

Intellectuele Output 0

Casussen en Levensverhalen Casusvignetten



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OVER HET PROJECT

HET TEAM

Het strategische partnerschap NursEduPal@Euro is een internationaal consortium dat samenwerkt rond innovatie in de palliatieve zorg opleiding van bachelors in de verpleegkunde.

HET DOEL

Het Erasmus+ project heeft tot doel de kwaliteit van het onderwijs in de palliatieve zorg te verbeteren door docenten in de verpleegkunde in staat te stellen, te ondersteunen en te versterken om een reeks innovatieve leermiddelen te gebruiken om ervoor te zorgen dat palliatieve zorg wordt opgenomen in hun curriculum voor bachelor studenten verpleegkunde.

Het project heeft een op competenties gebaseerde Europese matrix ontwikkeld met innovatieve *blended* opleidingsinstrumenten voor docenten. Deze verbeterde leermaterialen hebben tot doel om studenten in staat stellen kerncompetenties in palliatieve zorg te verwerven zodat ze beter toegerust zijn om in de praktijk om te gaan met zorgvragers met palliatieve zorgnoden en hun naasten.

DE AANPAK

Het project bestaat uit vier fasen waarin negen intellectuele outputs worden gerealiseerd:

1. Het definiëren van de kerncompetenties die verworven moeten worden in palliatieve zorg (IO1);
2. Het ontwikkelen van innovatieve onderwijsmethoden over palliatieve zorg thema's en het beschikbaar stellen van onderwijsmateriaal (IO0, IO2, IO3, IO4, IO6; IO8);
3. Het opstellen van een Europese matrix voor curriculumontwikkeling en het trainen van docenten in het gebruik daarvan (IO7);
4. Het faciliteren van een Europees netwerk van docenten palliatieve zorg (IO5).

Het project heeft materialen ontwikkeld die docenten in de verpleegkunde ondersteunen bij het verwerven van de juiste kennis, vaardigheden en attitudes om op een innovatieve en boeiende manier onderwijs in de palliatieve zorg te bieden aan hun studenten. Door het implementeren van gamificatie, klinisch en moreel-ethisch redeneren en simulatie als ervaringsgerichte en activerende leermethoden in verpleegkunde curricula verwacht het consortium een positieve impact te realiseren op de palliatieve zorg vaardigheden van toekomstige verpleegkundigen.



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HOSPICE CASA SPERANȚEI
PREȚUIM FIECARE CLIPĂ DE VIAȚĂ

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Voorwoord

Dit document is een deel van het boek *Casussen en Levensverhalen*: het omvat enkel de casusvignetten waarop de levensverhalen zijn gebaseerd. Het volledige boek *Casussen en Levensverhalen* kan gedownload worden van de project website.

Als docenten in de verpleegkunde zijn wij ons zeer bewust van de uitdagingen waarmee studenten verpleegkunde worden geconfronteerd wanneer zij beseffen hoe onzeker en complex het verlenen van zorg aan palliatieve patiënten is. Tegen elkaar opwegende eisen, tegenstrijdige prioriteiten en diagnostische twijfels, samen met de persoonlijke, sociale en culturele eigenschappen van de patiënt en zijn familie en hun onderlinge dynamiek, kunnen ertoe leiden dat de student een overdaad aan informatie ervaart en zich erg overweldigd voelt.

Het team van de Transilvania Universiteit van Braşov (UnitBv) heeft de casussen die zijn opgenomen in deze Intellectuele Output 0, ontwikkeld in samenwerking met het personeel van Hospice Casa Sperantei (HCS). In HCS worden studenten verpleegkunde blootgesteld aan verschillende klinische scenario's, waarvan vele ethische dilemma's met zich meebrengen die een holistische, multidisciplinaire aanpak vereisen. Mentoren ondersteunen de studenten met de directe patiëntenzorg en de klinische interventies en faciliteren discussies en reflectie over hoe klinisch redeneren en ethisch beraad bijdragen aan de zorg voor de patiënt en de familie.

Om een selectie in de casussen te maken werden focusgroepen georganiseerd met palliatieve zorgdeskundigen van UnitBv en HCS die de beschikbare literatuur hebben doorgenomen en hebben besproken hoe bepaalde situaties de ontwikkeling van klinisch redeneren en ethisch beraad voor verpleegkundestudenten kunnen ondersteunen. Op basis hiervan werd een lijst van 20 klinische situaties uitgewerkt als vignetten, waaruit in samenspraak met het projectconsortium uiteindelijk 10 casussen werden weerhouden voor de intellectuele output. De geselecteerde casussen zijn representatieve situaties die verpleegkundigen kunnen tegenkomen wanneer zij werken met patiënten en families die te maken hebben met ernstige, chronisch progressieve ziekten en/of situaties rond het levenseinde. Alle casussen zijn gebaseerd op echte mensen en echte situaties. Ze hebben een hoog niveau van detail en complexiteit en kunnen daardoor als inspiratie dienen voor alle niveaus van studenten. Bovendien kunnen ze aangepast worden aan een verscheidenheid van Europese culturele contexten.

De 10 klinische casusvignetten, hier aangeboden in het Engels zoals origineel aangeleverd door het Roemeense team en nagezien door het EAPC team, zijn vervolgens vertaald in levensverhalen op het niveau van gevorderden en beginnelingen.

De vignetten en verhalen die samen het boek *Casussen en Levensverhalen* vormen, dienen als uitgangspunt voor alle andere intellectuele outputs van het NursEduPal@Euro project. Het boek bevat voldoende informatie om aan studenten te geven om een oefening klinisch redeneren uit te werken, om een moreel beraad sessie aan te vatten of om een simulatie of escape game mee te maken.

We hopen dat het boek jullie zal inspireren om nieuwe verhalen te creëren die het onderwijs in de palliatieve zorg verder zullen ondersteunen, afhankelijk van de unieke leerbehoeften van studenten verpleegkunde uit verschillende delen van Europa en van de wereld.

Wij nodigen jullie uit om creatief en innovatief om te gaan met dit boek en jullie eigen praktijkverhalen te delen met de NursEduPal@Euro gemeenschap. Je kan dit doen door deel te nemen aan ons interactieve forum dat je kunt bereiken via onze website <https://nursedupal.eu/>.

Dankbetuigingen

Het NursEduPal@Euro team wil zijn dank uitspreken aan het personeel van Hospice Casa Sperantei en de studenten verpleegkunde van de Universiteit van Transilvania uit Braşov die moedig hun ervaringen en hun perspectieven op de casussen en de klinische situaties die ze tegenkwamen hebben gedeeld met het onderzoeksteam in UnitBv.

Wij willen ook onze dank uitspreken aan de mensen die hier als casussen/vignetten worden gepresenteerd. Het is een eer en een voorrecht geweest om deze patiënten en hun familie op hun weg te begeleiden.

De casus van L

General information	
Patient Demographic data:	L.D male, 65 years old, married, 2 children, 2 grandchildren, retired
Underlying disease and treatment	Right axillary sarcoma, chemotherapy, radiotherapy, right upper limb amputation
Medication	
Comorbidities	Type II Diabetes, hypertension
More detailed description: Medical history	<p>2018 - biopsy, diagnosis, surgery – commence chemotherapy, lymphoedema occurs in the right upper limb</p> <p>2019 - local recurrence – surgery + chemotherapy - significant lymphoedema - high intensity pain requiring analgesia step III on the WHO ladder</p> <p>04.2019 - starts Radiotherapy + kineto-therapy + orthopaedic consult</p> <p>08.2019 – Major surgery - amputation of right upper limb</p> <p>Post-operative - phantom limb pain - treatment with Amitriptyline with some effect</p> <p>09.2019 - general condition improved – morphine no longer used – moves to treatment with step II on the WHO ladder (tramadol)</p> <p>12.2019 - Chemotherapy for pulmonary metastasis</p> <p>01.2020 – Displays anxiety + depression-psychological consultation</p> <p>04.2020 - Severe pain – recommences morphine</p> <p>02.2021 – Disease progression – decision to discontinue curative treatment</p> <p>03.2021 - General physical condition deteriorates patient has severe dyspnoea</p> <p>patient admitted to hospital via ambulance</p> <p>Thoracocentesis is performed - patient goes into cardio-respiratory arrest - is intubated and dies 24 hours later</p>
More detailed description: Issues identified: Physical Psychological Social Spiritual	<p>Physical - pain, functional impotence, dyspnoea, fatigue</p> <p>Psychological - anxiety, depression</p> <p>Social – no disability grade - gets assistance with the help of the social worker</p> <p>Spiritual – Nominally religious but does attend church regularly</p> <p>The patient knew he had a serious illness but his wife did not want the patient to know that he had a poor prognosis. The family and patient were keen to seek a second opinion in another country in the hope of a potential cure</p> <p>Unrealistic hope of cure - the patient had ordered a prosthesis and wanted to modify his car so that he could drive. During every visit, when we tried to talk about his prognosis, his wife always reassured him that he would be alright. The patient, now an amputee, was dependent on his wife for care. Whilst his care was exemplary, his wife was a barrier to telling the truth</p> <p>The patient, who was not fully informed about his condition and prognosis, expressed concerns that not enough was being done for him and that he would like a second opinion, he also requested a referral to a respiratory physician for review and treatment</p>
Care and treatment to date	Physical, Symptom control (lymphoedema, pressure sores wound care, postoperative wound management, Pain control (route of administration:

	syringe driver, Fentanyl patches), family involvement and education on how to care for their father/husband, psychological support on the course and prognosis of the disease
Particular details of the difficult situation	
Description of the challenging situation from an ethical-moral perspective	<p>Conspiracy of silence - the wife gives unrealistic hopes to the patient, does not want the patient to know the prognosis, Indications that the patient has unrealistic expectations (orders a prosthesis and wants to modify his car so he can drive even though the prognosis is limited) what does he understand about his condition and prognosis.</p> <p>The patient doesn't believe that everything has been done for his illness or thinks that there may be more that can be done, he requested a second medical opinion.</p> <p>Therapeutical decisions are difficult to make as long as the patient has unrealistic hopes.</p> <p>Involvement of patient and family in decision making</p> <p>Communication</p> <p>Hope</p>
What was the strategy used to approach the case?	<p>Communicating with the patient/wife about the evolution of the disease, but the wife was always present and created barriers to communication – but does this always stop good communication?</p> <p>Involvement of other members of the interdisciplinary team for the patient and his family aimed at providing information about diagnosis and prognosis and to provide psychological support to both spouses. They refused this intervention. Patient received psychological support following his arm amputation but refused any further support. Prescribed anxiolytic and antidepressant medication. The wife said she could not focus enough to get through the counselling process as she was very involved in caring for her husband.</p> <p>Family meeting</p> <p>The wife was invited to the office for discussions about the importance of truth telling but when the team visited the patient at home, she had the same attitude of putting up barriers.</p>
Which of the ethical - moral principles do you consider to have been undermined / ignored / neglected in this case?	<p>Challenges around truth telling and provision of information aimed at helping the patient make choices about his care.</p> <p>We don't know if the end-of-life care was what the patient wanted.</p> <p>Conspiracy of silence from the wife.</p>
Describe your personal perspective (values, feelings, emotions) on the case and how it was resolved	<p>I felt unable to do all I can to help the patient due to the conspiracy of silence. We, as professionals, felt powerless because we couldn't tell the patient the truth because his wife wouldn't let us. She was always there and when we tried to discuss the prognosis and the evolution of the disease, she would tell him that he would get better.</p> <p>Communicating with the wife, who finally accepted the prognosis. She has mixed feelings about her husband getting admitted (she regrets she's not there with him, but she's afraid he would die at home)</p>
What recommendations do you have for a better handling of the case, one that respects both the	<p>Communication with patient first.</p> <p>Involvement of patient in their treatment decisions and enable advance care planning.</p> <p>More frequent family meetings if the family would agree to it.</p>

patient's and professional values?	<p>Family support is very important. Pace of information giving and communication with the patient and family should be dictated by them. Challenging for the patient to have unrealistic expectations. These unrealistic expectations prevent open communication and the opportunity to establish the patient's wishes. The collusion between the patient and his wife hindered the team's ability to provide psychological, social and spiritual care.</p> <p>Although not talking about his diagnosis and prognosis, it is possible that the patient was aware of both but chose to not talk about these to protect his family.</p> <p>Support for the team to better handle such situations.</p> <p>Early referral and integration of palliative care for patients and the time to create a trusting relationship between patient, family and the professional team would provide the opportunity to address issues and communicate effectively.</p>
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De casus van E

General information	
Patient Demographic data:	Patient 42 years old, married to 4 years younger woman, former artist, small pension, no children
Underlying disease	Ovarian cancer, multiple metastases
Co-morbidities	Covid 19
More detailed description: Medical history	Patient diagnosed in March 2019 with ovarian cancer, operated on, chemo-treated. In early 2020, patient has medical investigations because she is not feeling well and is diagnosed with liver and peritoneal metastases. In June 2020 she is also diagnosed with Covid 19 and is transferred from the emergency unit to the former PC ward of the county hospital, which is now the COVID ward. At the time of transfer, the patient is suffering from severe anaemia, oxygen saturation 90, bedridden, ECOG (functionality scale developed by Eastern Cooperative Oncology Group) = 4, lower limb oedema and ascites fluid. She is transferred and one of the recommendations is transfusion.
More detailed description: Issues identified: Physical Psycho-emotional Social Spiritual	Physical-abdominal pain, dyspnoea, astheno-fatigability, inappetence, oedema, ascites, severe anaemia Haemoglobin 6mg/dl Emotional: anxiety due to COVID infection, fears that it will cause her death Social: Patient's partner has no income, but is involved in care. Both live on small pension of the patient. Spiritual: Does not believe in God, but while in hospital wants a visit from a chaplain.
Care and treatment to date	After stopping chemotherapy, symptom control was initiated, the family was involved and taught how to take care of the patient. Counselling on the evolution and prognosis of the disease.
Particular details of the difficult situation	
Description of the difficult situation from an ethical-moral perspective	Due to the severe anaemia, the issue of transfusion administration arises. The dilemma is whether transfusion will be effective in this patient because several factors have been identified in the evaluation that show a limited prognosis of 2-3 weeks.
What was the strategy used to approach the case?	The team aimed to comfort the patient and relieve symptoms. Communicating with the patient about the prognosis, involving other members of the interdisciplinary team to accept the prognosis. Patient is cooperative and understands possible advantages and disadvantages of transfusion. She wishes to be pain-free, to improve dyspnoea. The partner claims that the patient needs the transfusion to feel better. She does not understand that it is a burden for the patient, that she does not want this treatment and that it is important to respect the patient's decision. However, the partner wants any treatment that can prolong the patient's life.
Which of the ethical - moral principles do you consider to have been undermined / ignored / neglected in this case?	Making a medical decision, benefit vs burden of transfusion administration. The partner ignores and does not respect the informed therapeutical decision made by the patient.

Describe your personal perspective (values, feelings, emotions) on the case and how it was resolved	I had a feeling of helplessness in communicating with the partner. As she did not have access to the hospital it was difficult to talk on the phone and not observe her non-verbal language. The inability to hold family meetings led to misunderstandings with the partner who verbally accused us of not doing everything we could for their mother.
What recommendations do you have for a better handling of the case, one that respects both the patient's and professional values?	<p>Family meeting online on a tablet or phone?</p> <p>The team has done well respecting the patient's wishes, we are given the opportunity to help the person as long as they want that. The important thing is to understand what the patient wants and to accompany and support them.</p> <p>The decision to provide symptom control and comfort to the patient was correct because this is a patient with ecog 4, ovarian cancer, multiple metastases, ascites fluid which indicates a limited prognosis. COVID 19 infection may further limit the prognosis and then the aim of care is to provide dignity and comfort, symptom control.</p> <p>Life belongs to the individual, not to the family.</p> <p>Involve all team members in discussions with the family, perhaps online discussions with patient and family at the same time. The message of all team members needs to be the same.</p>

De casus van J

General information	
Patient Demographic data:	Male patient, 66 years old, married, 2 children, retired, lives in an urban area
Underlying disease	Liposarcoma
Co-morbidities	no comorbidities
More detailed description: Medical history	<p>In 2016, lump on the left lower limb is discovered. Investigations and then surgery follows. Biopsy shows no evidence of oncological disease. After 6 months another nodule appears. Re-investigation and diagnosis of liposarcoma is made. Patient starts chemotherapy and radiotherapy but during them his general condition deteriorates. Chemotherapy has to be stopped, local necrosis occurs and the lower limb is amputated. Until 2020 good general condition, in Dec 2020 - syncope, seizure, left hemiparesis. Investigations (Computer Tomography, Magnetic Resonance Imaging) show diagnosis of hemi-cranial tumour, 10 radiotherapy sessions, marked weight loss (20kg in 10 days).</p> <p>In January 2021, a nodule appears at the level of the coxo-femoral joint, exulcerated with a voluminous adenopathy block, biopsy is done and the diagnosis of metastasis is issued. Chemotherapy is resumed January 2021 but the general condition progressively deteriorates, the patient has trouble moving around, displays balance disorders, headaches, asthenia, temporo-spatial disorientation, confusion.</p>
More detailed description: Issues identified: Physical Psycho-emotional Social Spiritual	<p>Physical - symptoms: pain, constipation, disorientation, confusion, occasional nausea</p> <p>Care - local dressing at the level of the fungating tumor.</p> <p>Assisted movement due to amputation</p> <p>Psycho-emotional - anxiety due to deterioration and lack of prognostic knowledge</p> <p>Social - change in disability grade</p> <p>Spiritual – believer, non-practitioner</p>
Care and treatment to date	<p>Symptom control</p> <p>Local wound dressing</p> <p>Medication: Tramadol 200mg / 12 hours, non-steroidal anti-inflammatory, Metoclopramide, Lactulose</p>
Particular details of the difficult situation	
Description of the difficult situation from an ethical-moral perspective	<p>Conspiracy of silence - family opposes discussing diagnosis and prognosis with patient</p> <p>Our services also cared for the patient's father-in-law who died. In this situation, too, the family objects to the patient knowing what happened to the relative.</p> <p>The wife is in denial, refuses to accept the evolution of the disease and does not want support from the psychologist, she is very spiritual.</p>
What was the strategy used to approach the case?	<p>Family meeting with the patient's wife and daughter so they can integrate the evolution of the disease. They claim they agree and they say they understand that the patient needs to know the diagnosis but during the next visit they behave the same as before and erect barriers to communication with the patient.</p>

	Discussing with the children and trying to make them understand that they should learn from the previous death in the family they had to deal with, so as to avoid further contrition.
Which of the ethical - moral principles do you consider to have been undermined / ignored / neglected in this case	<p>patient autonomy</p> <p>loyalty - tell the patient the truth about his situation. From the beginning I promised the patient that I would be honest with him and that whenever he has a question, I would tell him the truth.</p>
Describe your personal perspective (values, feelings, emotions) on the case and how it was resolved	<p>Failure to stay loyal to the patient</p> <p>Failure to do more for the patient</p>
What recommendations do you have for a better handling of the case, one that respects both the patient's and professional values?	<p>Family meeting</p> <p>Being realistic, getting to know each other and accepting our limits. The patient is confused, disoriented because of brain metastases and it is unlikely that we can discuss the diagnosis of metastases and prognosis with him. The objective remains to provide comfort and dignity to the patient.</p> <p>We all experience these feelings in patient care. It is difficult in-home care where the family is present during every visit and is our partner in the care process. It takes balance and patience with each party involved in care. In this patient's case, care is more important than discussing relapse.</p> <p>During every family discussion, we could ask "Do you think about what you're losing if you don't tell him the truth?"</p> <p>Involve all members of the interdisciplinary team.</p>

De casus van P

General information	
Patient Demographic data:	Woman, 96 years old, widow, 2 children, retired, lives in urban area alone in an apartment
Underlying disease	Neo mammary, chemo-threatened, radiotherapy-treated, lymph node secondary determinations in 2017, breast ulcerated tumour 2020
Co-morbidities	Pulmonary fibrosis, hypertension
More detailed description: Medical history	Insidious onset in 2010 a lump in the right breast, discovered by the family doctor during a routine check-up. He sends her for a breast ultrasound and other investigations after which she is diagnosed with breast cancer. She undergoes chemotherapy and radiotherapy then begins hormone therapy. Since January 2020 an fungating tumour appears in the breast, the patient dresses herself or with the help of a friend and then comes to the Hospice for a home care service appointment. Before coming to the Hospice, the patient attended a day centre in the city.
More detailed description: Issues identified: Physical Psycho-emotional Social Spiritual	<p>Physical - symptoms: bone pain, dizziness, constipation, fatigue, dyspnoea, insomnia</p> <p>Care - local dressing at the level of the fungating tumour</p> <p>Active mobilisation around the house. Sometimes forgets to take medication.</p> <p>Psycho-emotional - anxiety due to disease progression and loneliness. She has fears, worries, fears because she is alone in the house and she may get sick and there is nobody to find her.</p> <p>Social: Patient lives alone, she had only one daughter who died at the age of 33. After the death of the daughter, she raised her grandson since he was 10 years old. The grandson now lives in Bucharest with his family, calls her daily and rarely visits his grandmother. The patient lives alone and a neighbour shop for her. She lives in a large house with several apartments, but is the only tenant in the building. She does not a disability grade because the patient does not want one. I called the nephew and he answered that it is not necessary to give her a disability grade, as the patient needs materials for dressings and other needs.</p> <p>Spiritually: Orthodox Christian, reads prayer books, keeps fasting, is sometimes visited by priest. Patient states that it is her faith that sustains her.</p>
Care and treatment to date	<p>Symptom control</p> <p>Topical dressing several times a week</p> <p>Emotional support</p> <p>Social support - patient alone, nephew is not involved but does not want anyone else to help the patient. Only a neighbour is accepted who does shopping and sometimes dresses the patient. Whenever he comes to Brasov, the grandson does not contact us and we cannot have a discussion to establish care goals and to understand what his expectations are about his grandmother's illness. Social department involvement</p>

Particular details of the difficult situation	
Description of the difficult situation from an ethical-moral perspective	<p>Failure to understand the prognosis - the lady partially knows the diagnosis and prognosis. We discuss her understanding with her but she won't accept it. Because in the past she has had drips that "got her back on her feet", now, even though she is deteriorating, she hopes those same drips will make her feel better.</p> <p>We can't plan the patient's care in advance, which is important because she's alone.</p> <p>Lack of family - non-involvement of grandchild.</p>
What was the strategy used to approach the case?	<p>Involvement of the neighbour in the care including doing the dressing on weekend days</p> <p>I suggested that she be admitted to the hospice unit with beds but she refuses</p> <p>Social department involvement</p>
Which of the ethical - moral principles do you consider to have been undermined / ignored / neglected in this case?	<p>Patient has unrealistic hopes and is waiting to regain full independence</p> <p>Telling the truth</p>
Describe your personal perspective (values, feelings, emotions) on the case and how it was resolved	<p>Overwhelmed, burdened, at every visit I hear the same complaint from the patient that the grandchild doesn't have time to talk or spend more time with her.</p> <p>Powerless to do more for the patient</p> <p>Fear - if I visit her and find her fallen in the house or deceased, what do I do?</p>
What recommendations do you have for a better handling of the case, one that respects both the patient's and professional values?	<p>We can't take away the family's responsibility to help the patient</p> <p>Discuss the limited prognosis again with grandchild</p> <p>Nephew manipulates relationship with care providers, relies on hospice help because he gets it easily and does not waste time trying to get other help for patient</p> <p>The grandchild should be faced with a choice that is decisive regarding involvement in the grandmother's care, which may include termination of the care contract.</p> <p>Limits must be imposed and the care contract renegotiated</p> <p>Visits to the patient along with colleagues from the social department</p>

De casus van S

General information	
Patient Demographic data:	Patient aged 53, married, sickness pension, 3 adult children living in other towns.
Underlying disease	Right breast tumour
Co-morbidities	no comorbidities
More detailed description: Medical history	Patient diagnosed in 2017, undergoing surgery, chemotherapy and radiotherapy. Under treatment the tumour does not have a favourable evolution and ulcerates, the biggest problem being the haemorrhage in the tumour. She is admitted to the bed unit for symptom control and because the husband feels exhausted due to care, especially dressing the ulcerated tumour.
More detailed description: Issues identified: Physical Psycho-emotional Social Spiritual	<p>Physical - symptoms: pain in the anterior thorax and right upper limb, constipation, insomnia, anxiety</p> <p>Care - specific for a bedridden patient and local dressing at the level of the exulcerated tumour</p> <p>Psycho-emotional – the internalization of the patient, she doesn't want to communicate with her family, she doesn't want her children to know how damaged she is</p> <p>Social - financial problems, she lives with her husband who is overwhelmed by the care needs of the patient in the process of getting a disability grade</p> <p>Spiritual - religious, non-practitioner</p>
Care and treatment to date	<p>Symptom control - Morphine 60mg/24h, Gabaran, Anxiar</p> <p>Local dressing is done as needed</p> <p>Psycho-emotional and spiritual counselling. While she was hospitalized, she was visited by the priest and counselled by the psychologist</p>
Particular details of the difficult situation	
Description of the difficult situation from an ethical-moral perspective	<p>There is no consensus between the spouses as to where the patient should be cared for - after she has been admitted for a few days and the symptoms have started to be controlled, the patient wants to go home. She is deteriorating and says she wants to die in her bed. Her husband feels overwhelmed by all the care issues and does not want to take her home.</p> <p>The children don't know what the patient's situation is and he won't tell them.</p>
What was the strategy used to approach the case?	<p>The team discussed with the patient the advantages and disadvantages of each place of care, but she wants to go home. The need to discuss with the children about her health and the involvement of the children in the care was also discussed, but the patient refuses.</p> <p>Discussions were also held with the husband about the patient's wish to be cared for at home, he was told that he would be helped by the home care team but he is afraid to take her home because he does not know how to care for her.</p> <p>Discussion of the case in the interdisciplinary meeting</p>
Which of the ethical - moral principles do you consider to have been undermined /	<p>Confidentiality - we cannot tell children without the patient's consent</p> <p>Patient care where she wishes to be cared for</p> <p>Benevolent/non-maleficent</p>

ignored / neglected in this case?	Quality of care at home vs. quality of care in bed unit, she is a patient with complex care issues, at risk of massive bleeding at the level of ulcerated tumour
Describe your personal perspective (values, feelings, emotions) on the case and how it was resolved	Both patient and caregiver are members of the care team. When there are different opinions between them and each is right from their own point of view (the patient's desire to be cared for at home vs. the husband's fear that he won't be able to provide quality care) it puts you in a difficult situation and you can't help them both. You choose to help the patient and respect her wishes even though you doubt she will be better cared for at home.
What recommendations do you have for a better handling of the case, one that respects both the patient's and professional values?	<p>Meeting with the family, with the patient, husband and team members attending.</p> <p>Discuss the patient's and husband's fears about the care process and the evolution of the disease</p> <p>Discuss with the patient the reasons why she does not want to tell her children about her situation.</p> <p>During the period of hospitalization involving and educating the husband when dressing, mobilizing, toileting the patient. It can be a method of gaining confidence.</p> <p>Discussions between the patient's husband and the home care team to get to know each other and start building a relationship based on trust.</p>

De casus van A

General information	
Patient Demographic data:	3-year-old patient, only child with very young parents
Underlying disease	Agenesis of corpus callosum and palatoschisis
Co-morbidities	Epilepsy
More detailed description: Medical history	<p>Taken in the paediatric hospice service two years ago when the little girl was almost a year old. Until then the child stayed in the paediatric hospital, there were a few attempts to go home but they all failed due to severe symptoms. Then the paediatric team from the hospital sent the child to palliative care for symptom control. The patient is being fed via a nasogastric tube; it is desired to correct the palatoschisis so that feeding tube is not used.</p> <p>On admission, the mother was asked what she expected from our service and her answer was to be helped heal her child.</p>
More detailed description: Issues identified: Physical Psycho-emotional Social Spiritual	<p>Physical - symptoms: convulsions, agitation, feeding on a nasogastric tube, fever due to disturbances in the thermoregulatory centre</p> <p>Psycho-emotional - family support, the mother is very tired and anxious, her mood changes according to the child's condition</p> <p>Social – the mother is taking care of the child, she is unemployed, she is alone with the child for many hours a day and does the same thing every day</p> <p>Spiritual – parents feel that their child's disease is a punishment</p>
Care and treatment to date	<p>Symptom control</p> <p>Educating the mother about nutrition and non-pharmacological symptom control</p> <p>Change nasogastric tube every 2 weeks, sometimes I extend my visits because the baby has seizures and I have to wait for her to calm down and then make the manoeuvre</p> <p>Psycho-emotional support for parents</p>
Particular details of the difficult situation	
Description of the difficult situation from an ethical-moral perspective	<p>Mother does not accept the diagnosis, is in a continuous search for healing solutions</p> <p>Family wants correction of cleft palate but there is a benefit vs burden dilemma</p> <p>Patient's quality of life</p> <p>Mother's exhaustion</p>
What was the strategy used to approach the case?	<p>Communication with the family about prognosis</p> <p>Explaining the advantages and disadvantages of surgery</p> <p>Involvement of interdisciplinary team members</p> <p>Psycho-emotional support for mother and father</p>
Which of the ethical - moral principles do you consider to have been undermined / ignored / neglected in this case?	Benevolence/non-malevolence of surgery
Describe your personal perspective (values, feelings,	Frustration because no matter what we do as a medical team, it is hard for a mother to accept what is happening to her child

emotions) on the case and how it was resolved	Fatigue, the family trusts me and hardly accepts another member of the team
What recommendations do you have for a better handling of the case, one that respects both the patient's and professional values?	Admitting the patient to the bed unit to give the mother a period of respite Help the mother meet other parents who have children with the same problems

De casus van D

General Information	
Patient demographic data:	D.G., male, 54 years old, retired, divorced, rural background, smoker
Underlying disease	Bronchopulmonary neoplasm, stage 4 (neuroendocrine), brain metastases, irradiated, right hemi-body motor deficit, lung metastases, lymph metastases, mediastinal metastases, bone metastases, axillary metastases, latero-cervical metastases, supraclavicular metastases, abdominal metastases, irreducible chronic pain, secondary epileptic seizures (petit mal), right adrenal metastases.
Co-morbidities	none
More detailed description: - Medical History	Clinical onset two years ago with shortness of breath and a spastic cough with white aerated sputum, sometimes bloody. He is transferred from a penitentiary to a specialist hospital for investigations where a crude diagnosis is made and chemotherapy is indicated. He is admitted to the oncology ward for chemotherapy. Sindaxel 240 mg and Cisplatin 120 mg are well-tolerated under haematological and biochemical control.
More detailed description: - Issues identified: o Physical o Psycho-emotional o Social o Spiritual	Patient with stage 4 left bronchopulmonary neoplasm (neuroendocrine) with right hemi-body motor deficit and secondary epileptic seizures. Recently released from prison for aggravated murder, having served 20 years in prison. No social life, left by his wife and daughter many years ago. Admitted to the Palliative Care ward for pain and symptom control. Relatively good general condition, chronic pain, dysphagia, altered physical integrity, changes in skin appearance, anxiety, temporal-spatial disorientation, fatigability, spastic cough, dyspnoea, hypotension, oedema. Behavioural disorders, uncontrolled reactions, verbal and physical violence. In addition to how his physical needs have been affected, the patient's need for socialization is also affected. Spiritual: He is anxious, depressed, turned against formal religious traditions. He completely refuses the idea of confession and communion. He refuses meetings with the unit's psychologist and refuses to give the contact details of his ex-wife and daughter or close acquaintances.
Care and treatment to date	Analgesics, co-analgesics and opioids, management of associated symptoms, namely prevention of seizures, cessation of vomiting, cough relief, preservation of mucosal and skin integrity. Antibiotics, corticosteroids, antitussives, anticonvulsants and analgesics were administered only with the patient's consent following discussions about the beneficial effects of these on his state of health.
Particular details regarding the difficult situation	
Description/definition of the difficult situation from an ethical/moral perspective	Ethical issues increase as the patient's health deteriorates. There is no family and no relatives. Communication with the patient becomes increasingly difficult due to brain damage and dysphonia. He is not willing under any circumstances to give up cigarettes, becomes recalcitrant when he does not smoke.

	<p>The case is very delicate, requiring a lot of physical and emotional involvement, with the period of hospitalization being very long - about 6 months - and the general condition of the patient being in a progressive deterioration.</p> <p>Symptom management: during hospitalization the patient is treated with non-steroidal anti-inflammatory drugs, gastric protectant, analgesics, a diuretic depletive, anticonvulsants, anxiolytics. He adapts to the hospital and ward rules for a while and accepts treatment. The treatment scheme is modified according to pain and symptoms. The first epileptic seizures appear.</p>
What strategy was used to resolve the case	<p>In the case of patient D.G, all necessary measures were taken to ensure the comfort of the patient, both physically and mentally. He was accommodated in a room with a private bathroom, a TV and a refrigerator. We were aware that he did not accept to be looked at with pity, he did not want to be seen by other patients as dependent. We observed during his hospitalization all 5 emotional reactions to death, namely: denial (minimizing reality through ignorance and to hide his fear), anger (directed at family members, he always maintained that he had been abandoned, that he had endured torment in prison and that no one had looked for him for 20 years; at us, the medical professionals, for not giving him enough attention and not curing him, even though he was aware of the seriousness of the situation and the impossibility of curing him; at his own person, he always accused himself of not taking enough care of himself and that this was the reason why he had acquired the disease, and at God. Each time we gave him the opportunity to express his outrage); negotiation (accepting the idea of death, but negotiating to live a little longer); depression (the patient was withdrawn, isolated, with feelings of helplessness and inferiority, eating alone, eating slowly and coughing in the process of swallowing) and acceptance.</p> <p>The patient D.G. presented throughout the hospitalization a maladaptive behaviour, namely: guilt, pathological denial, anger against those who help him, anxiety, depression, unrealistic hopes, despair, manipulation.</p> <ul style="list-style-type: none"> - non-maleficence: no treatments with uncertain benefits or unacceptable side-effects for the patient were administered. - the principle of autonomy: the patient participated in making therapeutic decisions and treatment planning in full knowledge of the facts. - the principle of justice and utility: the right to equal access to care and resources, i.e., getting the maximum benefit for the maximum possible number with limited resources.
Which of the ethical/moral principles do you consider to have been undermined/ignored/neglected in this case?	<p>I believe that in the case of terminally ill patients the following essential rights should be guaranteed:</p> <ul style="list-style-type: none"> - the right to be treated as a living person until the end of life - the right to have hope - the right to be cared for by people capable of maintaining my hope - to express my feelings and emotions about death - I have the right to participate in decisions - to receive care, even if healing is not possible - I have the right not to die alone - I have the right not to suffer

	<ul style="list-style-type: none"> - I have the right to receive honest answers to questions - I have the right not to be lied to - I have the right to die in peace and dignity - I have the right to hold and express my religious beliefs and opinions without being judged, regardless. - I have the right to be cared for by capable people who understand my needs, people who have the satisfaction of helping me through this stage of life. - the sanctity of a person to be respected even after death.
Describe your personal perspective (values, feelings, emotions) about the case and how it was resolved	<p>During the first months of hospitalization, life was supported at all cost and by all means - biological samples were taken, antibiotic therapy was carried out, treatment schedules with oral and parenteral medication were discussed in advance with the patient. The anxiety and depression issues he was experiencing were eliminated with the passage of time and interpersonal relationships were improved. He was informed and counselled at the occurrence of each change in his general condition and the appearance of symptoms associated with the disease. His rights and needs were respected. He was given mental, emotional and physical support in times of distress. Doors were opened for him, through which he found understanding and empathy. He was not judged for his past and his secrets were kept. His fears were listened to, and also his desires. He was assisted spiritually and also educated in this respect. He was assured that he would have a Christian burial and that he had served his punishment on earth and would be received into heaven with human wrongs acknowledged and forgiven.</p> <p>For 6 months we were his family. We were the people he learned to trust. We ensured he came to a dignified end, as every person deserves. We stood by his side in his last moments and eased his suffering.</p> <p>On 21 June, after approximately 6 months of hospitalization, two weeks of immobilization and a severely comatose general condition, the patient's death was recorded in the observation sheet.</p>
What recommendations would you have for a better handling of the case, which respect the values of the patient and the professional?	<p>"If the time comes that I can no longer take part in decisions concerning my own future, let this statement be regarded as a testament to my wishes:</p> <p>If there is no reasonable hope for my recovery from a physical or mental illness, I,, ask to be allowed to die and not to be kept alive by artificial means or heroic measures. Death is as real as birth, growing up, maturing and aging - that is a certainty.</p> <p>I am not afraid of death as much as I am afraid of the indignity of degradation, dependence and pain without hope. I ask that medication be administered out of pity for my terminal suffering, even if it will hasten my death.</p> <p>This request is made after careful deliberation. Although this document has no legal force, you, who I hope care about me, will feel morally obliged to proceed according to this mandate. I recognise that it places a great burden of responsibility on you, but I make this statement with the intention of sharing that responsibility and lessening any sense of guilt."</p> <p>The last moments of patient D.G. were peaceful, with serenity of mind, reconciliation with people and God, without pain, surrounded by people</p>

	<p>who offered him support. He had a "Christian end of life, without pain, in unopposed peace."</p> <p>I conclude by saying that each patient, each with their own story behind them, is a life lesson for us medical professionals, and palliative care is a never-ending wellspring of knowledge for professional and emotional self-development.</p>
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De casus van M

General Information	
Patient demographic data:	P.M., female, 61 years old, unmarried, unemployed, Orthodox Christian, urban background, lives alone in a 2-room house with high hygiene conditions. Biographical elements related to health: mother/father - deceased (of old age), one sister - aged 57, apparently healthy.
Underlying disease	Cancer of the gallbladder
Co-morbidities	none
More detailed description: Medical History	<p>The patient, aged 61, is admitted, through the emergency department, 4 days after the onset of superior digestive tract haemorrhagic episode, externalized by melena stools (4 stools) and vomiting. The medical history shows a marked weight loss for several months (10-15kg) with decreased appetite.</p> <p>Clinical: on admission the patient shows signs of haemorrhagic shock (blood pressure), grade 2 malnutrition, melting of muscle masses. Local examination of the abdomen shows grade 1 hepatomegaly, mild painful tenderness in the right hypochondrium. Rectal exam confirms melena.</p> <p>Personal pathological history: chronic hepatitis B virus for 20 years, ultra-sonographically confirmed biliary lithiasis and operated appendiceal peritonitis. Biological investigations at admission showed severe anaemia Haemoglobin=12%, Haematocrit=26%, Leucocytes = 8700/mm, Glutamic Oxalic Transaminase = 36UI/1, Glutamic/Glutamate Pyruvic Transaminase =22UI/1, urea=88mg, total bilirubin = 0.6mg. Electrocardiogram and cardiological examination showed myocardial ischemia secondary to anaemia. The patient responds favourably to volemic rebalancing therapy and drug haemostasis.</p> <p>Imagistic investigations:</p> <p>Upper digestive endoscopy performed in the first 24 hours reveals a 4cm hiatal hernia, without haemorrhagic stigmata in the oesophagus, stomach or duodenum.</p> <p>Abdominal ultrasound: liver with 16cm right lobe, 8.4cm left lobe, in segment VII there is an image of a 39mm isechogenic nodule having the appearance of a metastatic tumour. An 11,5cm transonic image of the gallbladder shows it with a thick wall, anfractuous, with vegetation inside and a 3cm gallstone.</p> <p>Computerised tomography: hypodense images with appearance of metastases in segments VIII (18mm) and VI (34mm), gallbladder very distended, thick-walled, irregular, focalised parietal thickening, with tissular structure, iodophilic, 2cm diameter gallstone.</p>
More detailed description: - Issues identified: Physical Psycho-emotional Social o Spiritual	<p>The patient's state at the time when the home palliative care service took over:</p> <p>Physical state: high intensity pain (VAS – visual analogue scale 9/10) in the abdomen, postprandial vomiting about 15-20 minutes after eating, marked weight loss in recent months, melanic stools, difficulty moving around the house.</p> <p>Psycho-emotional state: marked anxiety, panic attacks, melancholic mood and marked sadness at the thought that she has no one to care for her and "will die alone, like an abandoned dog". Under no circumstances does she agree to leave her home.</p>

	<p>Social: single. Has a sister who tries to help her. The sister has a family and is currently caught up in helping her daughter who recently gave birth.</p> <p>Spiritual: she expresses regrets about some choices she made in life, the fact that she did not start a family "at the right time" and now she is alone without support.</p>
Care and treatment to date	Mild analgesics - as needed, antiemetics, Anxiar (Lorazepam).
Particular details regarding the difficult situation	
Description/definition of the difficult situation from an ethical/moral perspective	<p>Autonomy - the patient wants her wish to be cared for at home to be respected.</p> <p>Beneficence - home care would be the most beneficial option for the patient, according to her wishes.</p> <p>Non-maleficence - inability to properly organise and control her own treatment plan and implementation of interventional care - dependent on the presence of a caregiver.</p> <p>Utility - Justice: although it is the ideal service to provide for this patient - the palliative home care offered by our specialist service - it does not provide 24/7 care, only consultative service, in order, on the one hand, to keep costs as low as possible, and on the other hand, to be able to help as many patients/families as possible.</p>
What strategy was used to resolve the case	<p>The burden of care, which is most often carried by family members is, in this case, impossible to take over by the care team.</p> <p>Contacting partner institutions to take over the burden of ongoing care of the case.</p> <p>Meeting with the family</p>
Which of the ethical/moral principles do you consider to have been undermined/ignored/neglected in this case?	Autonomy - it is difficult to maintain the dignity of the patient when the patient's number one priority is to be cared for (with all that this entails) at home, and we cannot respect this, limited as we are by financial resources and the lack of organisation of the health service system adapted to needs.
Describe your personal perspective (values, feelings, emotions) about the case and how it was resolved	<p>Frustration</p> <p>Job dissatisfaction</p> <p>Non-concurrence between what should be done and what is realistically possible to offer this patient in terms of palliative home care services</p>
What recommendations would you have for a better handling of the case, which respect the values of the patient and the professional?	<p>Allocation of financial resources to develop a network of home caregivers</p> <p>Transfer of roles and responsibilities from doctor to nurse in order to streamline care delivery and to implement appropriate interventions in this case</p>

De casus van G

General information	
Patient Demographic data:	Patient G. F., Age: 44 years old, Gender: female, Marital status: married, has a 20-year-old son, Habits: smokes 6-8 cigarettes a day, has 2-3 coffees/day
Underlying disease	Stage III B cervical neoplasm
Co-morbidities	menarche at 14, normal flow menstrual cycle, 1 pregnancy, 6 miscarriages, operated ectopic pregnancy, gastritis.
More detailed description: Medical history	<p>Stage IIIB cervical neoplasm, confirmed by clinical examination and histopathological examination, showing large keratinized cell squamous cell carcinoma.</p> <p>Before the surgery the patient undergoes radiotherapy treatment via Uterovaginal Curie therapy.</p> <p>Before surgery the patient undergoes paraclinical examinations.</p> <p>The operation consists of: radical abdominal hysterectomy with bilateral adnexectomy.</p>
More detailed description: Issues identified: Physical Psycho-emotional Social Spiritual	<p>The patient has a free and intact upper airway, normal chest, lung sounds, vesicular murmur, normal, wide breathing, 18 breaths/minute. Respiratory mucosa is moist with reduced secretions. Heart sounds even, rhythmic, strong, 75 beats/minute, blood pressure is =130/80 mmHg. The skin is warm, pinkish in colour.</p> <p>The usually has her meals on a regular schedule. She has pinkish mucous membranes, no ulcerations, gums are adherent to teeth. Chewing is light, digestion slow and unhindered.</p> <p>Likes pastries, cookies and oranges, consumes about 1800-2000 ml of liquids daily, by drinking coffee, soups, mineral water, etc.</p> <p>The patient weighs 70 kg and is 1.62 m tall.</p> <p>The patient presents painless spontaneous urination with a frequency of 3-4 /day, having yellow colour with clear-transparent appearance and a diuresis of 1300-1400 ml per 24 hours.</p> <p>The intestinal transit is normal.</p> <p>The patient is a tranquil person, shows harmonious coordination of movements, is a polite person, likes to talk a lot.</p> <p>After the surgery she is adynamic, feels weaker, does not have full physical strength, stays in bed more and reads. She refuses to get out of bed, alone, for fear of falling.</p> <p>The patient sleeps well, sleep is restful, the problem is that she falls asleep with difficulty. She sleeps for 6-7 hours a day. The problem is that she has a harder time falling asleep in the hospital as well, showing signs of irritability.</p> <p>The patient states that she likes to wear elegant clothes, she wears make-up. She dresses appropriately to the environment. In the hospital she has her own clothes.</p> <p>She is a clean, neat person, showers daily, is very concerned about her physical appearance. Skin is clean, nails are clean.</p> <p>The patient has a warm complexion with minimal sweating. She states that she likes the summer season. Her normal temperature ranges between 36.2 - 36.9.</p> <p>She adapts to the environment in which she lives and works, knows how to avoid potential conflicts. Adapts easily to new situations.</p> <p>She knows little about her current state of health, about her illness, is worried and wants to know what to expect.</p>

	<p>Mrs. G. F. is an easily sociable person, she talks with pleasure about herself, her family, her job. She likes to talk about the Black Sea, Constanta being her hometown.</p> <p>She is not so easily persuaded to make decisions.</p> <p>She is Pentecostal, she believes in God. She prays daily for her and her family's health. Even if she is not healed, she knows she is "going to the Lord". She considers herself a sinner, now saved. The 6 abortions follow her like a shadow. She believes that through this suffering the Lord has "rewarded her" with redemption/salvation.</p> <p>According to her, she is satisfied with what she has achieved so far in life.</p> <p>The patient takes an interest in her illness, and confidently turns for information to the medical staff in charge of her care.</p>
Care and treatment to date	<p>Needs affected:</p> <ol style="list-style-type: none"> 1. Need to rest and sleep 2. Need to move and have good posture 3. The need to hydrate and feed oneself 4. The need to be clean, neat, to protect the skin and mucous membranes. <p>Addiction problems:</p> <ol style="list-style-type: none"> 1. Discomfort 2. Pain 3. Alteration of the skin and the furrows 4. Gastritis - nausea, vomiting, localized epigastric pain 5. Refusal to move
Particular details of the difficult situation	
Description of the difficult situation from an ethical-moral perspective	<p>Benevolence/non-maleficent</p> <p>Denial of pain control medication for religious reasons</p> <p>Pain versus quality of life</p> <p>Multidisciplinary team's limited willingness to understand, process and get over their own biases led to a limited capacity to provide care</p>
What was the strategy used to approach the case?	<p>The care provided by the multidisciplinary palliative care team was limited, on the one hand by the patient's choices, and on the other by the frustrations and lack of conformity of team members confronted with such spiritual and religious concepts of suffering.</p>
Which of the ethical - moral principles do you consider to have been undermined / ignored / neglected in this case?	<p>Benevolence/ Non-maleficent</p> <p>Autonomy</p> <p>Respect for dignity</p>
Describe your personal perspective (values, feelings, emotions) on the case and how it was resolved	<p>Frustration</p> <p>Helplessness</p> <p>Worry</p> <p>Guilt</p> <p>Professional dissatisfaction</p>
What recommendations do you have for a better handling of the case, one that respects both the patient's and professional values?	<p>Adequate additional training of professionals</p> <p>Assertive communication</p> <p>Moral debate/ deliberation of cases</p>

De casus van B

General information	
Patient Demographic data:	B.I. aged 53, single, unemployed He is accompanied to the hospital by his mother, in whose house he lives
Underlying disease	HIV infection AIDS stage
Co-morbidities	Diabetes mellitus, lower right limb amputated Mild heart attack
More detailed description: Medical history	<p>Tendency to isolate himself, refusal of food, refusal of personal hygiene, refusal of communication, psychomotor restlessness, decrease of initiative and interest in hobbies. He likes to consume alcoholic beverages even though the doctor explained the harmful effect on his health. He refuses to go on a diet so he reaches a weight of 104 kg with a height of 1.68 m. His B.A.=146/85 Unkempt clothing shows depressive moods, limited communication, low-pitch voice, depressive ideation, reduced gestures.</p> <p>The patient is uncooperative with marked anxiety and in moral distress. Does not look at the interlocutor, respects the reciprocity of the dialogue. Capacity of self-conduct and self-care partially disturbed. Dress attire is deficient. Has a sober look aimed downwards.</p> <p>Verbal discourse is difficult, there is a long delay between question and answer. He has a sad mood, rebellious insomnia, a negative opinion of himself and shows social isolation.</p> <p>The timing and context of HIV infection is unknown. The mother blames the lack of continuous supervision in the hospital for the HIV infection.</p>
More detailed description: Issues identified: Physical Psycho-emotional Social Spiritual	<p>Generalized neuropathic pain, VAS 10/10, alopecia, antalgic squatting position with knees to the chest</p> <p>The patient's mother is legally designated to make decisions for him because he is a non-communicative, introverted person, cannot make rational decisions and is always afraid that something bad will happen to him that he cannot cope with. He has a hard time adapting to new places (hospitalisation), and he manages to collaborate with and talk to few people.</p>
Care and treatment to date	Antiretrovirals Refuses food and hydration
Particular details of the difficult situation	
Description of the difficult situation from an ethical-moral perspective	<p>According to him, the patient says that if he is going to be a burden to his mother, then he wants to be euthanized. He has this idea in his mind and he repeats it over and over again not wanting to listen to the advice and opinions of other people or doctors. It is an idea that he repeats over and over again, obsessively. He says that he isn't a danger to himself and therefore, doesn't want his mother to take care of him, which would cause a lot of pain and suffering to both parties for many years to come. Thus, he would rather die. Euthanasia comes from the Greek word "eu", meaning "good", and "thanatos", meaning "death", meaning the voluntary induction of death in a person suffering from an incurable disease, with the intention of preventing suffering.</p>
What was the strategy used to approach the case?	<p>The patient was listened to, understood and valued for what he is, beyond the limits imposed by a strictly medical diagnosis. It is not often that we hear patients thanking staff for this attitude, as the hardest thing is to face prejudice and public ignominy</p>
Which of the ethical - moral principles do you consider to have been undermined /	<p>Providing care and treatment for patients with stigma: HIV infection/AIDS Euthanasia as the only possible alternative from a patient's point of view</p>

ignored / neglected in this case?	
Describe your personal perspective (values, feelings, emotions) on the case and how it was resolved	<p>As a nurse I aim to:</p> <p>a) Prevent suicidal risk</p> <ul style="list-style-type: none"> - establish a therapeutic relationship with the patient to meet his needs, to monitor suicidal risk - provide a warm and safe atmosphere - remove any dangerous objects, drugs or toxic substances that could harm him - supervise the patient closely - administer medically prescribed treatment - engage the patient in various activities such as reading, crossword puzzles, ward conversations - help the patient relieve discomfort by promoting emotional support - encourage the patient to open up, speak in a calm voice, use short, easy-to-understand sentences - show understanding, warmth and honesty <p>b) I help the patient to eat properly:</p> <ul style="list-style-type: none"> - with the help of the patient's mother, I provide him with his favourite foods - I encourage the patient to eat in the dining room <p>c) I create conditions for the patient to have a peaceful sleep:</p> <ul style="list-style-type: none"> - I provide the patient with a calm and safe environment - I provide the comfort of airy room and clean clothes - I talk to the patient and seek to identify the causes of sleep disturbance <p>d) I help them understand the need for personal hygiene:</p> <ul style="list-style-type: none"> - I make sure the patient has a towel, soap, shampoo, toothpaste, clean clothes - I remind him of the need to maintain his hygiene - I supervise the patient and encourage him to take care of his body and clothing. - I advise him to brush his teeth at least twice a day - I remind him that a warm bath before bedtime is beneficial <p>e) I talk to him and help him stop being socially isolated</p> <ul style="list-style-type: none"> - I adopt an attitude that encourages the patient to express his feelings and needs - I give the patient the opportunity to participate in different activities that have made him useful and valued - I explain to the patient that he does not have to dwell on past failures - I praise the patient's past achievements - I avoid criticism when discussing with the patient - Discussing with the patient, I establish a schedule of activities according to his possibilities
What recommendations do you have for a better handling of the case, one that respects both the patient's and professional values?	<p>Adequate additional training of palliative care professionals to deal with situations where euthanasia is requested</p> <p>Additional appropriate training of palliative care professionals to provide quality, non-judgmental and equitable care for all types of patients, regardless of their sexual preferences or medical conditions</p>