**A Critical Analysis of Care for Mrs Amina Hassan**

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Assignment Due Date

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**Introduction**

In assessing the care provided to Mrs Amina Hassan, the translation of palliative care theory into practice is evaluated through sociocultural and ethical lenses. The National Palliative Care Standards for All Health Professionals and Aged Care Services (Palliative Care Australia, 2022) and evidence-based literature underpin the critique, identifying strengths and limitations in symptom management, cultural safety, decision-making and family support. Recommendations prioritise culturally responsive care, clear advance care planning, and interprofessional communication to safeguard patient autonomy and optimise quality of life. Emphasis is placed on aligning practice with national standards to ensure dignity and holistic support at end of life.

**Section 1: Sociocultural Care Evaluation**

**Assessment and documentation of sociocultural needs**

Assessment processes identified some relevant sociocultural information - Amina's devout Muslim faith and practice of Salah, anxiety about dying, financial barriers preventing parental travel, expressed preference for Yasmin as substitute decision-maker, and concern regarding care in a Catholic-run hospice. Such data are integral to person-centred planning and should be systematically recorded and revisited in the comprehensive care plan so that cultural, spiritual and social needs inform all aspects of care (Palliative Care Australia, 2022). The National Palliative Care Standards require explicit assessment of cultural and social dimensions and their translation into care arrangements; partial identification of needs without time-framed, documented responses risks fragmentation of care (Palliative Care Australia, 2022).

**Strengths in current care provision**

Positive actions include prompt referral to a social worker to address childcare and psychosocial concerns, the nursing team's offer to contact a Muslim Imam, and GP referral to specialist palliative care (Madni et al., 2022). These steps align with Standards that mandate linking individuals to appropriate services and supports when needs are identified (Palliative Care Australia, 2022). Referral pathways create opportunities for interdisciplinary responses and specialist input, which are essential when complex sociocultural and practical needs coexist with advanced illness.

**Limitations and risks**

The principal limitation is inadequate operationalisation of assessed needs into measurable care actions. The offer to contact an Imam remained unfulfilled in documented care, and there is no indication that Amina's preference for Yasmin as decision-maker was recorded, explored or formalised through advance care planning. Failure to document and action these preferences undermines autonomy and may lead to decisions that are not concordant with the patient's values - contrary to the Standards' expectations for supported decision-making and documented care preferences (Karako-Eyal, 2025).

Additional risks include insufficiently planned transitions to the Catholic-run hospice without explicit, documented arrangements to ensure religious practice and culturally appropriate facilities (prayer space, access to an Imam, dietary requirements), and limited targeted support for family-centred issues such as guardianship planning and caregiver preparation for the young children. These gaps increase the likelihood of distress, spiritual isolation, and unmet practical needs during the terminal phase (Gill et al., 2021).

**Evidence-based recommendation**

Introduce a culturally responsive care pathway that mandates conversion of assessed sociocultural needs into documented, time-bound actions within the comprehensive care plan. Required elements should include completion of a cultural needs checklist on admission and at review points; formal recording of the nominated substitute decision-maker with initiation of advance care planning discussions; prompt facilitation of faith support through scheduled Imam contact (in-person or virtual) documented in the plan; and active social work-led care planning for childcare and family communication. Such structured approaches reflect the Standards' emphasis on culturally safe, coordinated care and are supported by literature demonstrating improved goal-concordant care and patient/family satisfaction when cultural and faith needs are explicitly integrated into care pathways (Cheluvappa & Selvendran, 2022).

**Implementation and quality assurance**

Implementation requires staff education in cultural safety, establishment of formal links with local Muslim community leaders and organisations, and clear documentation templates to capture decision-maker preferences and faith-support arrangements. Regular audit of care plans and escalation processes for unmet sociocultural needs should be embedded in service quality-improvement cycles to ensure standards compliance and continuous improvement (Albaadani et al., 2024).

**Section 2: Ethical Analysis of Care**

**Ethical framework and relevant standards**

Key ethical principles relevant to Amina's care include respect for autonomy, beneficence, non-maleficence and justice. The National Palliative Care Standards for All Health Professionals and Aged Care Services emphasise person-centred decision-making, supported decision-making processes, clear documentation of preferences, and respectful communication to promote goal-concordant care (Kluger et al., 2023). These requirements explicitly support the ethical imperative to recognise and act on a person's expressed preferences regarding decision makers and care choices, and to ensure that decision-making arrangements are recorded and revisited as clinical circumstances change.

**Application of ethical principles to Amina's care**

Respect for autonomy appears inadequately protected in the current care pathway. Amina has explicitly expressed a preference for Yasmin as her decision maker and articulated concerns about Rohan's reluctance to acknowledge prognosis and discuss end-of-life wishes. Ethical practice would require proactive documentation of this preference, initiation of advance care planning, and facilitation of supported decision-making to ensure that Amina's values guide future care if capacity is lost. The absence of documented steps to formalise or support Yasmin's role risks decisions being made that are not concordant with Amina's wishes, thereby undermining autonomy and potentially causing moral distress for the patient and family. The Standards require actions that operationalise such preferences into the care plan, yet the record indicates only informal discussion and referral pathways without formalised documentation (Kuusisto et al., 2023).

Beneficence and non-maleficence intersect where the husband's hope for recovery limits open discussion of realistic goals of care; clinicians have an ethical duty to provide honest, compassionate information to support informed choices while minimising harm from futile or burdensome interventions. Failure to facilitate clear, timely goals-of-care conversations risks the provision of non-beneficial treatments and reduces the likelihood of goal-concordant palliation (Aller et al., 2024).

**Ethical tensions and risks**

An important ethical tension exists between family-centred cultural expectations and individual autonomy. Cultural practices often emphasise family involvement and collective decision-making, and sensitivity to these norms is ethically necessary. However, when family preferences (for example, a spouse's focus on cure) conflict with the patient's expressed wishes, clinicians must balance cultural respect with duty to the person's autonomy. Without supported decision-making processes and documented preferences, there is a risk of surrogate decisions that reflect family hopes rather than the patient's values. This raises justice concerns insofar as equitable respect for Amina's cultural and religious identity may be compromised if systems do not actively protect her choices. There is an additional risk of inadequate communication around both hospice transition and spiritual support, which, when unaddressed, can cause spiritual harm and trust in the services being offered, which violates the ethical principles of dignity and respect detailed in the Standards (Ibrahim et al., 2024).

**Recommendation: strengthening ethical practice**

A transparent, evidence-supported recommendation is that a structured advance care planning process that is documented in the clinical record and integrates supported decision-making principles in the National Palliative Care Standards should begin as soon as possible. This process should include a clinician-facilitated goals-of-care discussion with Amina present and, with her consent, Yasmin and Rohan invited as appropriate; formal recording of Amina's nominated substitute decision-maker; and exploration of legal mechanisms or documentation (where applicable) that recognise Yasmin's role. Use of an independent advocate or cultural liaison may support ethically robust decision-making when family dynamics complicate the process (Abusaleh et al., 2025). These actions respect autonomy, reduce the risk of unwanted interventions, and align care with beneficence and non-maleficence obligations outlined in the Standards.

**Implementation and interface with legal practice**

Operationalising the recommendation requires clinician training in facilitation of difficult conversations, use of standardised advance care planning templates, and prompt capacity assessments where decision-making ability is in question. Documentation should be time-stamped and visible in all handovers and discharge/transfer communications, particularly given the planned hospice referral. Where legal advice is needed to formalise substitute decision-maker status, referral to legal or guardianship services should be facilitated in a timely manner. Embedding these processes in routine practice upholds ethical obligations, improves transparency, and supports compliance with the National Palliative Care Standards.

**Section 3: Survivors Teaching Students Lived Experience Critique**

**Summary of the Lived Experience**

An ovarian cancer survivor who attended a session of STS reported a long and painful process of diagnosis. She first reported to her general practitioner about bloating, pelvic pain, and tiredness over a series of months. Her fears were over and over again brushed off as stress, hormonal fluctuation, or food-related problems, and no diagnostic test or specialist referral was triggered. Things eventually got out of control, and he was taken to an emergency department and was found to have advanced-stage ovarian cancer. She has gone through surgery and chemotherapy, but has claimed that the delay in diagnosing her condition had narrowed down her treatment options and decreased her control. Some clinicians offered compassionate speech and practical advice during treatment.

Conversely, a number of the other providers she encountered were rather insular in their practice and did not want to discuss prognosis, coping mechanisms, or emotional aspects. She just remembered feeling alienated from decision-making, whether she had a future, and that she did not get support on how to address her family's fears. Though there were circumstances when staff members were trying their best and had good intentions, her experience was predominantly rife with gaps in care and an even larger delay in continuity.

**Critique of the Care Provided and Its Impact on Quality of Life**

The outlined care involves multiple breaches of holistic and person-centered practice, revealing failures to promote autonomy, psychological well-being, and timeliness in accessing appropriate treatment. The National Palliative Care Standards for All Health Professionals and Aged Care Services claim to clearly reflect the necessity of understanding needs and being responsive to those needs in a timely manner, as well as the transmission of information and the coordination between providers (Birgisdóttir et al., 2021). The communication gap between identifying symptoms and instituting investigations is a failure to respond to the early signs of severe disease, as it does not adhere to the Standards' requirements that the assessment process must be proactive, evidence-based, and culturally sensitive.

Termination of her symptoms led to distrust of her healthcare providers and unnecessary physical and mental damage. Later diagnosis leads to worse outcomes and higher levels of distress, which in this scenario restricted the extent to which treatment could be given (Min et al., 2022). The absence of communicative consistency also compromised her autonomy, as involvement in decisions requires access to relevant, precise, and empathetic information.

She was influenced by the differences in clinician engagement during treatment. Even though compassionate communication enhanced her feelings of dignity and emotional security, continuity and person-centredness were weakened by the lack of regular psychosocial evaluation, discussion of goals of care, and recognition of family-related issues. These loopholes are not in line with Standards, which mandate coordination, documentation of clear information, and participation of the person and their carers in planning and decision-making.

Lack of integration of the supportive services like palliative care, counseling, and social work at an early stage of the illness trajectory also comes out in the account given by the survivor. The Standards also call for a comprehensive evaluation that assesses the psychological, social, and spiritual contexts, not just medical care. Without that, her emotional distress, and family anxiety were not well addressed, impacting her coping ability, treatment compliance, and quality of life.

**Recommendations for Improvement or Alternative Actions**

In order to provide service in these situations, the earlier identification and investigation of nonspecific or nonspecific ongoing symptoms is encouraged. Primary care settings can also mitigate treatment delays in future diagnosis by following evidence-based assessment pathways that prompt escalating management. General practitioners and primary care providers can also be educated regarding the first symptoms of ovarian cancer, as well as the implications of patient-reported outcomes.

Using systematic communication processes will allow for formulating autonomy and improved quality of life. This is inclusive of clinician-facilitated dialogue which enables some basic information regarding diagnosis, prognosis, and treatment options, as well as the opportunity to ask questions and voice concerns. If co-decision-making practice and documentation of patient preferences are normalised consideration, as suggested in the Standards, it could help advance dignity and agency (Alanazi et al., 2024).

After a diagnosis of a life-limiting illness, it should be standard practice for a psychosocial referral. Access to psychosocial referral will aid in overcoming isolation and anxiety, if we can facilitate family communication and develop practical plans. When emotional distress is tracked longitudinally over the course of treatment and interventions are implemented to support the expectations highlighted in the Standards for holistic assessment.

Coordination across various medical disciplines is also important. Continuity and responsiveness to care can be achieved through collaborative communication among oncologists, palliative care specialists, nurses, and allied health professionals to enable continuity and coordination of care. Palliative care, clearly identified and integrated at the time of early disease modification, can facilitate coordinated symptom assessment, advanced care planning, and quality of life in the context of curative treatment (Walker et al., 2025).

By teaching clinicians to use empathetic communication, cultural competence, and trauma-informed care, it would decrease the amount of disjunction within their practice. Training that is supported by the policies of the institution should be highlighted that all providers have a duty both emotional and clinical care; it is in agreement with the Standards that encourage dignity, respect, and inclusivity (Chakravorty and Nageswaran, 2022).

Lastly, patient-reported experience measure ought to be employed as a feedback system whereby services come up with strategies to address the gaps and enhance accountability. An integration of practice which is in line with the Standards and evidence-based models of holistic care, would not only enhance the clinical outcomes, but also the emotional outcomes, trust, and satisfaction of individuals with life-limiting conditions.

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