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Editorial

Welcome to this Sixth volume of *The Journal of Undergraduate Nursing Writing.* This journal is a compilation of original articles written by senior nursing students in the Bachelor of Science in Nursing program at The University of Kansas School of Nursing.

The articles presented in this volume originated as assignments completed by students as part of their senior level coursework. The original call for papers did not limit their entries to any particular topic.

Writing about these issues was not easy. What is unique about these articles is that they provide insight into the thought processes of today's college graduates in nursing. These student authors all show an ability to describe complex societal issues in their own manner. Examples of topical choices this year include controversy surrounding medical uses of marijuana, sex education in schools, the notion of preconception sex selection of a child, informed consent issues with minors, expanding the donor criteria for transplant patients, ICU Visitation policies, use of psychedelic drugs in mental illness treatment and intimate partner violence. These students all display an ability to investigate the current evidence on their chosen topics and emerge with a unique perspective. One that encourages all of us to believe that the future of the nursing profession is positive.

This endeavor would not have been possible without the support of several dedicated individuals and organizations. The Dykes Library staff at the University of Kansas Medical Center campus was wonderful. Delta Chapter of Sigma Theta International provided the financial support along with the positive encouragement of the Chapter Executive Board. Lastly we commend the faculty and staff at the University Of Kansas School Of Nursing for their patience and responsiveness as we sorted through all the issues necessary to make this happen. We would have been lost without their willingness to listen and share their own personal experiences.

We hope you enjoy this sixth volume and await your feedback. Let us know what you think.

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A Closer Look at Visitation Hour Policies in Intensive Care Units

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Introduction

Visitation policies on intensive care units establish the groundwork for balancing the needs of a critical patient and family members as well as the unit staff. The unit's specific policy on visitation hours sets the tone for interactions between all parties and can have a significant effect on patient outcomes, family satisfaction, and stress for nursing staff. A growing body of evidence points toward better outcomes for patients and families on units with more open visitation policies yet there are a number of hospitals, patient care units, and individual nurses that still support restricted visitation hours. While many intensive care units have legal backing to establish visitation policies, it becomes an ethical battle when balancing the needs and satisfaction of nursing staff, patients, and family. It is important to understand the rationale behind arguments on both sides to better address the issue, especially to understand why some units do not follow evidence-based practice guidelines that support open visitation policies. The purpose of this paper is to explore the relevant research regarding visitation policy on intensive care units to better understand the status quo and to clarify major rationales. This will be accomplished by a review of literature that will discuss the topic and a conclusion that provides nursing implications for practice in light of the research presented.

Review of Literature

Intensive care units were initially guided by the idea that outside visitors would detract from the ability of critically ill patients to heal so their involvement was greatly limited to brief visits. As more research was released regarding visitation hours, many institutions began to shift their paradigms to reflect current trends. As there is "an increased emphasis on customer needs, hospitals are searching for better ways to enhance satisfaction" (Whitton & Pittiglio, 2011, p. 365), which has placed a greater emphasis on visitation hours and other ways that the institution

interfaces with patients and families as consumers. Nurses are in a unique position to facilitate these interactions as they serve not only as patient advocates but also as "primary gatekeepers" (Farrell, Joseph, & Schwartz-Barcott, 2005, p. 19) to intensive care units and generally have the ability to direct traffic related to their patient care. Farrell et al. (2005) noted inconsistencies in the enforcement of hospital policy where 70% of five hospitals in a Midwestern city were shown to have "restrictive" policies in a study while 78% of the nurses had "nonrestrictive" policies of their own (p. 20). Although individual institutions may effectively curb the varying enforcement of their own visitation policies, it is assumed that this phenomenon is not unique to the Midwest. This kind of "inconsistent enforcement" can "[confuse] visitors and [cause] strife among nursing staff" (Lee et al., 2007, p. 500), which is not only in conflict with institutional policy but distressing to all parties, involved. This frustration could contribute to resistance to change. Livesay, Gilliam, Mokracek, Sebastian, & Hickey (2005), noted in their study of a neuroscience intensive care unit that inconsistent policy implementation continued to be an issue, "a clear and uniform policy and implementation procedure could decrease the frustration and dissatisfaction of the nurse at the bedside as well as patients and their visitors" and that "multilevel education" is suggested to ensure consistency (p. 188). Nurses are given great power regarding visitation and it is clear that this power can become a source of great consternation to patient, families, and nursing staff when individual adherence to unit policy is not consistent across the unit. Given the evidence that individuals do not always follow restrictive policies, it is clear there is significant resistance to restrictive policies and the rationale behind the decisions of such a large number of nurses should be analyzed.

Open visitation policies are being slowly adopted across intensive care units. Whitton & Pittiglio (2011), suggest that "an increased understanding of family members' needs and wants in

regards to the care of their loved one while in the ICU may lead to improved satisfactory outcomes" such as a decrease in anxiety (p. 365). Lee et al. (2007) notes that the family members can become a part of the care team itself (p. 499) and Daniels & Ventura (1996) suggested that "the nurse can teach the family almost continually" to eventually empower the family members to provide certain aspects of patient care themselves while the authors also noted some anecdotal examples of family members benefiting patient outcomes, such as a family calming down a confused patient who "otherwise would have necessitated restraints". Having family members around for these occasions allows for more positive consumer experiences in intensive care units while their presence has tangible benefits to the patient as well.

Opponents to open visitation policies suggest that visitors can upset vulnerable patients and expose them to pathogens. However, research indicates just the opposite. Lee et al. (2007) notes "published studies have failed to demonstrate any physiologic change during or after family visitation that may hinder patient recovery" (p. 500). Livesay et al. (2005) came to a similar conclusion regarding neuroscience intensive care unit patients in that there is "no conclusive evidence to support a deleterious physiological effect of family visitation on neurological patients" (p. 183) nor was there "evidence to support detrimental effects of liberal visitation on the patient in the 24-bed ICU" (p. 183). In fact, Livesay et al. (2005) noted studies which indicated that family visits had decreased patient intracranial pressure and had improved mental status scores (p. 183). Fumagalli et al. (2006) conducted a pilot study comparing unrestrictive visiting policies with restrictive visiting policies and concluded that while there is an increase in introduced infective agents, there was no increase in risk of sepsis as well as the associated reduction in anxiety is "associated with a somewhat more favorable hormonal profile" that could "be beneficial in terms of reduced cardiovascular complications" (p. 950). There is

clearly a large amount of evidence that suggests family visitation is at the very least benign and potentially beneficial under the right circumstances.

It is germane to discuss why some nurses oppose open visitation hours in spite of the breadth of research suggesting significant benefits. Lee et al. (2007) suggests that some nurses feel that the benefits are gained only "at the expense of nursing satisfaction" and that "staff safety is a real concern" along with the transference of anxiety and stress from family to nurse (p. 497). Lee et al. (2007) determined that the three main areas of nursing concern through their study's questionnaire were space, involving confidentiality and overnight guests; communication and conflict, involving family as a physical barrier and issues with inconsistencies with restrictive visitation hour enforcement; and burden, involving the need to attend to the family's needs in addition to the patient's needs (p. 500). To establish a medium ground, Lee et al. (2007) utilized focus groups of intensive care unit nursing staff to assist with establishing interventions which included establishing a visitor liaison to address family needs as well as creating educational pamphlets that brief visitors on policies and what to expect from the unit, among other suggestions (p. 500). Farrell et al. (2005) suggests, "perhaps another role should emerge… that of family caregiver. A knowledgeable person to focus on the family's needs leaving the nurse to focus on managing the unstable patient" (p. 27) which is similar to the visitor liaison suggested by Lee et al. (2007, p. 500). Daniels & Ventura (1996) suggest that large families establish their own spokesperson to get information from the nurse as well as a way to streamline information flow and care to the patient. In any case, Whitton & Pittiglio (2011) point out, "although ICU nurses agree that open family visitation may interfere with some aspects of patient care, the benefits to the patient overwhelmingly outweigh the risks" (p. 363).

Conclusion

The review of literature establishes a few trends regarding visitation hour policies in intensive care units. Various studies noted the nurse's power to regulate traffic is a strong tool that should be used consistently to avoid problems with visitors and units should work to establish clear guidelines. Evidence indicates no harm in having open visitation policies for the patient and in fact points to some potential benefits. Trends show that resistance to adopting open visitation policies is based on nurse concerns with additional stress from visitor involvement and potential miscommunication. The actual benefits from evidence-based practice and quality research should be presented to units and individuals who do not agree with open visitation policies and intensive care units should work to establish some ways to reduce nurse stress while adopting an open visitation policy. A number of studies suggested establishing a liaison and educational materials for families that would directly address many nursing concerns. As a patient advocate, nurses should consider the benefits to their patient gained from visitor interaction and spark change on their own units rather than resist change that would benefit patients simply because it opens the doors to having to interact with patient families. It is important to care for the patient and his or her family as a unit to better address the needs to all involved for better outcomes. While legal, to exclude visitors through a restricted visitation policy on intensive care units in the face of the mounting evidence presented above seems to be an act of questionable ethics as beneficence is not being upheld.

References

Daniels, D. Y., & Ventura, M. J. (1996). Visiting hours: an open ICU. *RN, 59* (10), 30-32.

Farrell, M. E., Joseph, D. H., & Schwartz-Barcott, D. (2005). Visiting hours in the ICU: Finding the balance among patient, visitor and staff needs. *Nursing forum, 40* (1), 18-28.

Fumagalli, S., Boncinelli, L., Lo Nostro, A., Valoti, P., Baldereschi, G., Di Bari, M., et al. (2006). Reduced cardiocirculatory complications with unrestrictive visiting policy in an intensive care unit: Results from a pilot, randomized trial. *Circulation, 113* (7), 946-952.

Lee, M. D., Friedenberg, A. S., Mukpo, D. H., Conray, K., Palmisciano, A., & Levy, M. M. (2007). Visiting hours policies in New England intensive care units: Strategies for improvement. *Critical care medicine, 35* (2), 497-501.

Livesay, S., Gilliam, A., Mokracek, M., Sebastian, S., & Hickey, J. V. (2005). Nurses' perceptions of open visiting hours in neuroscience intensive care unit. *Journal of nursing care quality, 20* (2), 182-189.

Whitton, S., & Pittiglio, L. I. (2011). Critical care open visiting hours. *Critical care nursing quarterly, 34* (4), 361-366.

Expanding Donor Criteria: Is it Safe?

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Introduction

With technological advances saving lives daily, one obstacle still plagues the medical community- organ shortages. Over 112,000 patients await a new organ in the United States alone and the numbers keep growing (Transplant trends, 2011). Between 2001 and 2010 this disparity between the number of patients on the waiting list and the number of organ donors caused over 7,000 people to lose their lives every year (Death removals, 2011). Although modern medicine can keep patients awaiting a new organ living longer, the only way to save lives is to increase the number of available organs. One way to solve the organ shortage is to use organs that the medical community would have discarded before, or put another way, marginal organs.

Donors previously thought unable to provide organs are now being considered to decrease the disparity between the waiting list and the number of organs available. "Marginal or extended criteria donors (ECD) are defined as those with a greater risk of initial poor function or graft failure" (Gastaca, 2009, p. 975). Although extended organ criteria are more commonly accepted now, there are benefits and risks to consider. Patients awaiting organs now have another choice to make, is a marginal organ worth the risk? It is important to both understand the implications of the organ shortage and the benefits and risks of using marginal donor organs.

Literature Review

Many factors are considered when choosing an organ. Prolonged organ ischemic time, an individual's age, and non-heart beating donors (NHBDs) are just a few examples of factors that play into a surgeon's decision to use an organ (Busuttil & Tanaka, 2003, p. 651). Time between the preservation of the graft and the re-warming of the graft is considered ischemic time. The ischemic time is normally a non-negotiable factor when choosing organs. "Grafts with more than 14 hours of cold ischemia have been associated with a two-fold increase in preservation damage"

(Busuttil & Tanaka, 2003, p. 652). However, the transplant community has made ischemic time a priority in an effort to increase the number of donor organs available.

"Donor age has been steadily increasing over the past decade" (Busuttil & Tanaka, 2003, p. 651). Before, organs over fifty years old were "associated with poor graft outcomes" and now organs over 60 years are being used (Busuttil & Tanaka, 2003, p. 651). Controlled NHBDs are organs taken after "planned withdrawal of life support, most often in an operating room, with a donor surgical team present" (Busuttil & Tanaka, 2003, p.653). Uncontrolled NHBDs "either fail cardiopulmonary resuscitation and/or arrive dead at the hospital" (Busuttil & Tanaka, 2003, p. 653). In the past, only controlled NHBDs were considered viable for donation. In a study of twenty-four recipients, of both controlled and uncontrolled NHBDs, a survival rate of 93% in one year has opened up the possibility of using uncontrolled NHBDs as well (Busuttil & Tanaka, 2003, p. 653). Seemingly, these singular risks can be minimal but it is rare to have one risk factor in a donor organ.

Beyond general elements, organ specific issues are also considered, such as the fatty liver and a kidney with a decreased filtering rate. The increase in obesity in the United States has caused the liver transplant community to "expect a further increase in the prevalence of steatosis" (Gastaca, 2009, p. 976). In the past, livers with less than thirty percent fat have been considered no different than non-fatty livers (Gastaca, 2009, p. 976). In contrast, livers, with greater than sixty percent fat, have been discarded because they are associated with higher mortality rates (Gastaca, 2009, p. 976). To combat this problem in the liver transplant community, matching donors with recipients has never been more important. "Grafts with moderate steatosis can be safely used in low risk patients" and they are passed over in patients with higher MELD scores (Mullhaupt, Dimitroulis, Gerlach & Clavien, 2007, p.S61). The kidney

transplant community has also made an effort to combat the shortage of organs. Kidneys with lower creatinine clearance rates have been accepted but depend heavily on the histologic condition in the recipient (Pascual, Zamora & Pirsch, 2008, p. 558). "If histological evaluation is performed before the kidney allocation", there is a better chance of graft survival (Pascual et al., 2008, p. 558). In the end, the organ specific criteria have changed from wasting organs considered unfit in the past to using every resource to match donors and recipients for the best outcome.

With a waiting time of over three years for over 36,000 patients, every possible organ needs to be assessed (Organ by waiting, 2011). "The use of the high risk, so-called marginal or expanded donors, may be the simplest way to increase the donor supply" (Gruttadauria et al., 2005, p. 2568). The use of these organs can be successful. One study showed that a cold ischemic time of less than 8 hours had the long term graft function "equivalent in donors greater than 50 years of age" (Busuttil & Tanaka, 2003, p. 652). The marginal donor also opens up possibilities for using donors with viral infections, such as hepatitis. In one report, the hepatitis positive recipient had a greater survival rate when a hepatitis positive graft was used (Gastaca, 2009, p.977). Furthermore, transplantation with an ECD for kidney patients may by more beneficial for quality of life, especially in elderly patients. "Mortality is decreased with an ECD kidney transplant compared with dialysis therapy" (Pascual, Zamora, & Pirsch, 2008, p. 553). Another group of patients that would benefit from ECD are diabetes patients. Diabetes patients "receiving an ECD kidney transplant after waiting 2 years showed similar life expectancy compared with waiting 4 years" for a standard kidney (Pascual et al., 2008, p. 574). Depending on the circumstance of the recipient, marginal donors seem the best solution for organ donation disparity.

With every new medical practice, there are risks to be considered. Although moderate steatotic donors are being considered, graft function in the first three days is impaired and can cause death (Busuttil & Tanaka, 2003, p. 653). Also, fatty livers are not helpful and should not be considered for patients with higher MELD scores. On report suggests that "early post-transplant survival was significantly reduced when moderately steatotic grafts were used in high-risk patients" (Gastaca, 2009, p. 976). McCormack showed that using steatotic livers presents a higher risk of renal failure that would require hemodialysis in the future (McCormack, 2007, p. 944).

For kidney patients, transplantation has limited the morbidity of longstanding dialysis but in the long term, these patients have a shorter graft life (Pascual, Zamora & Pirsch, 2008, p. 579). Furthermore, one group of patients that does not benefit from the marginal organ is retransplanting patients. The morbidity of ECD retransplantation was equal to remaining on the waiting list (Pascual, Zamora & Pirsch, 2008, p. 572). The last risk to consider when receiving a marginal organ is finance. Patients that received steatotic grafts had much longer ICU and hospital stays and increased medical costs overall (McCormack et al., 2007, p. 944). Depending on the patient situation, the ECD graft can be dangerous and unnecessary.

Conclusion

The use of marginal donors has both benefits and risks. The use of these organs is still too new to call it safe. Not enough research has been conducted to speak to the legal and ethical aspects of these organs. Although the medical community is making strides to match donors and recipients, is it considered maleficent to knowingly give a patient a sub-par organ? Two different ways have been suggested to solve this dilemma. First, "it would be reasonable for transplant centers that use marginal donors to establish a 'secondary list' of recipients who might be

suitable for a marginal graft" (Busuttil & Tanaka, 2003, p. 658). Second, restrict marginal organs in programs with short waiting times and allocate those organs to programs with long waiting periods (Pascual, Zamora & Pirsch, 2008, p. 574). Even with these suggestions, the patient must be informed of the dangers of using these risky organs.

The nursing role must also change with the use of ECD in transplantation. Education is first and foremost in giving the patient the ability to make this difficult decision. Even the decision to transfer to a marginal donor list can be daunting because it is still an unknown practice. Also, the nurse must also encourage the use of advance directives. The outcome of these transplants is not predictable and the patient needs to be prepared. I believe that with optimal donor care and precise matching, using marginal donor organs is more beneficial than detrimental to the transplant community.

References

Busuttil, R. W., Tanaka, K. (2003). The utility of marginal donors in liver transplantation. *Liver transplantation, 9*(7), 651-663. doi: 10.1053/jlts.2003.50105

Gastaca, M. (2009). Extended criteria donors in liver transplantation: Adapting donor quality and recipient. *Transplantation proceedings, 41*(3), 975-979. doi: 10.1016/j.transproceed.2009.02.016

Gruttadauria, S., Cintorino, D., Mandala, L., Musumeci, A., Volpes, R.,Vizzini, G.B., et al. (2005). Acceptance of marginal liver donors increases the volume of liver transplant: Early results of a single-center experience. *Transplantation proceedings, 37*(6), 2567-2568. doi: 10.1016/j.transproceed.2005.06.020

McCormack, L., Petrowsky, H., Jochum, W., Mullhaupt, B., Weber, M. and Clavien, P. (2007). Use of severely steatotic grafts in liver transplantation: A matched case-control study. *Annals of surgery, 246*(6), 940-946; discussion 946-948. doi: 10.1097/SLA.0b013e31815c2a3f

Mullhaupt, B., Dimitroulis, D., Gerlach, J. T., and Clavien, P. (2008). Hot topics in liver transplantation: Organ allocation--extended criteria donor--living donor liver transplantation. *Journal of hepatology, 48 Suppl 1*, S58-67. doi: 10.1016/j.jhep.2008.01.013

Organ Procurement and Transplant Network. (2011). *Death removals by UNOS status by year.* Retrieved from http://optn.transplant.hrsa.gov/latestData/rptData.asp

Organ Procurement and Transplant Netowrk. (2011). *Organ by waiting time*. Retrieved from http://optn.transplant.hrsa.gov/latestData/rptData.asp

Pascual, J., Zamora, J., and Pirsch, J.D. (2008). A systematic review of kidney transplantation from expanded criteria donors. *American journal of kidney diseases, 52*(3), 553-586. doi: 10.1053/j.ajkd.2008.06.005

United network for organ sharing. (2011). *Transplant Trends.* Retrieved from http://www.unos.org/

Intimate Partner Violence Screening: A Nursing Concern?

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Introduction

One of the Healthy People 2020 objectives is to "reduce violence by current or former intimate partners" (United States Department of Health and Human Services, 2011, p. 16). Several health organizations such as the American Medical Association, American Nurses Association and the American Association of Colleges of Nursing have recommended routine screening for IPV. This is due to the many negative health associations with intimate partner violence (IPV). About one fourth of women and one ninth of men over age 18 in the United States have experienced IPV (Centers for Disease Control, 2008). Approximately 15% of adults in the United States report having been a victim of IPV and three-fifths of adults report knowing someone who has been a victim of IPV (Krane, 2006). These victims may attend medical visits for trauma or for a wide range of other symptoms. It has been found that the majority of women with headaches, stomach problems, chronic pain, vaginal bleeding, substance abuse, depression, and suicidal thoughts have experienced lifetime physical and or emotional abuse (Kramer, Lorenzon, & Mueller, 2003). Campbell, Jones, Dienemann, Kub, Schollenberger, O'Campo, Gielen, & Wynne (2002) found that victims of IPV have increased sexually transmitted infections, gynecological disorders, gastrointestinal disorders, central nervous system disorders, chronic stress related problems, and circulatory disorders. Silverman, Raj, Mucci and Hathaway (2001) found that IPV is associated with several behaviors that have a negative impact on health such as engaging in high risk sexual behavior, using harmful substances, using unhealthy weight control methods, suicidal thoughts and attempts, and adolescent pregnancy. Intimate partner violence is also prevalent during pregnancy, placing the mother and child in danger. Fulton (2000) found that abused women do not receive prenatal care until as late as the third trimester and experience a higher rate of complications.

Intimate partner violence has many negative health associations which increase the importance of screening and awareness in the hospital setting. With all of this information, it seems ethically correct to screen patients for IPV. However, it is not always current practice. Currently there is no standard screening tool or protocol to help identify victims of this abuse and screening is consistently not being done. The purpose of this paper is to outline the lack of screening for IPV in spite of its prevalence and adverse health effects, the barriers that hinder screening, if all of those barriers are well founded, and ways to increase screening. This will ultimately inform healthcare providers about the ethical dilemma at hand and the need to increase IPV screening in future practice.

The Problem

The aforementioned negative health associations and recommendations from various groups have not transformed the practices in healthcare settings. Many studies have demonstrated the lack of routine IPV screening and the barriers to screening by nurses. Kramer, Lorenzon and Mueller (2003) found that only 25% of women had ever been asked about IPV. In a study by Miller, Decker, Raj, Reed, Marable and Silverman (2010), only 30% of urban adolescents were screened in their lifetime for IPV when 40% had experienced it. Out of 645 women aged 15-24 in family planning clinics, 45% reported having been abused by a partner and only 55% of those who were abused reported having been asked by a provider about the abuse (Breitbart & Colarossi, 2010). In another study, only 7% of all charts had IPV screening documented (Owen-Smith, Hathaway, Roche, Gioiella, Whall-Strojwas, & Silverman, 2008). Yam (2002) found that abused women felt that health care providers did not understand IPV and often blamed them for abuse, were unconcerned and not compassionate, or did not address the issue of IPV at all. There are many reasons documented for this lack of screening. In a study by Robinson

(2009) reasons for not screening included a lack of time and training, frustration when victims return to the abuser, views that IPV is not a health problem but a social problem, and that victims view screening as offensive and will not be truthful or follow advice. In another study, barriers include forgetting to screen, discomfort with screening, time constraints, patients having more immediate problems, patients being accompanied by family, fear that the documentation might end up in the wrong hands, and uncertainty about the best way to document (Owen-Smith et al., 2008). Felblinger and Gates (2008) found that nurses did not feel that they had adequate training to care for IPV victims and were not aware of policies in their workplace. Jeanjot, Barlow and Rozenberg (2008) found that the lack of screening was due to fear of shocking the patient, cultural barriers and lack of training in managing the problem. In a study by Yonaka, Yoder, Darrow, Sherck (2007), barriers to screening identified by emergency room nurses were a lack of education on how to ask questions about IPV, language barriers between nurses and patients, a personal or family history of abuse, and time issues. There is a common consensus that there is a lack of screening for IPV, as well as several common themes that have been identified for the lack of screening.

Overcoming the Barriers

Due to the importance of screening and the lack of screening for IPV, it is important to look at ways to overcome barriers and implement IPV screening in the medical setting. Barriers such as offending and shocking patients, being able to tell a victim by looking at them, lack of comfort with screening by healthcare providers, the view that women will lie, the lack of time, the presence of friends and family with the patient, forgetting to screen and document and a lack of training are all capable of being overcome as demonstrated through many studies. Eighty three percent of women welcome abuse screening and 86% would disclose abuse if asked

directly, respectfully, and confidentially (Kramer et al., 2003). Women welcome screening when the provider does it in a nonjudgmental, compassionate and sensitive way while maintaining confidentiality and understanding the complexity of IPV (Feder, Huston, Ramsay, Tacket, 2006). Breitbart and Colarossi (2010) found that women preferred speaking about IPV with a health provider over their mother or a counselor and women thought screening provided a means of education and acknowledges IPV as a health concern. It has also been shown that patient characteristics and clinical presentations are not able to consistently predict IPV (Zachary, Mulvihill, Burton, Goldfrand, 2008). The use of language that is not stigmatizing and constraining such as "physically hurt" instead of "abused" with answer options of "always, often, sometimes, seldom or never" instead of "yes or no" increases the likelihood of women reporting violence by four times (Breitbart and Colarossi, 2010). In another study, strategically placed posters and brochures that disseminated information without directly pointing out a woman in front of the abuser, training for providers and questions placed on health questionnaires increased case finding 1.3 fold and documented IPV screening 3.9 fold (Thompson, Rivara, Thompson, Barlow, Sugg, Maiuro, Rubanowice, 2000). A study by Thurston, Tutty, Eisener, Lalonde, Belenky, and Osborne (2009), found that helping nurses understand the purpose of asking about IPV, quickly recognizing problems, validating staff concerns, and adapting procedures helped incorporate universal screening into routine nursing practice. Breitbart and Colarossi (2010) found that providers could adequately screen without interrupting their work flow. In the study by Owen-Smith et al. (2008), additional suggestions to increase screening include adding screening questions to intake and follow up forms, sending email reminders to nurses and intermittent and mandatory IPV training.

Conclusion

There is a disconnect between the prevalence and negative health impact of intimate partner violence and the current screening practices in spite of the evidence of ways to overcome the barriers and increase intimate partner violence screening. The lack of screening needs to be addressed so that health care providers are not overlooking an important health care concern in the lives of many patients. This will allow healthcare providers to fulfill their role as advocates and protectors of health. Assessing intimate partner violence in patients falls into the scope of a nurse. Nurses are on the front line in the hospital, assessing and communicating with patients every day. They are in an excellent position to screen and have a responsibility to advocate for their clients as holistic beings which includes the health of their intimate relationships in addition to their immediate health concerns. Despite there being barriers to implementing screening, it is the ethical obligation for nurses to address this health concern and find ways to overcome the barriers. This could be through working to identify barriers specific to their hospital unit or clinic and their personal beliefs and implementing systemic and personal changes in those designated areas, learning about and being an advocate for policies in the workplace and in the government as well as research. Learning about the issue of intimate partner violence can help raise awareness of the problem and how to assess and respond to it and resources available in the community. Nurses have great influence and manpower to be able to assess and combat intimate partner violence. In spite of the difficulty of assessing for intimate partner violence, nurses have an ethical duty of beneficence and that duty to the patient outweighs the barriers nurses may face. The American Nurses Association (2001) Code of Ethics for Nurses states that the nurse "promotes, advocates for, and strives to protect the health, safety and rights of the patient" (p. 6).

Nurses have an ethical duty to screen for intimate partner violence to fulfill this role as laid out by the American Nurses Association.

References

The American Nurses Association. (2001). Code of ethics for nurses with interpretive statements. Retrieved from http://www.nursingworld.org/MainMenuCategories/EthicsStandards/CodeofEthicsforNurses/Code-of-Ethics.aspx.

Black, M., & Breiding, M. (2008, February). Adverse health conditions and health risk behaviors associated with intimate partner violence- United States, 2005. *Morbidity and Mortality Weekly Report, 57*(5), 113-117. Retrieved from http://www.cdc.gov/mmwr/PDF/wk/mm5705.pdf

Breitbart, V., & Colarossi, L. (2010). Implementing intimate partner violence screening in family planning clinics. *Family Violence Prevention and Health Practice, 1*(10). Retrieved from http://futureswithoutviolence.org/health/ejournal/2010/06/implementing-intimate-partner-violence-screening-in-family-planning-centers/.

Campbell, J., Jones, A., Dienemann, J., Kub, J., Schollenberger, J., O'Campo, P., Gielen, A., & Wynne, C. (2002). Intimate partner violence and physical health consequences. *Archives of Internal Medicine, 162*(10), 1157-1163. doi: 10.1001/archinte.162.10.1157

Feder, G., Hutson, M., Ramsay, J., & Taket, A. (2006). Women exposed to intimate partner violence: Expectations and experiences when they encounter health care professionals: A meta-analysis of qualitative studies. *Archives of Internal Medicine, 166*(1), 22-37. doi: 10.1001/archinte.166.1.22

Felblinger, D., & Gates, D. (2008). Domestic violence screening and treatment in the workplace. *AAOHN Journal, 56*(4), 143-150. Retrieved from

http://proquest.umi.com.proxy.kumc.edu:2048/pqdlink?Ver=1&Exp=11-02-2016&FMT=7&DID=1459776681&RQT=309

Fulton, D. (2000). Recognition and documentation of domestic violence in the clinical setting. *Critical Care Nursing Quarterly, 23*(2), 26-34. Retrieved from CINAHL: http://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=2000068939&site=ehost-live

Jeanjot, I., Barlow, P., & Rozenberg, S. (2008). Domestic violence during pregnancy: Survey of patients and healthcare providers. *Journal of Women's Health, 17*(4), 557-567. doi: 10.1089/jwh.2007.0639

Kramer, A., Lorenzon, D., & Mueller, G. (2003). Prevalence of intimate partner violence and health implications for women using emergency departments and primary care clinics. *Women's Health Issues, 14*(1), 19-29. doi: 10.1016/j.whi.2003.12.002

Krane, D. (2006, June 16). Over thirty million adults claim to be victims of domestic violence. *PR Newswire*. Retrieved from http://www.prnewswire.com/news-releases/over-thirty-million-adults-claim-to-be-victims-of-domestic-violence-56182742.html

Miller, E., Decker, M., Raj, A., Reed, E., Marable, D., & Silverman, J. (2010). Intimate partner violence and health care-seeking patterns among female users of urban adolescent clinics. *Maternal and Child Health Journal, 14*(6), 910-917. doi: 10.1007/s10995-009-0520-z

Owen-Smith, A., Hathaway, J., Roche, M., Gioiella, M., Whall-Strojwas, D., & Silverman, J. (2008). Screening for domestic violence in an oncology unit: Barriers and potential solutions. *Oncology Nursing Forum, 35*(4), 625-633. doi: 10.1188/08.ONF.625-633

Robinson, R. (2009). Myths and stereotypes: How registered nurses screen for intimate partner violence. *Journal of Emergency Nursing, 36*(6), 572-576. doi: 10.1016/j.jen.2009.09.008

Silverman, J., Raj, A., Mucci, L., & Hathaway, J. (2001). Dating violence against adolescent girls and associated substance abuse, unhealthy weight control, sexual risk behavior, pregnancy, and suicidality. *Journal of the American Medical Association, 286*(5), 572-579. doi: 10.1001/jama.286.5.572

Thompson, R., Rivara, F., Thompson, D., Barlow, W., Sugg, N., Maiuro, R., & Rubanowice, D. (2000). Identification and management of domestic violence: A randomized trial. A*merican Journal of Preventative Medicine 19*(4), 253-263. doi: 10.1016/S07493797(00)00231-2

Thurston, W., Tutty, L., Eisener, A., Lalonde, L., Belenky, C., & Osborne, B. (2009). Implementation of universal screening for domestic violence in an urgent care community health center. *Health Promotion Practice, 10*(4), 517-526. doi: 10.1177/1524839907307994

United States Department of Health and Human Services. (2011). Healthy People 2020. Retrieved from http://www.healthypeople.gov/2020/topicsobjectives2020/pdfs/Injury.pdf.

Yam, M. (2002). Seen but not heard: Battered women's perceptions of the ED experience. *Journal of Emergency Nursing, 26*(5), 464-470. doi: 10.1067/men.2000.110432

Yonaka, L., Yoder, M., Darrow, J., & Sherck, J. (2007). Barriers to screening for domestic violence in the emergency department. *Journal of Continuing Education in Nursing, 38*(1), 37-45. Retrieved from CINAHL: http://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=2009499503&site=ehost-live

Zachary, M., Mulvihill, M., Burton, W., & Goldfrank, L. (2001). Domestic abuse in the emergency department: Can risk profile be defined?. *Academic Emergency Medicine, 8*(8), 796-803. doi:10.1111/j.1553-2712.2001.tb00209.x

Taking the Guess Out of the Gender Game: Ethical Issues in Pre-Conception Sex Selection

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Introduction

"It's a boy" or "It's a girl"! These two simple sentences are by far the most exciting news a mother and father hear in their careers as parents. It's a flip of a coin, 50 – 50, boy or girl. What if, that ratio could be predicted or even ensured to go in your favor? With technology advancing as fast paced as it is in the world, this chance game of gender may be completely negated. As this is an advance in medical-based technology, nurses may be involved in the genetic aspects and help facilitate the decision-making process of a family choosing whether or not to use this technology. Therefore, nurses need to become more educated in this area of research and begin to understand the variety of ramification of this advance.

As one would assume, this process of gender selection can create a complex ethical dilemma. Where does this idea of selection end? With the development of preconception sex selection, one must wonder if those interested may want to make their choices more detailed. First gender, then intelligence, sense of humor or maybe even beauty. Or looking at this topic in a different light, could it be used to prevent gender-biased diseases? According to the World Health Organization (2011), this technology could be seen as a preconception form of sexism and could result in the ultimate imbalance of gender in the world. Inevitably, a line must be drawn. The purpose of this paper is to explore these pros and cons of the ethical dilemma created by this new technology as well as its importance in the nursing profession. To begin to discuss the implications, one must understand the process itself and the consequences it creates.

Literature Review

Appropriately named "Preconception Sex Selection" or PPS, this scientific breakthrough is new in regards to technology; however the idea of choosing gender has been in existence for quite some time. According to the article, "*Sex-Selection of Human Spermatozoa: Evolution of*

Current Techniques and Applications" (1998), the goal of sex selection has been attempted since as early as the Egyptians. In fact, in 500-428 B.C., the Anaxagoras believed that "semen from the right produced the males, while female progeny derived from "seed" of left testicle" (Sills, Kirman, Thatcher & Palermo, p.109-110). Although the technology of choosing the sex of a baby has changed dramatically since these times, the idea that the male dictates the gender has not changed at all.

The concept of the male choosing the sex stems from the fact that it is the sperm that plays the role of gender-decider in the technique used for more current times. The most simplistic technique is seemingly logical. Ramaley (2000) explains the process quite well in the following:

> It works by using a laser beam to detect dyed chromosomes within the sperm. Since X chromosomes have 2.8% more DNA than Y chromosomes, they glow brighter underneath laser light. Following chromosomal detection, the sperm are sorted using an automated sorting machine. (p. 249)

After the sperm are sorted, the gender of choice is collected (X or Y) and implanted within the mother's ovum. This process completed removes the chance aspect as if one were flipping a one-sided coin.

As simple as the process of gender selection seems, the debate around it is actually quite complicated. Many different dilemmas stem from this advance in technology. These can range from the debate regarding the right to choose a child's gender all the way to the consequential inequality of gender ratios and gender sexism resulting from this choice. Each of these topics under the umbrella of gender selection is loaded with literature evidence supporting and opposing the overall issue.

According to Strange and Chadwick (2010), the idea of autonomy is the center stage of the pro-side of the debate in stating that gender selection is "appealing to the significance of parental autonomy" (p. 225). Continuing on this road of the parent's right to choose, J. Savulescu (1999) argues that the pre-selected male or female child may actually receive less psychological harm than a child whom is a gender that the parents did not choose. This psychological cushion stems from the fact that the "parents will treat a child of that sex [that they choose] more favorably" (p. 373-375). As autonomy is one of the eight ethical principles, the ability for parents to have this right to decide is a valid argument; however the issue lies in where this autonomy will end.

An additional subject area of the argument revolves around the idea of family balancing. This term can be seen as both a positive and negative aspect of this debate. Those who would be proponents of this side of the debate may include those in countries that highly value sons over daughters. With this ability, a family whose cultural beliefs favor males and whom have all female children, can begin to balance this issue with gender selection technology. For instance, in a discussion regarding a study of male to female birth ratios in the United States, it was stated that "Korea, India, China and some other countries rates have increased in excess to 1.08 (U.S. average is 1.05) have been found and these have been interpreted as having arisen through prenatal gender selection" (Egan et al., 2011 p. 563). Even countries that do not normally have known gender preferences the idea of a balanced family is valued. In a survey conducted in the United Kingdom, "68% of people would like to have as many girls as boys" (Dahl, Hinsch, Beutel & Brosig, 2003, p. 2238). While the idea of gender selecting will allow individuals to balance out their families, in an article entitled *Sexism, Family Selection and 'Family Balancing'* (2008), the author argues that the idea of family balancing makes families that are not balanced

inferior to those that are balanced equally (Wilkinson, p. 372). The issue of family balancing thus can be seen as culturally-bound and society-driven. The use of gender selection can deviate from the variety that stems from "unbalanced" families, but does coincide with the values of gender influenced cultures.

With a balancing of families, this can lead to an eventual gender imbalance within the world. Especially in cultures were sons are of great importance, the ability to gender select may lead to a greater number of males in that society than females. This selection of males over females can be seen as a method of sexism. In turn this is reinforcing the idea of oppressing women. According to Zilberberg (2007), "certain measures ought to be taken which would promote the belief that females are worthy of being born and living as males, and are intrinsically valuable" (p. 519). However, an opposing argument would bring up the fact that this issue may not be as present in cultures that do not favor show gender preference. For instance, in the United Kingdom survey discussed previously, 71% of people decided they would not take advantage of the gender selection technology (Dahl et al., 2003, p. 2238). This points to an absence in gender preference as individuals are not indicating an interest. Thus, yet again, culture deeply connected in the debate concerning gender-selection.

Conclusion

All of these issues revolve around the center concern that is preconception gender selection. Whether it is sexism, autonomy or family balancing, cases can be made for and against this ethical issue. The technology gives parents the power to decide what gender child they will have, but this also opens the door to the potential of choosing everything up to whether or not the child has a beauty mark. It also allows for gender balanced families, while creating the

potential for gender imbalance in countries that may choose to implement this technology more than others.

One must also look at the bigger picture. Gender selection can be a slippery slope. With the ability to choose the sex of a child, will one choose to select for intelligence, beauty or athletic ability? As shown, there are a plethora of studies looking into the issue regarding the consequences of gender selection, but research is lacking in the realm of how far technology and individuals are willing to go. Additional research assessing opinions of those of child-bearing age to determine what types of attributes people are willing or not willing to select would be a great topic of future study for this ethical dilemma.

No matter what the argument or selection criteria, nurses who choose to go into a field in which genetics or child bearing is the forefront of care, need to be aware of the complexity that comes with the gender selection process. As with any ethical dilemma, it is important for nurses to understand their own opinions and beliefs in order to better understand others. A healthy understanding of the process, pros and cons and cultural awareness, will help the nurse provide more effective and knowledgeable care.

References

Dahl, E., Hinsch, K. D., Beutel, M., & Brosig, B. (2003). Preconception sex selection for non-medical reasons: A representative survey from the United Kingdom. *Human Reproduction*, *18*(10), 2238-2239. doi: 10.1093/humrep/deg492

Egan, J. F. X., Campbell, W. A., Chapman, A., Shamshirsaz, A. A., Gurram, P., & Benn, P. A. (2011). Distortions of sex ratios at birth in the United States; Evidence for prenatal gender selection. *Prenatal Diagnosis*, *31*(6), 560-565. doi: 10.1002/pd.274

Ramaley, R.E. (2000). The original sexist sin: Regulating preconception sex selection technology. *Health Matrix: Journal of Law-Medicine*, 10(2), 249. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=heh&AN=4840948&site=ehost-live

Savulescu, J. (1999). Sex selection: Case for. *The Medical Journal of Australia*, *171*, 373-375. Retrieved from http://www.mja.com.au/public/issues/171_7_041099/savulescu/savulescu.html

Sills, E., Kirman, I., Thatcher, S., & Palermo, G. (1998). Sex-selection of human spermatozoa: Evolution of current techniques and applications. *Archives of Gynecology and Obstetrics*, *261*, 109-115. doi: 10.1007/s004040050209

Strange, H., & Chadwick, R. (2010). The ethics of nonmedical sex selection. *Health Care Analysis*,*18*, 252-266. doi: 10.1007/s10728-009-0135-

Wilkinson, S. (2008). Sexism, sex selection and 'family balancing'. *Medical Law Review*, *16*(3), 369-389. doi: 10.1093/medlaw/fwn013

World Health Organization (2011). Gender and Genetics. Retrieved from http://www.who.int/genomics/gender/en/index4.html

Zilberberg, J. (2007). Sex selection and restricting abortion and sex determination. *Bioethics*, *21*(9), 517-519. doi: 10.1111/j.1467-8519.2007.00598.x

Let's Talk About Sex

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Introduction

In the past sex was usually saved until marriage. This meant that talking about sex was taboo and there were not many unplanned pregnancies outside of marriage. Well, times have changed and people are having sex at a younger age, but usually this is without education and the proper protection. However, the taboo that is still placed on talking about sex prohibits those who are becoming sexually active from learning how to protect themselves from mishaps like unplanned pregnancies. Unplanned pregnancies hit teenagers the hardest because they are still in school and sometimes are barely able to take care of themselves, let alone another dependent human being. These circumstances make teens that are pregnant more likely to not finish their education (Bennet & Assefi, 2005).

In 2009 alone, there were over 400,000 births to teen moms in the United States, which is over nine times greater than any of the other developed countries in the world ("Vital signs: Teen pregnancy--United States, 1991—2009," 2011).These births account for about 59% of teen pregnancies, the rest are split between abortion and miscarriage or stillbirth at 27% and 14% (Salihu et al., 2005). This means that over half of the nation's teens are sexually active (Bennet & Assefi, 2005). Surprisingly, this rate is a decrease from past years, recently the national teen birth rate is the lowest rate recorded since 1991, costing the United States only $9 billion ("Vital signs: Teen pregnancy--United States, 1991—2009," 2011).

This was the same case when I was in high school. I graduated in 2006 and of my few very close friends I had, two became pregnant during high school. My first friend became pregnant the beginning of our junior year, she would later become pregnant again with her second right after graduation. When she told the rest of us, we were so excited. We were teen agers, we thought babies were cute and fun to dress up. We never thought about the

responsibilities a baby brought. After another one of my friends had her baby, I looked around at my high school class. We were seniors and there were at least ten girls in my senior class of one hundred that were pregnant or already had a child. The only things I had learned were from condom ads or from my friends. But none of us knew very much and this was apparent by two already having kids before they turned eighteen. We did not know where to find information and we were scared or embarrassed to ask our parents. There was no sex education classes offered at our high school, back then I didn't even know there were classes on that. So where were we going to learn?

This is what brings me to my dilemma. We as nurses are taught to educate our patients about all of their options. I wish someone would have taught us about sex when I was in high school. But when we talk about sex, everyone has different views. Some still believe that this is a topic that should not be talked about, or if it is talked about then abstinence is the only thing to be taught. Throughout this paper, topics like sex education in high schools, the knowledge of contraception, and parental involvement in sex education will be discussed on how they affect teen pregnancy rates in the United States.

Literature Review

There are two ways to teach sex education, one is abstinence-only programs and the other is comprehensive sex education. Federal dollars did not pay for comprehensive sex education programs, and even though the programs are very effective they are very expensive (Sawhill, Thomas, & Monea, 2010). In the past, federal dollars paid for abstinence only programs which is defined by Kohler, Manhart, and Lafferty as "teaching the social, psychological, and health gains to be realized by abstaining from sexual activity" and "teaches that abstinence from sexual activity outside marriage is the expected standard for all school-age children and the only certain

way to avoid out of-wedlock pregnancy and STDs" (Kohler, Manhart, & Lafferty, 2008, p. 345). Evaluations conducted by Sawhill, Thomas, and Monea "have found that abstinence programs have no statistically significant effect on sexual behavior" (2010, p.142). In contrast comprehensive sex education programs significantly lowered the teen pregnancy rate by 50% overall making them less likely to report pregnancy (Kohler et al., 2008). When President Obama came into office, he took note of this. Obama took over $100 million dollars that was being used for abstinence only programs and put it to use funding comprehensive sex education classes (Tanne, 2009).

Another factor to be considered in sex education is the rate of teen mothers who are becoming pregnant again. When added together, around 50% of teen mothers will give birth to their next child within two years of their first pregnancy (Salihu et al., 2005). When taking a look at the statistics, it makes you wonder if those who became pregnant their first time did so because of the lack of education, and then became pregnant again because they still did not receive appropriate education?

Schools should not be the only ones shouldered with the responsibility of teaching sex education to teens. Parents need to be involved too, especially since 78% said they wanted their teens to learn about safe sex (Bennet & Assefi, 2005). With the thought that parents will be talking with their teens about sex, they will need education as well to ensure correct information is being conveyed to their teens. Parents who attended a sex education class felt more comfortable talking with their children about sex related topics (Green & Documét, 2005). It has been shown that talking with parents has a higher success rate at doing what no other sex education class can do, it helps delay a teens first sexual encounter and reduce risky sexual behaviors ("Vital signs: Teen pregnancy--United States, 1991—2009," 2011). One of the huge

differences in reducing risky behaviors is that the percentage of females who receive and use a form of birth control from a health care provider is greater among those who spoke with their parents about birth control ("Vital signs: Teen pregnancy--United States, 1991—2009," 2011).

A part of sex education that has a great effect on teen pregnancy is the knowledge of contraception because it has increased in use among teens (Bennet & Assefi, 2005). Contraceptive methods play a big role in the regulation of unplanned teen pregnancies. Over 1.65 million teen pregnancies are prevented each year but only 30% of sexually active teens actually use contraception (Bennet & Assefi, 2005). This is an increase in contraceptive use to prior years ("Vital signs: Teen pregnancy--United States, 1991—2009," 2011). The only problem is how teens access and use the contraception. In schools the same belief is shared on contraceptive education as is for comprehensive sex education. According to Bennet and Assefi, "one-third of school districts in the United States prohibited contraceptive education unless it was to emphasize its limitations" (Bennet & Assefi, 2005, p.72). Also "only half of sexually active females receive birth control methods from a health-care provider" and "only half of those who received a method of birth control used it the last time they had sex" ("Vital signs: Teen pregnancy--United States, 1991—2009," 2011, p.419). Sawhill, Thomas, and Monea stated that, "about six in ten said they know "little" or "nothing" about birth control pills, and three in ten said they know "little" or "nothing" about condoms" (Sawhill et al., 2010, p.138). This lack of knowledge is what causes high teen pregnancy rates even when there are multiple birth control options available for use. "The Guttmacher Institute attributes 52 percent of unintended pregnancies to nonuse of contraception, 43 percent to inconsistent or incorrect use, and only 5 percent to method failure" (Sawhill et al., 2010, p.139).

Conclusion

Even though President Obama has taken notice and started funding for compressive sex education programs, there are still some that are opposed to this change. There were 78% of parents polled by Bennet and Assefi that said they wanted their children to learn about sex, but that still leaves 22% who did not (Bennet & Assefi 2005). With this in mind, it is still important to present the information to teens so they are able to gain an understanding on all sex education topics including abstinence, contraception, and inclusive sex education. Teens can still be taught abstinence, but in the case that they do decide to be sexually active they need to understand how to protect themselves.

> Programs for preventing teen pregnancy should be broad-based and multifaceted. The programs should provide evidence-based sex education, support parental efforts to talk with their children about pregnancy prevention and other aspects of sexual and reproductive health, and ensure that sexually active teens have ready access to contraception that is effective and affordable. ("Vital signs: Teen pregnancy--United States, 1991—2009," 2011, p.420).

"Fewer high school students are having sexual intercourse, and more sexually active students are using some method of contraception" ("Vital signs: Teen pregnancy--United States, 1991—2009," 2011, p.414). This gives hope that there will be fewer unplanned teen pregnancies that may cause teens to drop out of school to take care of their child. But overall, "to reduce the rates of teen pregnancy, programs must either improve teenage contraceptive behaviors; reduce teens' sexual activity, or both" (Bennet & Assefi, 2005, p.80).

References

Bennet, S. E., & Assefi, N. P. (2005). School-based teenage pregnancy prevention programs: A systematic review of randomized controlled trials. *Journal of Adolescent Health*, 36(1), 72-81. doi:10.1016/j.jadohealth.2003.11.097

Green, H. H., & Documét, P. I. (2005). Parent peer education: Lessons learned from a community-based initiative for teen pregnancy prevention. Journal of Adolescent Health, 37(3s), s100-s107. doi:10.1016/j.jadohealth.2005.05.002

Kohler, P., Manhart, L., & Lafferty, W. (2008). Abstinence-only and comprehensive sex education and the initiation of sexual activity and teen pregnancy. *Journal of Adolescent Health*, 42(4), 344-351. doi:10.1016/j.jadohealth.2007.08.026

Sawhill, I., Thomas, A., & Monea, E. (2010). An ounce of prevention: Policy prescriptions to reduce the prevalence of fragile families. *Future of Children*, 20(2), 133-155. Retrieved October 1, 2011 from EBSCOhost.

Salihu, H. M., August, E. M., Jeffers, D. F., Mbah, A. K., Alio, A. P., & Berry, E. (2005). Effectiveness of a federal healthy start program in reducing primary and repeat teen pregnancies: Our Experience over the Decade. *Journal of Pediatric and Adolescent Gynecology*, 24(3), 153-160. doi:10.1016/j.jpag.2011.01.001

Tanne, J. (2009). Obama's budget changes sex education funding from abstinence-only to comprehensive education. *BMJ: British Medical Journal (Overseas & Retired Doctors Edition), 338b2008.* doi:10.1136/bmj.b2008

Vital signs: Teen pregnancy--United States, 1991--2009. (2011). MMWR: Morbidity & Mortality Weekly Report, 60(13), 414-420. Retrieved October 1, 2011 from EBSCOhost.

Legal and Ethical Issues Concerning Pro-Life Choices

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Introduction

For the past decade, the issue of pro-life has been a major topic of concern for the medical profession. Different opinions and attitudes have varied widely with regards to approving or disapproving termination of a pregnancy based on the each individual situation. The leading causes of termination are usually due to maternal and fetal mortality, pregnancy occurring from rape, or the period of gestation when termination is being carried out (Marshall & Raynor, 2001). These opinions have affected the way healthcare professionals look at their own personal beliefs in contrast with the professional options afforded to the patient. Furthermore, the articles reviewed and discussed below will describe in more detail the legal and ethical issues concerning life decisions and the healthcare professional's attitudes towards a patient's decision by looking at both sides of this choice. The purpose is to focus on life as a whole, and how healthcare professionals care for a mother who just aborted a child.

Review of Literature

Choices regarding life and death have always been a major concern for the health care industry. Human beings have addressed the issue of abortion, whether it be pro-life or pro-choice, from the inception of a medical procedure as defined in medical terms, in a care delivery system or if a woman was forced to take matters into her own hands often times referred to as a back alley abortion. Every human being should have the right to live whether they have a disability or not. They should be allowed to enjoy a normal life like any other human being. "In account, death is harm – hence being killed is harm – because it deprives the victim of the value of his future: that is, of the total value of future goods he would have attained if he had continued living" (Stretton, 2004, p. 150). Abortion is a concerning topic that withdrawals the fetus from a

valuable future (Stretton, 2004). Therefore, children should be allowed an option to live a normal life just like every other human being in the world.

Legal and ethical issues have developed based on the concerns of abortion in the health care field. In 1990, the Human Fertilization and Embryology Act amended the Abortion Act of 1967 which stated "a termination is considered lawful if the pregnancy is less than 24 weeks and the continuation of the pregnancy involves a risk of injury to the physical or mental health of the women or her existing children, greater than if the pregnancy was terminated" (Marshall & Raynor, 2001, p. 389). The act further considers termination of the fetus when an abnormality has occurred. "It allows termination at any stage in the pregnancy when there is substantial risk that the child, if born, would suffer from such physical or mental abnormalities as to be seriously handicapped" (Marshall & Raynor, 2001, p.389). For a termination to occur under the Abortion Act of 1967, two medical practitioners have to agree that the pregnancy can be terminated (Murphy, Jordan, & Jones, 2000).

"In 1977, Congress first passed the Hyde Amendment, which allows the use of federal Medicaid funds for abortions only in cases of rape, incest or when the woman's life is in danger" (Frietsche, 2004, p. 6). There were many obstacles the women had to face for Medicaid to pay for their abortion. For the abortion to occur, the woman had to report to the police department that a rape incident occurred and had to include the name of the assailant, if known (Frietsche, 2004). Also, if it was a life endangerment case, two physicians had to confirm that without the abortion the mother would die. As you can see, the government was beginning to move away from selective pregnancy termination unless the pregnancy happened from rape, incest or affected the mother's health status.

"Abortion is one area in which many nurse's struggle with the conflict between their personal convictions and their professional duty" (Marek, 2003, p. 472). There are three challenges that have occurred from the different belief stand points. "The first is in supporting a woman through the difficult decision-making process during a termination of pregnancy"(Murphy et al. 2000, p. 2235). As a healthcare professional, we need to inform our patients thoroughly about any healthcare decisions. The second challenge is providing the highest quality care to the woman during the termination process of the pregnancy (Murphy et al., 2000). "The third is in responding to the need for care and information that addresses sexual health and contraception"(Murphy et al. 2000, p. 2235).

Our personal beliefs affect our decisions, but should not affect the healthcare provided to a human being. Healthcare professionals need to continue improving professional behavior regarding termination of a pregnancy. Awareness of the patients' decisions may not be in the best interest of healthcare providers, but confidentiality, privacy, fidelity, autonomy, non-maleficence, beneficence, justice and veracity still should be provided (Marshall & Raynor, 2001). "Doctors must not be allowed to use conscientious objection as an excuse to evade their professional duties"(Amado et al. 2010, p. 123). Healthcare professionals can request to not provide care to a patient if it affects their personal beliefs, but the nurse manager must be informed prior to the situation, so staffing arrangements can be altered (Marek, 2003). "Although respect for conscience is important, conscientious refusals should be limited if they constitute an imposition of religious or moral beliefs on patients, negatively affect a patient's health, are based on scientific misinformation, or create or reinforce racial or socioeconomic inequalities" (Amado et al., 2010, p. 123). "Refusing a patient assignment should not allow refusal to answer the call light when the primary nurse is unavailable or refusal to render other

nonprocedural care, such as providing food or assistance to the bathroom" (Marek, 2003, p. 478). The nurse should not refuse the patient, but just their decision that is against their personal beliefs.

After reviewing the literature, a study was conducted describing the abortion attitudes in pregnant women who are receiving prenatal care. "Factors associated with opposition to abortion include religiosity, low educational attainment, low socioeconomic status, young age, residence in the South or Midwest versus North or rural regions, Catholic, Baptist, or fundamentalist religion, male gender, and black ethnicity" (Learman, Drey, Gates, Kang, Washington & Kuppermann, 2005, p. 1939). "A cross-sectional interview study of 1082 demographically diverse gravid women enrolled in prenatal care at less than 20 weeks' gestation was performed" (Learman et al., 2005, p. 1939). Of the 92 percent of women who supported abortion, only about half were willing to have an abortion in the first trimester (Learman et al., 2005). Amongst the women considering abortion, about 84 percent would do it after rape, incest or if their life were endangered (Learman et al., 2005). "Gravid women considering abortion were more likely to be white, older, have had a previous abortion, and to express distrust in the health care system" compared to "women who would not consider abortion were more likely to be multiparous, married/living with partner, and to express greater faith and fatalism about their pregnancy outcome" (Learman et al., 2005, p. 1939). In conclusion, the majority of pregnant women receiving prenatal care supported abortion therefore, healthcare professionals need to provide early prenatal screening, counseling and testing (Learman et al., 2005).

Abortion has been frowned upon, but if a mother follows through with an abortion it has shown after effects. In the mid 1980s, post-abortion syndrome was proposed as a syndrome affecting the mother or family after a pregnancy has been terminated (Dadlez & Andrews, 2010).

Mothers suffering from post-abortion syndrome may suffer from the following: survive guilt, depression, thoughts of suicide, re-experiencing the abortion, eating disorder or alcohol and drug abuse (Dadlez & Andrews, 2010, p. 447). Life is full of decisions, but sometimes we regret the decisions we make, therefore, women need to think about this topic prior to proceeding with the procedure. As healthcare professionals, if we provide thorough education about this topic, we may decrease the number of terminations.

Conclusion

Overall, pro-life is a controversial debate that has been occurring for several decades. Some individuals believe termination of a pregnancy is acceptable if it happens within the first trimester, occurred from rape, incest or affects the health of the mother. These situations affect individuals' decisions, but some believe the fetus should be capable of a successful life. If a pregnant mother decides to proceed with termination, it has been know that they regret their decision in the future. Therefore, healthcare professionals need to educate pregnant women and their families about the procedure and the concerns after the procedure is complete. As nurses, we need to provide competent care, even though this decision is against our personal belief. If a nurse cannot provide competent care due to personal reasons, then they need to inform their nurse manager, so a different nurse can attend to the patient. Nurses need to remember that they can still provide the patient with competent care that does not include the termination procedure.

References

Amado, E. D., Calderon Garcia, M. C., Cristancho, K. R., Salas, E. P., & Hauzeur, E. B. (2010). Obstacles and challenges following the partial decriminalization of abortion in Colombia. *Reproductive Health Matters. 18*(36), 118-126, DOI: 10.1016/S0968-8080(10)36531-1.

Dadlez, E. M., & Andrews, W. L. (2010). Post-abortion syndrome: Creating an affliction. *Bioethics. 24*(9), 445-452, DOI: 10.1111/j.1467-8519.2009.01739.x.

Frietsche, S. (2004). How one state removed barriers to Medicaid-funded abortion. *Women's Health Activist. 29*(5), 6-7

Learman, L. A., Drey, E. A., Gates, E. A., Kang, M., Washington, A. E., & Kuppermann, M. (2005). Abortion attitudes of pregnant women in prenatal care. *American Journal of Obstetrics and Gynecology. 192*(6), 1939-1947, DOI: 10.1016/j.ajog.2005.02.042

Marek, M. J. (2003). Nurses' attitudes toward pregnancy termination in the labor and delivery setting. *JOGNN. 33*(4), 472-479

Marshall, J., & Raynor, M. (2001). Conscientious objection 1: Legal and ethical issues. *British Journal of Midwifery. 10*(6), 389-392

Murphy, F., Jordan, S., & Jones, L. (2000). Care of women having termination of first-trimester pregnancy. *British Journal of Nursing. 9*(21), 2235-2241

Stretton, D. (2004). The deprivation argument against abortion. *Bioethics. 18*(2), 144-180

Medical Marijuana: The Legal and Clinical Facts Regarding Medical Use

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About the author:
Alexandra Ramsey is from Lake Saint Charles, Missouri. While at the School of Nursing, Anne received The School of Nursing, School of Nursing Endowment, and the University of Kansas Medical Center Bookstore scholarships. She plans to begin her career at the University of Kansas Hospital in the acute care area. She wants to return to school to pursue opportunities in nursing leadership. She is dedicating this article to her Aunt Chris who recently lost her battle with cancer. "She always encouraged me to pursue my dreams and never give up no matter how large the obstacle".

Introduction

The Chinese Shen-nung Pen-tshao Ching is the oldest medical text found in the world today. This text mentions the use of marijuana to treat such ailments as digestive disorders and pain from rheumatism. Marijuana also made its way into many American and European medical journals in the late 1800's and early 1900's. The Dispensatory of the United States of America stated that "the complaints in which [marijuana] has been specially recommended are neuralgia, gout, rheumatism, tetanus, hydrophobia, epidemic cholera, convulsions, chorea, hysteria, mental depression, insanity, and uterine hemorrhage" (Thomas, 2010, p.1). Marijuana was prescribed by physicians regularly in the United States through the 1930's, and then in the 1970's laws were passed to prohibit marijuana prescriptions. (Thomas, 2010, p.1) Since then, the use of marijuana as a medicinal intervention for such diseases as cancer and HIV complications has been a very controversial topic in both the legal and medical realms in the United States. The use of medical marijuana has made a comeback in recent years. The Office of the Deputy US Attorney General made a statement on October 19, 2009 stating:

A federal policy to abstain from investigating or prosecuting "individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana." The memo made clear, however, that it did not "legalize marijuana or provide a legal defense to a violation of federal law." Rather, it was "intended solely as a guide to the exercise of investigative and prosecutorial discretion." (Thomas, 2010, p.1)

The purpose of this paper is to simply present the facts about this controversial topic so that the reader can become informed and make his or her own conclusion about the medicinal use of marijuana.

Literature Review

Alaska, Arizona, California, Colorado, Washington D.C., Delaware, Hawaii, Maine, Michigan, Montana, Nevada, New Jersey, New Mexico, Oregon, Rhode Island, Vermont, and Washington have legalized smoking marijuana as a therapeutic alternative (2010). Each state has its own regulations for how much marijuana one patient can have at a time. On average a patient can have 2 oz of usable marijuana on hand and can grow anywhere from 4 to 24 plants, but the larger majority of these plants have to be immature plants (2010). Each patient who has a prescription for marijuana must have an ID card to prove they can legally possess marijuana (2010). About half of the states that have legalized medical use of marijuana allow people from the other states to fill a prescription as long as the patient presents their ID card (2010).

Even though the US Deputy Attorney General made a memorandum to federal law about the medicinal use of marijuana the state and federal laws about this topic are still very clouded. "In the United States, marijuana is considered a Schedule I controlled substance under the federal Controlled Substances Act (CSA) in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970" (Seamon et al, 2007, p. 1039). By definition being classified as a Schedule I controlled substance means that marijuana "has no accepted medical use, a high potential for abuse, and a lack of accepted safety" (Seamon et al, 2007, p. 1039). However these 16 states and physicians practicing in these states continue to prescribe and allow the use of marijuana for medical purposes legally. The American Medical Association, the Institute of Medicine, the American College of Physicians, and patient advocates are joining together to "[call] for changes in federal drug-enforcement policies to establish evidence-based practices in this area" (Hoffman & Weber, 2010, p.1453). The AMA also stated that they are "urging review of marijuana as a Schedule I controlled substance, noting it would support

rescheduling of doing so to facilitate research and development of cannabinoid-based medicine" (Hoffman & Weber, 2010, p.1453). According to R. Eric Barnes the federal government has three options regarding the legalization of marijuana:

> They can remove marijuana from the list of controlled substances entirely, so that everyone can buy it. They can remove marijuana from schedule I of the controlled substances act and place it on another schedule (most likely schedule 2), so that doctors could prescribe it and drug companies would be allowed to distribute it. They can reschedule marijuana and allow it to be marketed on a limited scale to those in need while more extensive testing of it is done. (2000, p.19)

The state governments are leading this movement to federally legalize marijuana because of its clinical significance in relieving ailing symptoms of debilitating diseases (Hoffman & Weber, 2010, p. 1454). This symptom list used by many states that have legalized medical marijuana includes:

> serious, chronic, or debilitating medical conditions, such as (1) severe nausea and vomiting associated with cancer chemotherapy or other causes, (2) weight loss associated with debilitating illnesses, including HIV infection and cancer, (3) spasticity secondary to neurologic diseases, such as multiple sclerosis, (4) pain syndromes, and (5) glaucoma (Seamon et al, 2007, p.1040).

There is a lot of new research currently taking place that is investigating more illnesses that the use of marijuana may be warranted for because it prevents symptoms that severely interfere with a patient's quality of life. Research has found that marijuana relieves pain associated with endometriosis and PTSD (Trossman, 2010, p.1). Research is being done on the actual receptors in the body that respond to any form of marijuana. This system is called the

endocannabinoid system. In the 1980's researchers thought that the receptors of this system were only found in the brain. However research has shown that receptors of the endocannabinoid system lie throughout the body. According to this research the endocannabinoid system "affects how we eat, sleep, relax, protect, and forget" (Trossman, 2010, p.1). Patient-guided research has also shown that some medical conditions respond better to different strains of marijuana. For example, patients have found that one strain of marijuana treats spasticity caused by MS better than other strains (Trossman, 2010, p.7).

Although there is starting to be more research in favor of use of medical marijuana; many people still argue that there are dangerous implications to prescribing marijuana. "The consequences that are of most concern to clinicians and patients are the risks of developing cannabis dependence, exacerbation of cardiovascular disease, precipitation of psychotic disorders and cancers" (Degenhardt & Hall,2008, p.1685). Research regarding the increased risk of psychosis was done on recreational users of marijuana not those using medical marijuana (Degenhardt & Hall, 2008, p.1686). However according to John Thomas there has also been research done that "medical marijuana use may pose particular problems for some psychiatric patients, since marijuana may exacerbate positive symptoms of schizophrenia and increase the risk of psychotic relapse" (2010). Patients who have previous history of psychosis or a family history of psychosis should be very cautious or refrain from using medical marijuana due to the fact that use may cause a relapse (Degenhardt & Hall, 2008, p.1686). Finally a major concern for those who are opposed to the use of medical marijuana is the risk for developing cardiovascular disease or an exacerbation of cardiovascular disease. The reason this causes worry is that many of the patients using medical marijuana have cardiovascular comorbidities that could cause complications as severe as death. There is not much research in the area of cardiovascular

complications but it is a serious concern that needs to be addressed (Degenhardt & Hall, 2008, p.1686).

Conclusion

In the United States the use of medical marijuana has been a very controversial topic for over 40 years. Currently the use is on the rise and the number of states legalizing use has become higher as time progresses. There is still not consensus in the actual mechanism of action about how marijuana affects any comorbidity that patients may have. The American Medical Association, the Institute of Medicine, the American College of Physicians, and patient advocates are continually pushing for more extensive research about the effects (both positive and negative) marijuana has on the body and conditions it is currently being used for (Hoffman & Weber, 2010, p.1453). The goal of more extensive research is to provide the medical field with a better grasp on how effective medical marijuana can be, so that in the future it may become more widely legalized for debilitating conditions that a great percentage of the population in the United States faces today.

Today in the realm of medical marijuana treatment nurses have one role: safety. Nurses need to be aware that the use of medical marijuana can cause adverse effects in the cardiovascular, respiratory, and nervous system (Seamon et al, 2007, p.1040). It is important for the nurse to assess patients for symptoms of these adverse effects for early recognition and discontinuous before further complications occur.

Finally on a personal note, I chose to write my paper about medical marijuana because I recently had an aunt pass away from cancer. She battled with unrelenting nausea and vomiting for over a year and was only relieved by dronabinol which is a pill form of marijuana.

References

(2011, Sept. 19). 16 legal medical marijuana states and DC: Laws, fees, and possession limits. *ProCon.org*. Retrieved from http://medicalmarijuana.procon.org/view.resource.php?resourceID=000881

Barnes, R.E. (2000). Reefer madness: Legal & moral issues surrounding the medical prescription of marijuana. *Bioethics, 14(1)*, 16-41. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=2001046718&site=ehost-live.

Degenhardt, L. & Hall, W.D. (2008). The adverse effects of cannabinoids: Implications for use of medical marijuana. *Canadian Medical Association Journal, 178(13)*, 1685-6. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=rzh&AN=2009947462&site=ehost-live.

Hoffman, D.E. & Weber, E. (2010). Medical marijuana and the law. *New England Journal of Medicine, 362(16)*, 1453-7. doi: 10.1056/NEJMp1000695

Seamon, M.J., Fass, J.A., Maniscalco-Feichtl, M., & Abu-Shraie, N.A. (2007). Medical marijuana and the developing role of the pharmacist. *American Journal of Health-System Pharmacy, 64(10)*, 1037-44. Retrieved from http://search.ebscohost.com/login.aspx?direct=true&db=hch&AN=25060007&site=ehost-live.

Thomas, J. (2010). The past, present, and future of medical marijuana in the United States. *Psychiatric Times, 27.1,* 1. Retrieved from

http://go.galegroup.com/ps/retrieve.do?sgHitCountType=None&sort=DA-SORT&inPS=true&prodId=EAIM&userGroupName=ksstate_kumc&tabID=T002&searchId=R1&resultListType=RESULT_LIST&contentSegment=&searchType=AdvancedSearchForm&currentPosition=2&contentSet=GALE%7CA218449804&&docId=GALE|A218449804&docType=GALE&role=

Trossman, S. (2010). Exploring the science of medical marijuana. *The American Nurse, 42(3)*, 1,7. doi: 10.1007/s00198-009-1105-9

The Benefits of Psychedelic Drug Application for Clinical Treatment of Mental Illness

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Tim Shumate is from Wichita, Kansas. He was the recipient of the John F. and Ella Hull Scholarship while a student. He is starting his career in the Wichita area in an acute care setting. In his future he sees himself becoming involved in nursing leadership and management then eventually returning to school for a Doctorate of Nursing Practice with specialization in Family Medicine. He thanks his wife Lindsay for all the time she spent editing and discussing his papers and for her continued support throughout his journey of becoming a nurse. He also credits the School of Nursing at KU for providing one of the best experiences of his life.

Introduction

The use of psychedelic drugs, such as lysergic acid diethylamide (LSD), ±3,4-methylenedioxymethamphetamine (MDMA), and 4-phosphoryloxy- N,N -dimethyltryptamine (psilocybin), in the clinical treatment of mental health disorders has sparked a broad spectrum ethical debate amongst both the medical field and the general public. This is due to the negative connotations of the drugs being illegal and that they are used by subpopulations of our society for recreational use.

The discovery of the psychedelic drug LSD in the 1940's was the beginning of the use of psychedelics for clinical trials in the United States. It was used for the clinical application in psychological treatment studies, but quickly fell into recreational use. By 1965, psychedelic studies had been performed on tens of thousands of people and had begun to yield positive results for treatment of drug addiction, anxiety, and pain of terminal cancer patients. The illicit use of these drugs had grown out of control by this time and legislation was soon passed in 1966 to make possession of psychedelics illegal; thus leading to the cessation of clinical trials being performed (Sessa, 2005). Since the 1960's several attempts to reestablish the use of psychedelics in clinical trials by the scientific and medical communities have failed to take hold. Recently clinical trials have begun once again and have shown some positive aspects of treatment in mental disorders. Even with these findings, researchers are still meeting resistance both from legal and ethical substantiations of our society. The purpose of this paper is to discuss the positive implications of the use of the psychedelic drugs towards mental well-being of patients and explore the role of a nurse in its clinical application.

Review of Literature

A recently published article in the 2010 *Journal of Psychopharmacology* describes the first pilot study of 3,4- methylenedioxymethamphetamine (MDMA), also known as ecstasy, in the management of chronic treatment resistant post-traumatic stress disorder (PTSD). The study consisted of a population of twenty patients who were suffering from medium to severe PTSD. They had received prior treatment for the disorder either in the form of multiple sessions of psychotherapy or had taken part in several medication trials with little to no success. The study was a double blind procedure that consisted of an open label cross-over segment in the study two months after the second experimental session, which allowed for the participants to continue the MDMA or begin use of the MDMA if they were the control group. To measure the outcome of the effects of the drug, the researchers used the Clinician Administered PTSD Scale (CAPS) before the trial began, four days after each session, and two months after the second session. The results of the experiment were a greater than thirty percent decrease from the baseline CAPS score, including the patients who were in the control group that decided to accept the second leg of the experiment and take the MDMA. The participants of this study had comparatively minimal side effects, both on the MDMA and the placebo. The study also contained three participants who were so debilitated by PTSD that they could not work and after going through the clinical trial they were able to return to work and function fully. The majority of the clinical participants after the trial of MDMA no longer met the criteria for the DSM VI diagnosis of PTSD (Mithoefer,Wagner, Mithoefer, Jerome, & Doblin, 2010).

The use of MDMA for the treatment of PTSD would seem to be controversial in many ways due to the lack of knowledge of drug use in a clinical setting and the overabundance of knowledge in the effects of its use on the street. With the growing number of U.S. soldiers

returning from war and suffering from PTSD, a further probe into its efficacy needs to be performed and this study should support further research.

There are many other treatments in the form of psychotherapy or legal pharmacotherapy drugs that are currently being researched with positive results like virtual reality exposure therapy and the use of D-cycloserine (Seromycin) (Cukor, Spitalnick, Difede, Rizzo, Rothbaum, 2009). However, all of these patients had previous treatments either in psychotherapy or pharmacology with little to no resolve to their PTSD symptoms. This would suggest that results vary depending on the patient. Many MDMA supportive psychotherapists "suggest that MDMA is entactogenic, that it stimulates the release of negative troublesome material from the past, and it fosters the bonding between client and therapist" (Parrott, 2010, p. 191). This theory could be explanatory as to why using MDMA in this study had positive results in reducing their PTSD levels to a functional level.

Another pilot study on the use of psilocybin for the reduction of anxiety in patients with advanced cancer was published by the *Archives of General Psychiatric* in January 2011. This was a double-blind placebo controlled study that allowed for the patients to be their own control. Twelve advanced stage cancer patients who were suffering from anxiety were given separate trials of psilocybin (0.2mg/kg) and a placebo (niacin) several weeks apart and were surveyed two weeks before the trial, after each trial, and six months after the study was done. The effects of the study were measured with Becks Depression Inventory (BDI), State-Trait Anxiety Inventory (STAI), and the Profile of Mood States (POMS). The results of the study showed a significant reduction in the patients' anxiety over the evaluated period as shown by the STAI, as well as a positive improvement in overall mood of their situations as shown by the POMS. They also showed a thirty percent reduction in the depression scale rating as measured by the BDI of the

patients using the psilocybin. This was sustained over the 6 month study period. It is also important to note that no significant reaction to the psilocybin treatment was noted and the only side effects were a slight increase in heart rate and blood pressure that returned to normal within a few hours (Grob, Danforth, Chopra, Hagerty, McKay, Halberstadt, Greer, 2011).

The use of psilocybin in the treatment of anxiety in terminal cancer patients has also shown positive results, but they are also limited to the size of the study. The reduction of anxiety and mood elevation in patients suffering from terminal cancer are important parts of patient comfort especially when dealing with palliative care. According to commentary by W.G. (1960) on an article about the history of psilocybin and the pharmacological implications, "In small doses the drug produces a change in mood and in contact with the environment which is subjectively pleasant and consists of relaxation and detachment from the outside world" (p. 936). The use of moderate amounts, 0.2mg/kg of psilocybin, on the patients of the trails resulted in similar results as was suggested by this commentary that was made more than fifty years earlier. So why has there been such a delay on the medical and clinical use of these drugs on patients that could benefit from them?

The use of psychedelics in clinical trials has been very minimal and and have been prevented due to several reasons. "Scientific research with psychedelics was almost entirely stopped through a combination of regulation, cessation of federal and other sources of funding, and social pressure on researchers" (Doblin et al., 2000, p. 47). The Controlled Substances Act classifies psychedelics as a schedule I drug, putting them in the highest restricted class and required scientists to register studies with the Drug Enforcement Agency (DEA). The Food and Drug Administration (FDA) must also give its approval to use these drugs but it has had several issues with the efficacy of psychedelics in clinical trials. It requires a very lengthy and stringent

review process and due to the high possibility of substance abuse and the evidence of major adverse effects in uncontrolled amounts the FDA it has been very limited in its approval of studies. Finally, a lack of political approval both in the FDA and the government caused by social pressures has limited the use of psychedelics in clinical trials (Doblin et al., 2000).

Conclusion

The implications of the use of psychedelics for psychological therapy in clinical trials have been one of controversy both legally and ethically. The positive results of the studies on the use of MDMA for the treatment of PTSD and the use of psilocybin on anxiety treatment of terminal cancer patients should be supportive enough to further studies with use of psychedelics in a clinical setting. The stigma that a drug is illegal should have no bearing on whether the drug should be used in a medical setting. Following this logic, an argument could be made for the banning of the use of opiate derivatives, such as Morphine Sulfate and Fentanyl, in a clinical setting because they are made from the opium plant that is also used to make heroin.

The most important aspect of treatment with these drugs is that they take place in a clinical setting in which professional psychiatrists and nurses are available to help guide patients through the experience. According to Johnson, Richards, and Griffiths (2008), "The monitors should be knowledgeable about the medical and psychological markers of potential adverse reactions to the drug. Furthermore, monitors should have significant human relation skills and be familiar with descriptions of altered states of consciousness induced by hallucinogens" (p. 610). As a nurse, knowledge of how a drug works and monitoring for side effects is a major part of our job because we are usually the party responsible for administering them. Nurses also interact with patients on a frequent basis and in a trial of psychedelic use our interpersonal skills would be of great importance as having a positive environment is conducive to yielding positive results.

The use of psychedelics in a clinical trial should be supported by both the public and medical community because of the numerous positive applications they have in treatment of patients.

References

Cukor,J., Spitalnick J., Difede J., Rizzo A., Rothbaum B. (December 2009). Emerging treatments for PTSD. *Clinical Psychology Review*, 29(8) 715-726.

Doblin, R. (2000). *Regulation of the Medical Use of Psychedelics and Marijuana.*(Doctoral dissertation). Retrieved from http://www.maps.org/dissertation/

Grob, C.S., Danforth A. L., Chopra G. S., Hagerty M., McKay C. R., Halberstadt A. L., & Greer, G. R. (2011). Pilot study of psilocybin treatment for anxiety in patients with advanced stage cancer. *Arch Gen Psychiatry,* 68(1).

Johnson, M. W., Richards, W. A., & Griffiths, R. R. (2008). Human hallucinogen research: Guidelines for safety. *Journal of Psychopharmacology,* 22(6), 603-620.

Mithoefer, M.C., Wagner, M.T., Mithoefer, A. T., Jerome L., & Doblin R. (2010). The safety and efficacy of ±3,4-methylenedioxymethamphetamine-assisted psychotherapy in subjects with chronic, treatment-resistant posttraumatic stress disorder: the first randomized controlled pilot study. *Journal of Psychopharmacology,* 25(4), 439-452.

Parrott, A. C. (2007). The psychotherapeutic potential of MDMA (3, 4-methylenedioxymethamphetamine): an evidence-based review. *Psychopharmacology*, 191(2), 181−193.

Sessa, B. (2005). Can psychedelics have a role in psychiatry once again? *The Business Journal of Psychiatry,* 186, 457-458.

W. G. (1960 April 30). Psilocybin, its history and pharmacology. *Editorial and Comments,* 82, 936.

Ethical Issues of Children as Research Subjects

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Introduction

Children in past centuries were often recruited and exploited as research subjects for vaccine testing trials and to study the outcomes of infectious disease. According to Knox and Burkhart (2007), procedures to protect children were not implemented until after World War II, and since that time, "protecting" children in research has often been interpreted as excluding children from clinical studies. Currently, only 20 to 30 percent of drugs approved by the FDA are labeled for pediatric use, and many other therapeutic interventions used for children have been derived by extrapolating data from adult studies to younger groups (Knox & Burkhart, 2007). Continuing to apply this limited scope of evidence-based practice has the potential to cause severe, adverse effects. The need for child participation in research is indicated in order to develop new treatments and to protect against harmful practices.

Although necessary, including children in research raises serious ethical considerations. Children are considered a vulnerable population because their decision-making and comprehension skills are not fully formed. Schwenzer (2008) describes how children have a diminished ability to protect themselves, making them "more susceptible to both intentional and inadvertent harm," and there are "legitimate concerns about their capacity to understand information presented to them and to make informed choices" (p. 1343). Although regulations and additional precautions have been implemented in order to protect this population, problems exist in the various interpretations of these guidelines, obtaining informed consent from parents and assent from the child, and recruitment strategies. The purpose of this paper is to describe current safeguards for child research, explore the continuing problems, and discuss the implications related to nursing practice and the nurse's role in child research.

Review of the Literature

In 1998, the U.S. Department of Health and Human Services (USDHHS) added specific regulations based on risk assessment to further protect the rights and welfare of children involved in research studies.

Guido (2010) outlines how these regulations presented guidelines in child research that:

1. Does not involve greater than minimal risk.
2. Involves greater than minimal risk, but presents the prospect of direct benefit to the individual subjects.
3. Involves greater than minimum risk and no prospect of direct benefit to the individual subject, but is likely to yield generalizable knowledge about the subject's disorder or condition.
4. Is not otherwise approvable, which presents an opportunity to understand, prevent, or alleviate a serious problem affecting the health or welfare of children. (p. 169)

Minimal risk as defined by the USDHHS is when "probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during performance of routine physical or psychological exam or tests" (as cited in Schwenzer, 2008, p.1344). If there is no more than minimal risk or if greater than minimal risk exists but could benefit the child, permission from one parent is sufficient. Consent from both parents is required in other categories unless a parent is deceased, incarcerated, reasonably unavailable, or only one parent has legal custody. Tait, Voepel-Lewis, and Malviya (2003) explained that children cannot legally give valid consent but they may assent or dissent to participation, although federal guidelines have not formally described regulations or

a process to do so. Assent is required and obtained "when in judgment of the Institutional Review Board (IRB) the children are capable of providing assent" (Tait et al., 2003, p. 609).

According to Chesney (2005), the interpretation of "minimal risk" and "prospect of direct benefit" may lead to confusion. The definition of minimal risk may differ between a healthy child and a child in a disease state, and there is currently no consensus on what defines minimal risk for children involved in clinical research and for children from different socioeconomic backgrounds. Application of the federal risk and benefit ratios of IRBs across the country is inconsistent, and the available data is often contradictory (Knox & Burkhart, 2007). The subjective definition of minimal risk dictates when and what type of parental consent is needed. Therefore, obtaining standard parental consent is also variable across clinical studies. In some adolescent cases, parental consent can be waived by the IRB if there is "potential to yield great benefit to adolescents and parental permission would pose considerable risk to them" (Knox & Burkhart, 2007, p. 314). Overall, there is no agreement and little government guidance concerning interpretation of the terms "risk" and "benefit" and risk/benefit ratios.

There is also considerable debate as to the ability of a child to assent to participation. Questions arise regarding a child's cognitive ability to understand a described study, the risks and benefits, what it means to be a part of research, and the right to withdraw. This depends not only on age but also developmental level, health status, and environmental factors. Tait et al. (2003) conducted a study regarding child assent and concluded that children had a very limited understanding of many elements of the study they had assented to and that children 11 years of age and older had a significantly greater understanding than younger children. Meaux & Bell (2001) described studies showing that most children as young as five years were able to understand descriptions of research and were capable of giving assent, but it also revealed that

less than half of children across all age groups did not understand what it meant to stop participation or thought withdrawing was only temporary; furthermore, children "as a whole voiced willingness to participate in all hypothetical studies, yet even when children were capable of identifying ethical problems, they would continue to agree to participate" (p. 246). Overall, age parameters for obtaining child assent vary across different IRBs, while available studies contradict each other as to what age children develop appropriate cognitive abilities. Additionally, federal regulations do not describe the assent process as they do parental consent, leaving investigators at liberty to design their own process (Schwenzer, 2008).

Knox and Burkhart (2007) described how financial incentives as recruitment strategies for pediatric research have also been controversial. Poor families are more susceptible to pressure from monetary rewards, and this can create the potential for children to be coerced by their families into participating in research. Reimbursements to children and large cash payments are investigated by the IRB, but explicit standards for acceptable and unacceptable payments and other incentives for child participation in research are not clear as different agencies and organizations have conflicting rules (Chesney, 2005).

Conclusion

For several years, there has been support to close the gap in pediatric research, yet disparities continue and guidelines remain insufficient. Ethical and legal considerations should incite future revisions to provide a more concise outline of terms and guidance in applying risk and benefit ratios. More information is needed to form specific definitions on the challenges children face in daily life and during procedures. Continued research is also necessary to develop tools that accurately measure a child's cognitive and developmental levels. Finally, regulations

should specify types and amounts of incentives and reimbursements that are appropriate to offer in exchange for research participation.

Research is at the core of evidence-based practice for nurses, and despite shortcomings and discrepancies in implementation, child research will inevitably continue due to the lack of information. There are many nursing implications to reflect on considering this reality. Pediatric nurses are often involved in recruiting children, collecting data, or assisting with protocols for research studies, even if they are not the chief investigator (Knox & Burkhart, 2007). They must be aware of federal guidelines and ethical and legal controversies in order to advance the success of these studies while protecting the rights of child participants.

Nurses in this role should consider their responsibilities to the safety of the child as an advocate, caregiver, and health professional. They should obtain consent from the parent and obtain assent from the child separately to avoid undue coercion or influence. They should also make a concerted effort to explain procedures at a level appropriate for the child's developmental level and maturity, and afterward, the child should be asked to explain in their own words their understanding and what their involvement would mean. Nurses should also be aware of external factors that may influence child participation and take appropriate measures when these factors appear to have overtones.

As a future nursing professional currently working in pediatrics, I was surprised at how many fundamental aspects of research in this population fell short. Considering how this directly affects evidence-based practice, it made me reflect on the slow process of change in healthcare. Best practices can only be attained by advancing research efforts, and it is important for nurses to help resolve issues with child research in order to implement the best care.

References

Chesney, R. W. (2005). Children as clinical research subjects. *The Journal of Pediatrics, 146*, 579-580.

Guido, G. W. (2010). *Legal and Ethical Issues in Nursing,* (5th ed.). Upper Saddle River, NJ: Pearson.

Knox, C. A. & Burkhart, P. V. (2007). Issues related to children participating in clinical research. *Journal of Pediatric Nursing, 22*, 310-318.

Meaux, J. B. & Pegge, L. B. (2001). Balancing recruitment and protection: Children as research subjects. *Issues in Comprehensive Pediatric Nursing, 24*, 241-251.

Schwenzer, K. J. (2008). Protecting vulnerable subjects in clinical research: Children, pregnant women, prisoners, and employees. *Respiratory Care, 53*, 1342-1349.

Tait, A. R., Voepel-Lewis, T., & Malviya, S. (2003). Do they understand? Assent of children participating in clinical anesthesia and surgery research. *Anesthesiology, 98*, 609-614.