evening shift again. Mrs. Smith had a severe anxiety attack, and with all of our efforts we could not help to relieve her symptoms. It was very difficult to watch her and to feel helpless. I was in charge with only the help of the care aides. I felt alone and unsure of what to do but had to do something. Mrs. Smith’s quality of life was seriously affected, she was scared, dying, and uncomfortable and not fully aware of what was going on. I was frustrated with her doctor, because I had all the medications that she needed but was unable to give them because we didn’t have a doctor’s order. I had to send her to the hospital by ambulance. I wrote a long letter that I sent with the paramedics, explaining the situation and her diagnosis, and that we were unable to contact and receive an order from her GP. I asked if they could assess her, have a medication script sent for morphine as well as referral for palliative home support. Thankfully after a couple of hours she was sent back home. The emergency nurse was very supportive. She called and spoke with me before I left off shift and asked if there was anything else that we needed before they discharged her home. Although I felt bad for having to put Mrs. Smith through the ambulance ride and emergency where she was probably asked questions she didn’t understand, I was relieved we would be able to keep her comfortable. The next day, palliative home support came in with a new mattress, spoke with the family offering hospice support and was there to teach all the nurses how to provide appropriate palliative care and manage her respiratory distress. The VIHA nurse also went to Mrs. Smith’s GP’s office and confronted him and had him write orders for her to pass along to us. Mrs. Smith passed away comfortably about two days after all of this happened, with the dignity she deserved.

### **Dressing Change**

The ethical issue to be discussed in this paper occurred during one of my practicum days in acute care. During this practicum, I was assigned a patient by my instructor and would work with the registered nurse team leader (Sue) to provide care to the patient that was inside my scope of practice. When I arrived one morning, I was told that the patient I had been assigned had taken a turn for the worst. Overnight, the patient, Mrs. Smith, had started hemorrhaging from the cancerous growths on her chest and had needed numerous dressing changes throughout the night shift. She remained in a low level of consciousness and had become non-verbal. I had not met her yet, but had started a nursing care plan for her based on the information from her chart. I knew that prior to her deterioration, she was able to swallow, communicate verbally and was mobile with assistance. Normally, the doctor looking after Mrs. Smith would have been by to see her, but it had been decided that she was no longer in need of acute care and the goal of her care was comfort. While providing her with her morning assessment and

bed bath, I noticed that the dressing covering her chest wounds had soaked through onto the bed. After informing Sue, we contacted the registered nurse responsible for wound care on the floor to discuss having the dressing changed. When the wound care nurse (Ed) was ready, we tried to give Mrs. Smith her pain medication as the dressing change would be painful and take at least 20 minutes. Since she was drowsy, she was not able to swallow the crushed up pain medications completely. She did not have an order from the doctor for any other route, so Ed decided to begin the dressing change anyway. I assisted throughout the change and held Mrs. Smith's hand and spoke with her about what we were doing. Though she did not respond to our voices, she winced and groaned with pain when we turned her to remove the tensor bandage around her chest. I could see she was in a lot of pain and talked to her and rubbed her hand. We completed the dressing change and allowed her to rest. Next day, I found out that Mrs. Smith had passed away the afternoon after her dressing change.

### **Dialysis at the End of Life**

During my career as an LPN, I most often worked on floor one with telemetry patients and renal dialysis patients. This patient of mine, AB, had been my patient for weeks at a time several times throughout my career. AB was a dialysis patient with chronic renal failure. AB was a free spirit who was just happy to be alive. Unlike most dialysis patients who get bogged down with their chronic disease, AB was always happy. AB was a victim of a brutal drinking and driving accident several years before I had met her, perhaps in her late twenties. The accident left her with a brutally dismembered body, major constructive surgery, chronic renal failure and emotional trauma. AB had her left leg removed along the left side of her pelvis. AB's rectum and vagina was also reconstructed. AB wore a brief; her urethra emptied to the outside of her body because her vagina had been removed. AB's stool normally emptied through an ileostomy. A portion of her large intestine and left buttocks had been removed and her anus was sewn up. AB attended renal dialysis 3-4 times a week and transferred with the assistance of one person into a wheelchair.

Many years after her tragic accident, after raising her only son with her supportive husband, she became my patient. AB could no longer continue her dialysis in the community, as her intestinal structures were no longer intact. AB had a necrotic herniated bowel on her LLQ, and an inferior medial fistula draining loose stool and a non-functional ileostomy to the RUQ. With the assistance of a wound care specialist and one to one nursing care, the nurses developed a wound care plan to best capture the stool from the fistula and protect the surrounding skin from the acidic stool. The innovation and good intentions were unsuccessful. AB bowels would spill out and there was no way to contain her feces. Her skin was raw, sore and breaking down. AB also had an undermining coccyx wound with tunneling that had no end point x. A surgical consult was made, but the surgeon was not willing to do surgery on AB. Nursing resources were exhausted; a one to one nurse was put in place to change her dressings and brief every two hours and manage her pain. AB did not want to die. Nurses were uncomfortable with taking AB as a patient. Her wounds were unbearable and dressing changes became torturous. The nephrologist and general surgeon consulted each other as to whether continuing with dialysis was unethical; the MRP had a thorough discussion with AB and her family.

The doctors felt it was morally wrong to continue giving her renal dialysis as it was only prolonging her suffering. AB's dialysis was discontinued and she died very shortly after. AB knew that if dialysis were discontinued she would die. It was hard for her to accept that the rest of her body was no longer manageable and there were no medical interventions that could be done. Her health was quickly deteriorating and on such a high dose of narcotic pain management she was no longer oriented or coherent as to depth of her situation.

### **Morphine at the End of Life**

After the death of my great grandmother approximately 10 years ago, my great grandfather was put into a long term care facility. He was no longer able to adequately care for himself. Throughout his time at the facility, my grandfather had discussed with our family and his care providers that he no longer wanted to live; and he wanted to 'join his wife.' As per his wishes, a Do Not Resuscitate order was put in place to ensure no medical interventions were used to prolong his life. After approximately six years in the facility, my family was notified by the staff that my grandfather was nearing the end of his life and was becoming less responsive. The nursing staff restricted food and water, and regularly scheduled doses of morphine to ensure he did not feel any pain. A senior nurse suggested an 'as needed' dose of morphine that would slow his respiratory rate to the point that he would finally pass away. As my family left that evening, the nurse administered this dose of morphine.

## Section XIII: Others

## **Pain Control**

John is a 31 year-old heroin addict admitted to hospital for treatment of cellulitis of the left forearm. This is an extremely painful infection of the tissues that many addicts develop as a result of intravenous (I.V.) needle use. He has come into Emergency and is seen by the physician on call as he does not have a regular doctor. He admits to using heroin. He is put on I.V. antibiotics to treat the infection and a standard dose of acetaminophen with codeine to treat the pain. Upon admission to the medical ward he requests that the nurse give him something for pain and she brings him the acetaminophen with codeine. He sees the pills and says to the nurse, "T-3's are like taking candy for me! I need something stronger." The nurse replies that she can only give patients what is ordered by the doctor and that he'd better take the acetaminophen with codeine or he'd get nothing at all. John is becoming increasingly agitated and diaphoretic. The nurse is annoyed with his constant requests. When he rings the call bell the nurse tells him that if he bothers her one more time for pills she won't give him any. When the nurse returns to the room two hours later, John is not there. He has unhooked the I.V. medication but there is no sign that he removed the I.V. line from his arm. Within 24 hours he is found dead in a hotel room with a syringe sticking out of his still intact hospital I.V. line.

## **Pain Control and Perceived Addiction**

A 25 year-old man was brought into emergency after fracturing both the tibia and fibula of his left leg. He had corrective surgery that night in emergency.

My first encounter with Ben was about three days later when I entered his private room to answer cries for help. He could be heard moaning and crying all over the floor, and being a student with a bit more time than the staff, I went in to see what I could do. Ben was crying; he asked me for his pain medication and described the pain in his foot as unbearable. I quickly went to find his nurse to describe the problem to her. The nurse stated that he was a 25 year-old guy who had two to three pages filled on his medication record with morphine. And nobody could be in that much pain. It didn't take long before I figured out that the consensus on the floor was that he was addicted to morphine and that all his moaning was a big act.

He could very well have been addicted to drugs and giving us Oscar performances. In that case, continuing to feed his habit would not do him much good. Or he could have been in severe pain. In the latter case, if pain medication was not given on a regular basis, we would only end up chasing the pain. And not believing he really is in pain (when he is) puts him at horrific risk. Compartment Syndrome is a very real risk when someone suffers an injury such as his. It could happen very quickly and the nerve damage is often irreversible. The possibility of infection was also there.

At the time there was much emotional engagement on my part; I had been taught to believe pain is what the patient says it is. I was torn between what I really felt to be true – that he really was in pain – and what everyone was telling me: it's an act. The staff reasoned their way around everything I said. They argued that his sudden pain appeared 'coincidentally' just after his PCA had been taken down, and that his surgery was three days ago, so it was too late for complications. If I mentioned his crying, they said he had lots of practice and that if you want something bad enough you will do anything for it.

As it turned out, Ben was in real pain because of an infection in his incision. He went through six surgeries and a month after his admission to Emergency he was discharged under the care of the home I.V. therapy department.

## **I.V. Judgment**

My loved one, Olivia, is no stranger to our healthcare system after battling two cancers and undergoing a host of treatments and surgeries. She can now recognize the difference between good nursing care and poor nursing judgment.

During her last hospitalization when she underwent yet another surgery, the health care staff were floored by how difficult it was to start an IV line on her. In the past nurses have resorted to starting IV's in her feet because not only are the veins in her arms very difficult, but the auxiliary lymph nodes on her left side were removed – so IV's can only be started in her right arm so as to avoid the risk of lymph edema to the left. Before this surgery, the anaesthesiologist (who can start IV's with his eyes closed), had to try several times before starting a successful IV.

When she returned to her room post-operatively, the IV went interstitial and the nurses had to restart it again. They tried many times unsuccessfully. They then called the 'IV pro' from the ICU to come and try – she too was unsuccessful. The anaesthesiologist was called for help in the end, and the IV was in. Needless to say, Olivia's arm looked like a pincushion.

Over the next two days she began to suffer some complications from the surgery and a CT scan was ordered. Much to her dismay, the lumen of the IV that she currently had was too small to administer the contrast dye needed to perform the CT. So, yet again, a new IV needed to be started.

You can imagine her surprise when two student nurses entered the room to start her IV. Having enjoyed being cared for by student nurses in the past, she had nothing against them. But it seemed that if the RN's, ICU specialists, and anaesthesiologist had difficulties starting her IV, then how could these students do it? And with a larger needle on top of it! She politely explained these circumstances to the students, informing them that they would probably have no success with her arm. The first student tried unsuccessfully, and then tried again. After her second failed attempt, the other student exclaimed, 'I want to try!' As you will guess, both of her attempts were unsuccessful as well. A more experienced nurse was called to begin her attempts...

## **Possible Rape**

In our clinical experiences, our instructors can sometimes arrange 'alternative experiences' for us in different areas or departments of the hospital. On this particular day, I was paired with a nurse for an exciting day of observation in the ER.

Upon arriving in the ER, my nurse, Sally, and I were taken into the back trauma room to take over the care of a patient, Mary, who had come in about four hours before. The night nurse gave us a report very quickly and impatiently since she had small children waiting for her at home. We learned that Mary had been brought in by ambulance after her brother had found her sprawled on her bed, unconscious, and surrounded by empty pill bottles. Apparently the house looked as though it had been trashed, and there was a broken window that someone could have come through. No one was certain about what had led to this event.

The night nurse went on to inform Sally of the many medical interventions they had done the night before to keep Mary alive, and that while taking a rectal temperature she noticed there was some bleeding and possible trauma to the area. There was some suspicion as to whether or not Mary had been raped. The night nurse mentioned it to the doctor who refused to take any action such as a 'rape kit', or informing the RCMP, because he said he could not legally take swabs without Mary's permission. However, it would have been impossible to ask Mary as she was still unconscious and intubated. The night nurse then rolled her eyes as if to say 'oh well', and dashed off even though my nurse expressed concern over her unfamiliarity with some of the complex equipment Mary was attached to.

None of the verbally passed on suspicions were recorded anywhere in the documentation. When I tried to broach the subject of reporting the possible rape, or at least of documenting it, my nurse refused and brushed me off. Mary was transferred to the ICU later that day.

### **Labelling Acting Out Patients**

When a patient at Nanaimo Regional General Hospital is assessed as an “Acting Out Patient”, they are given a green armband instead of the regular white bands. The patient is told why they have been given the coloured band, and all the hospital employees will know about this patient’s history of abuse or physical or verbal misbehaviour.

One day last year, while at the hospital for my clinical practice, I noticed that one of my patients, an elderly man with early dementia who had come in for hip surgery, was an A.O.P. One nurse warned me that he would swing out at nurses and to be careful.

I went into his room and saw an old man who could barely get out of bed on his own. I kept my distance when talking to him, always thinking about the potential abuse. As I got to know this patient, I saw no evidence whatsoever for the label he’d been given. I asked one of the senior nurses about this and was told that it was a safety issue, and I should just accept it.

The nurse ended up coming to my patient’s bedside. Because he wouldn’t comply with her requests, she ended up yelling in his face. I could see his smile quickly go away, and his face became a dark red. He was angry for being treated so poorly. She had given him no respect. I do note here that he did not swing out at her.

I talked to my teacher, and the next day at clinical, I looked at reassessing him and ended up doing so with her. We found no evidence to support the label of his being an “Acting Out Patient.” I then promptly cut off the green armband and gave him a regular white one.

The nurse stated that this patient was abusive towards staff; I had seen no evidence of this. Perhaps the patient acted differently because I was a male nurse and he felt more comfortable with me than a female nurse. Maybe it was simply that I treated him differently.

In the instruction of A.O.P. assessments, it states that the patient must be told why he is given the green armband, though he doesn’t have to agree with it. My patient may have been told by a nurse, but because of his dementia and hearing problem, I wonder if he really understood the label. If this was the case, I wonder if his wife and daughter should have been told. They were regular visitors, and it would have been easy to mention the armband issue to them with an explanation as to why the staff wanted him to have one. His wife was not aware of it at all and was actually quite shocked to hear about the claims of the nurses.

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