

Do Abstinence-only Sexual Educational Programs Stop Teens From Engaging in Sex?

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Do Abstinence-only Sexual Educational Programs Stop Teens From Engaging in Sex?

Introduction

In a perfect world, sexual education would be taught to all children by their parents, but in reality, many parents feel uncomfortable talking about sex and some lack the proper education to understand the information themselves. Instead, the sexual education curriculum is left up to government to decide and then it is up to the schools to carry out what is mandated. Within the United States, there has been much controversy about what is being taught to the students. Should the adolescent population be given the information in order to protect themselves from sexually transmitted infections (STIs) and unplanned pregnancies or should they only be taught to abstain from sexual activities altogether before marriage?

Comprehensive sexual education starts by talking about abstinence as the best choice for protection against STIs and pregnancies, but also includes information on contraception and different methods of avoiding STIs for those adolescents who choose not to abstain. These students are given the information in order to protect themselves in the event that they decide to perform sexual activities. The abstinence-only educational classes do not give students any information about contraception or protecting themselves. How can adolescents who choose to have sex be aware of the ways to protect themselves if the information is not being taught? The purpose of this paper is to discuss the lack of evidence there is that supports abstinence-only sexual education. The controversy over these two methods of teaching sexual education is extremely important in the health care system because in the United States, unplanned pregnancies and sexually transmitted infections are very prevalent among teenagers.

Literature Review

In 1996, Congress passed the “Personal Responsibility and Work Opportunity Reconciliation Act”. This Act was designed to promote sexual abstinence outside of marriage and stated that it was the only acceptable standard in our society for those who were not married (Social Security Act, 1996). Hauser (2004) addressed that even after this law was passed, the United States is still leading other industrialized nations in the highest teen birth rates and also one of the highest rates of STIs. In 2002, 10 studies were completed about the impact of abstinence-only educational programs and it was concluded that “abstinence education programs for youth have been proven to be effective in reducing early sexual activity” (Rector, 2002, p. 9). In response to that statement, the “National Campaign to Prevent Teen Pregnancy” reviewed the 10 studies and stated that “nine of them failed to provide credible evidence that they delayed the initiation of sex or reduced the frequency of sex” (Kirby, 2002, p. 5). They also concluded that there is not one abstinence-only program that has produced results showing that these methods delay sex or reduce teen pregnancy.

In 2003 Dailard presented evidence at the annual American Psychological Society meeting showing that 60% of college students that had pledged to stay virgins until they were married during their middle or high school years had broken that vow. They found that 55% of those that claimed to have kept their pledge, admitted to having oral or anal sex. Even though they were not having vaginal sex, they were still at risk for contracting STIs, including HIV. When these adolescents do not understand how diseases are spread and are not taught how to protect themselves, this makes them vulnerable to contracting diseases.

Borawski, Trapl, Lovegreen, Colabianchi, and Block (2005) studied seven different schools in the Midwest that were initiating the abstinence-until-marriage curriculum. They were able to

follow 2069 students following the intervention. It was found that students that were sexually inexperienced before having the curriculum reported five months later that they were not intending on using a condom in the future. There was no significant reduction in both the inexperienced and experienced students' intentions of having sex in the near future. On the contrary, researchers found that adolescents who had already had a sexual experience before the intervention, reported having less partners and sexual experiences less often.

Bearman and Bruckman (2005) discussed the virginity pledge movement. This is one of the ten studies mentioned previously that both Rector and Kirby disagreed on. It was estimated that over 2.5 million adolescents had taken the pledge to stay a virgin until marriage. Adolescents between the ages of 12 to 18 years were more likely to wait an average of 18 months until their first sexual experience. Also, those that failed to stay abstinent were less likely to use contraception when they did have sexual intercourse for the first time. Adolescents who pledged were more likely to get married earlier. Of the married and pledged adolescents, 88% reported having sexual intercourse before marriage. The adolescents that pledged were less likely to see a doctor for concerns regarding STIs and less likely to get tested for STIs.

Now that it has been shown that there are specific studies reporting that abstinence-only sexual education are not successful in reducing the number of adolescents that wait to engage in sexual activities until after marriage, it is time to discuss another issue associated with this education plan. Has the government taken into consideration the opinions of parties involved? The beliefs of parents (being the taxpayers) and adolescents are not taken into consideration when the government mandates the curriculum. What do current studies say that parents want their children to be taught?

In 1996, Mayer discussed that it should be expected that the programs funded by the government reflect the wishes of the people in America, but that is not the case at all. In 1996, the number of Americans that supported schools having programs that taught sexuality was 92%. With the increased knowledge of STIs, HIV, and those resistant to medications, it would be likely that this percent was increased today. Ninety-two percent of Americans believed that the education should include contraception. Even if adolescents were not sexually active yet, 83% of Americans believed that they should still be educated on how to protect themselves in the event that they did become sexually active. What about those parents that do not want their children to be taught sexual education? Simply put by the *Journal of Public Health Policy*, “If parents do not wish their children to receive information about contraceptive about contraceptive use, they could simply have their child opt out” (Perrin & DeJoy, 2003, p. 450).

Ito et al. (2006) surveyed parental opinion of students in public schools in North Carolina. North Carolina is a state mandated by the state government to teach abstinence-only as its only form of sexual education. There were 1306 parents that took part in this study and they had students in grades K-12. Of the 91% that supported sexual education being taught in schools, 89% of this population was in favor of a more comprehensive sexuality education class. Ninety percent believed that public health professionals and parents should determine what is taught in the sexual education classes. They concluded by stating “Parents were strongly opposed to politicians determining content. This is in direct contrast to the current policy of North Carolina’s abstinence-until-marriage curriculum mandated by state regulations” (Ito et al., 2006, p. 640).

In the Sexuality Information and Education Council of the United States held in 1994, teens were asked for their input on sexual education. More than two thirds believed that an ineffective

way of teaching sexual education was to teach kids to say no to sex. Santelli et al. (2006) stated “Sexually experienced teens need access to complete and accurate information about contraception, legal rights to health care, and ways to access reproductive health services, none of which are provided in abstinence-only programs” (p. 78). Those that are opposed to teaching comprehensive sexuality to teens are constantly saying that abstinence is 100% effective in preventing pregnancy and STIs. However, it is not effective because “many teens fail in remaining abstinent” (p. 78).

In the sexual education controversy, we are dealing with the element of beneficence. Health care providers are taught that we must do good and avoid harming our patients. If a teen is only taught abstinence as the only form of protection, what happens when that same teen first encounters sex? He or she will not have the needed education to make an informed decision to protect him or herself. The result from this lack of education mandated by the government may be an unplanned pregnancy or contracting a sexually transmitted infection. Are we then able to say we did good by teaching abstinence-only or have we done harm by allowing a teen to be uneducated when it comes to sex and protection? (Santelli et al., 2006)

Conclusion

To conclude, we are brought back to the question, “Do abstinence-only sexual educational programs stop teens from engaging in sex?” This paper addressed several different studies regarding abstinence-only education programs. The results show that this method of teaching teens that saying no as the only method of protection has not been effective thus far. There is a lack of evidence to support this type of education, but it still exists. Teaching abstinence is important, but we need to understand that some teens in our society will have sex regardless of teaching abstinence. As nurses, we have the responsibility of advocating for our patients and

their families. We need to look at the needs and wants of the parties involved and it has been shown that the majority of parents want their children to be taught something other than abstinence-only. This has taught me that as nurses, we must be providing families with sexuality education and be encouraging parents to talk to their teens about sex because schools that are teaching abstinence-only will not be protecting all of their students from contracting sexually transmitted infections and unplanned pregnancies.

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Pesticide-Related Cancers in Farmers

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Pesticide-Related Cancers in Farmers

Introduction

Currently the agricultural community has an estimated two million farmers, 2.7 million farm laborers, and almost six million family members (National Center for Farmworker Health [NCFH], 2002). All the while, the National Safety Council (2007) consistently ranks agriculture as one of the three most hazardous occupations in the United States. Agriculture is an important component of the national economy, which houses a population with some unique characteristics and exposures. American farmers have many occupational safety risks involved in farm labor including, but not limited to, machinery accidents, skin disorders, infection diseases, lung problems, hearing and vision disorders, as well as muscular-skeletal problems. However, a more insidious danger that exists in this vulnerable population is pesticide-related illness.

Studies done by the National Cancer Institute (2006) and others have shown that there is a greater risk of cancers in farmers using pesticides than those who do not use pesticides. Although farmers are said to have lower overall death rates than the general population, farming communities also often have higher rates of leukemia, non-Hodgkin's lymphoma, multiple myeloma, soft tissue sarcomas, and cancers of the skin, lip, stomach, brain, lung, kidney and prostate (National Cancer Institute, 2006; Blair, Zheng, Linos, Stewart, & Ahang, 2000). Because of this population's general lack of access to quality medical care, risks are consistently greater. This report will focus on how pesticides negatively affect the health of farmers, specifically regarding the incidence of cancer among this important segment of the population.

Background of the Problem

It is difficult, if not impossible, to accurately determine the incidence and prevalence of pesticide-related illness (National Agriculture Safety Database [NASD], 2004). This is mostly

due to the lack of reporting regarding the long-term effects of pesticides (Baker, 1992). No one fully knows why cancer develops. It is known that cancer is caused by a mix of heredity, lifestyle factors and cancer-causing substances in the environment called carcinogens. Sometimes it can take 20 years or more for cancer to develop after exposure to a risk factor, and farmers may be exposed to multiple risk factors in the course of their daily lives, such as pesticides. Pesticides can enter the body through many routes, but the most common ways are through the skin and through inhalation (NASD, 2004). More common than not, acute pesticide poisoning or chronic illness that develops many years after exposures to pesticides are not related back to a specified exposure and are poorly documented and identified (Baker, 1992). Symptoms of these pesticide exposures include a broad range of nonspecific symptoms including headache, dizziness, fatigue, nausea, weakness, difficulty breathing, confusion, and insomnia (McCauley et al., 2006). According to the NASD (2004), over one-half of farmers with a high pesticide exposure event have had symptoms, and of these, only one-half sought medical treatment from a health care provider.

Psychologically, farmers have many stressors relating to their occupation. They work long days in the fields and come home to a family that is dependent upon their work to earn a living. Some years are better than others, related to many variables of farming, and statistics show that farmers often face obstacles in providing for their family (NASD, 2004). This stressor is increased ten fold when the primary provider in the family finds out that he/she has cancer and that it is possibly related to the occupation from which their family is built around.

The physical environment is an important health determinant regarding this population as it is the supplier of the problem. It is where the targeted population is involved in their occupation. Even though no one set of risk factors explains the higher cancer rates, the range of

environmental exposures in the farming community are of concern. Farmers reside within the farming community and are more likely than not surrounded by other farmers who grow the same crops and use the same products and pesticides. The average farmer mixes or applies pesticides to their crops for approximately 16 years of farming (Alavanja et al., 1996). This also shows that farm populations will come into contact with a variety of potentially hazardous substances including pesticides, fertilizers, paints, solvents and dusts (Blair & Zahm, 1995). These are all environmental risk factors that increase the likelihood of cancers in the farmer.

In consideration of behavior, farmers are faced with choices in using pesticides for their crops. Pesticides kill or control destructive insects, weeds, and fungicides and are necessary to increase the production of food and fiber (Baker, 1992). According to Marlene Barnes, a retired Iowa farmer who lost her husband to pesticide-related cancer in 2003;

As a farmer you must decide which is more important- using possibly harmful pesticides that will benefit and protect your crops, or to not use the pesticides, which are considered a necessity to facilitate the modern agricultural production methods...When you do not see immediate negative effects of the pesticides it is hard to choose not to use them(personal communication, September 10, 2007).

Farmers also must decide if and when to use protective clothing or equipment which may involve extra work, time and expenses. Overall, educated and uneducated farmers alike make choices regarding the use and handling of pesticides that can be detrimental to their health.

Farmers are self-employed and work without the advantages of group health insurance or worker's compensation. They make their own schedules, as well as financial and political decisions. The societal norms and attitudes of a farmer are designed by the unit, or family, that comprises the particular farming community. Legal actions and economics directly affect

whether or not farmers can buy and use pesticides, the requirements for using pesticides, as well as whether or not they can financially allow for extra protective measures relating to the use of pesticides.

Health system considerations for controlling pesticide-related cancers in farmers include accessibility to health care (they occupy mostly rural areas), education regarding safety and protective measures when using pesticides, and early detection programs that fit into the schedule of this particular occupation (Baker, 1992). Economic conditions make farmers reluctant to miss work in order to seek health care services. Missing a day of work can be detrimental to their income as farmers are not protected by “sick leave” (NCFH, 2002). This can cause the postponing of health care and treatment in acute situations. Also, the job title “farmer” brings with it the population’s general lack of access to health care related to their socio-economic status (Blair & Zahm, 1995).

Role of the Nurse

Primary interventions to address the pesticide-related cancers in farmers include education regarding safety and health practices when using pesticides. In addition, it would be helpful to include a demonstration of how and when to use protective clothing. Assessing the farmer’s perceived risk is also very important in determining the intervention approach. Secondary interventions would include early detection and prompt treatment of the cancer. Also, equipping the tractors with bottles of water for decontamination of skin or eye exposure occurring in the field would save time in an emergency situation. An essential tertiary intervention for the farmer would be to provide emotional support and encouragement upon realization of the cancer. A goal would be to help the farmer find a way to continue farming if possible. A disabled farmer and peer support program would also be beneficial.

The nurse that practices in rural areas should be alert to the possibility of cancer being caused by the pesticides used throughout the community and in the environment. The nurse's role would be to address the lack of education regarding the use of pesticides within the farming community. Education about safety, prevention of poisoning, risk factors for cancer, and illness trends and symptoms are all topics that farmers need to be aware of in order to achieve more healthy benefits from farming and decrease the incidence of cancer. In the acute care settings the nurse would assess for signs and symptoms of pesticide poisonings and question farmers about particular chemicals with which they have been in contact. Also, the nurse should keep on-going records regarding pesticide-related illness and cancers observed. Promoting pesticide illness prevention strategies and education programs within the community would encourage the safest practices.

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Intimate Partner Violence Among Hispanic Pregnant Women

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Intimate Partner Violence Among Hispanic Pregnant Women

Introduction

It is estimated that anywhere from 6.6% to 42% of women are victims of domestic abuse, or intimate partner violence (Keeling, 2004). Even more shocking, 20% of pregnant women are abused. Abuse during pregnancy may be more common than preeclampsia, gestational diabetes, and placenta previa (Wiist, 1998). Women who are abused while pregnant have an increased risk of complications for both themselves and their infant, including “low weight gain, anemia, infections, and first and second trimester bleeding” (McFarlane, Wiist, & Watson, 1998, p. 740). While the exact mortality rates are unknown for intimate partner violence during pregnancy, “homicide is the leading cause of death for urban pregnant women” (McFarlane et al., 1998, p. 201). Demographically, minority women are at increased risk for intimate partner violence, especially Hispanic women. Younger mothers are more at risk, as research found that the average age of abused pregnant women is 24 (Wiist, 1998). Clearly Hispanic pregnant women are a population at risk for abuse, but the effects reach far beyond the abuse victims. The psychological impact on this population is immeasurable, and society must also bear the healthcare costs for treatment of the physical injuries. This report will examine the characteristics of these women, as well as possible interventions for helping this at-risk population.

Determinants of Health

The incidence of intimate partner violence increases in pregnancy and the first year postpartum. There is an increased risk for serious harm during these times, because pregnant women are in a physiologically vulnerable state. Women abused during pregnancy tend to have

lower birth weight babies (weighing less than 2500 grams), and have a higher incidence of miscarriage (Keeling, 2004).

Domestic abuse has many negative effects. Low self-esteem, depression, and emotional disturbances can all result from repeated abuse (Mattson, 1999). These psychological effects can intensify during pregnancy, because abuse tends to escalate during this time period contributing to emotional stress already associated with pregnancy. These stressors are prevalent in the Hispanic population, especially those members who have recently immigrated or undergoing acculturation. These include “daily hassles, chronic unresolved stress, role strains, and stressful transitions” (Mattson, 1999, p. 408). Social and familial support, a positive protector against abuse, is also in flux at this time, leading Hispanic pregnant women to experience less support (Charles, 2007).

Women who are cohabitating with their abusers are at greater risk for rapidly escalating violence during pregnancy (Charles, 2007). The presence of a gun, or easy access to a firearm in the environment is also associated with higher levels of abuse in pregnant women. In one study with Hispanic pregnant women who reported abuse, 31.8% of their abusers (N=66) had access to a gun (McFarlane et al., 1998).

Pregnant women who are abused also report significantly higher rates of tobacco, alcohol, and illicit drug use (McFarlane, Wiist, & Watson, 1998). The use of these drugs during pregnancy negatively impacts the fetus, compounding the previously mentioned complications that can already occur with abuse.

The sociocultural implications of abuse in pregnant Hispanic women are vast. As mentioned previously, the stress of acculturation presents the opportunity for abuse due to the social isolation and changing family roles. However, the acceptability of abuse lies deeper in the

Hispanic culture, with Latinas believing in *marianismo*, or martyrdom. Hispanic women “feel it is their lot in life to suffer,” and therefore they very easily fall into the role of abuse victim.

Hispanic men abuse their pregnant partners as a way to physically control the tenuous situation of cultural assimilation and the added stress of pregnancy. During assimilation, there is a value shift in the roles of men and women within the family, as Hispanic women obtain equal rights with their male partners (Mattson, 1999). This creates tension in the relationship with her partner, sparking the potential for abuse that escalates during pregnancy.

Many of the abused Hispanic women are in a lower socioeconomic status, and access to quality healthcare is therefore impeded. Healthcare clinics many times recognize this and provide prenatal care, and screening for intimate partner violence at these clinics.

Interventions

Primary interventions for this public health concern include education regarding intimate partner violence and the negative effects on both mother and infant. This could be done at prenatal classes and home visits. The nurse can provide a list of community resources for battered women, including the names and phone numbers of local shelters. Secondary interventions include screening Hispanic pregnant women at all prenatal visits with questionnaires and assessment scales, an intervention mandated by the Joint Commission on Accreditation of Healthcare Organizations (2007). An additional secondary intervention would be treatment of the injuries sustained by the pregnant abused woman. Tertiary interventions are aimed at minimizing the negative sequelae after abuse has occurred. The most vital of these interventions is providing an immediate safe environment, in the form of shelters or halfway houses, for women escaping abusive situations. To ensure more long-term changes, family members need to be contacted to provide a permanent living situation, removed from the abuser.

Role of Population-Health Nurse

The primary role of the population-health nurse is in assessment of the surrounding community. The population-health nurse is well suited to assess the access to firearms in the community, as well as observe the incidence of violence in the area. The nurse can also facilitate access to low-cost healthcare for pregnant Hispanic women, by providing resources and contact information about prenatal clinics in the area. While on home visits, the nurse can also educate this population about how to avoid and minimize intimate partner violence during this vulnerable time. Finally, the population-health nurse should connect with Hispanics who have recently immigrated to the area and conduct a family assessment. The nurse can observe the family coping patterns, and anticipate those families that might not cope effectively with the stressors of relocation and pregnancy. However, it is ultimately the responsibility of all healthcare providers to assess for intimate partner violence and take an active role in helping this population prevent injury and violence, and ensure maternal and infant wellness.

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Give it a Shot with Gardasil

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Give it a Shot with Gardasil

Cervical cancer is the second most common cause of cancer in women worldwide, with the primary cause being infection with certain forms of the human papillomavirus (HPV) (Agosti & Goldie, 2007; Constantine & Jerman, 2007). In the United States every year, an estimated 6.2 million persons are infected with HPV. For the year 2000, it was estimated that young people of both genders between the ages of 15-25 would account for three-quarters of new infections of HPV (Center for Disease Control, 2007; Constantine & Jerman, 2007). The National Health and Nutrition Examination Survey found that 57% of females aged 14-19, and 97% of those 20-59 years old, were sexually active. Among those females, the prevalence of HPV was highest for those in the younger age brackets, with approximately 40% occurring in those 14-19 years of age, and 50% in ages 20-24 years (CDC, 2007). Higher rates of cervical cancer in the United States have been found among African American and Hispanic women, and certain Asian subgroups of women (CDC, 2007). Additionally, geographic differences have been found to play a role in incidence and mortality (CDC, 2007).

More than two billion dollars per year are expended on the HPV infection (Temte, 2007). Cervical cancer is a major public health problem; as a result, the Gardasil vaccine was approved by the FDA in 2006, making it the first vaccine aimed at preventing infection of HPV. This vaccine targets strains 16 and 18, which cause 70% of cervical cancers, and strains 6 and 11, which cause 90% of genital warts (Harvard University Medical School, 2007). This report will focus on the Gardasil vaccine among adolescent girls, and will highlight the possible impact it will have on decreasing the rates of HPV among this population.

Determinants of Health

Biophysical

Adolescent girls are at risk for developing HPV since they are beginning at this age to engage in sexual intercourse, the primary route of HPV infection. Gardasil is aimed at girls 9-26, with recommended routine vaccination between 11-12 years of age. Vaccinating before sexual activity begins is based on statistics which report that HPV infection occurs in 54% of females within four years of their first sexual encounter. Sexual activity begins at a young age, with 7% of adolescents reporting their first sexual encounter before age 13 (Hernandez & Nestor, 2006). By the ninth grade, 29.3% of girls report sexual activity, which then increases to 62.4% by 12th grade (Temte, 2007). The average age of first intercourse by ethnicity is: African-American (15.8), Caucasian (16.6), Hispanic (17.0), Other (17.4), and Asian American (18.1) (Aneshensel, Levy-Storms, Upchurch, & Sucoff, 1998). Vaccinating adolescent girls before they begin sexual activity lessens the chance of them contracting the two strains of HPV that are the leading cause of cervical cancer.

Psychological

Psychologically, the Gardasil vaccine could lead to misconceptions of protection. Parents have voiced concern that such a vaccine would promote sexual promiscuity and encourage unsafe sex practices (Hernandez & Nestor, 2006). Parents are concerned that adolescents might misinterpret consent for the vaccine as approval for early sexual behavior (Zimet, 2006). Adolescents not properly educated about the vaccine may develop a false sense of security that it protects them from all forms of HPV and sexually transmitted infections.

Physical

Clearing up misconceptions on the extent of protection Gardasil offers, is also important when assessing the physical environment. Unsupervised after school hours provide an opportunity for adolescents to engage in sex. In one study, 56% of adolescents reported being at home unsupervised after school for more than four hours, and this did not differ between one or two parent families (Cohen, Farley, Martin, Schuster, & Taylor, 2002). If adolescent females have a false sense of protection from Gardasil, they may be less likely to use additional measures for protection. It is evident that sexual activity among adolescents is prevalent, therefore the need for proper education regarding Gardasil is critical.

Social

Within the social environment, viewpoints differ on acceptance of Gardasil. Societal attitudes can affect a parent's perception of their adolescent; for example, higher socioeconomic families often believe their adolescent is not having sex, therefore they do not see a need for Gardasil. Lower socioeconomic classes seem more aware of their adolescent's behavior and more accepting of the vaccination. Some parents oppose the vaccine because they trust their adolescents and "don't believe there is a need to vaccinate" (Constantine & Jerman, 2007). Pediatrician Dr. Marc Wager, says, "...some parents are totally in denial" (Wallis, 2007). This is despite the fact that almost two thirds of all females, by grade 12, are sexually active, despite their ethnicity.

Behavioral

The behavioral dimension is an area where teaching about Gardasil can have a positive effect because nurses are in a position to influence an adolescent's behavior. Gardasil is a protective measure against two strains of HPV and two strains of genital warts. Implementing

proper education regarding the vaccine, for both parents and adolescents, can eliminate misconceptions of the vaccine. Proper knowledge of the vaccine's protective measures should lead to more informed decisions.

Health Systems

Currently the Gardasil vaccine is a series of three shots and costs \$120 per dose. Most private insurance companies are covering Gardasil, and for those that do not have insurance, the Health Department will administer the vaccine for free. Gardasil has been added to the Vaccines for Children program, allowing children without coverage to get the vaccine for free (Wallis, 2007). All of these measures were taken to make the Gardasil vaccine affordable, accessible, and available to anyone.

Interventions

Primary

A primary intervention for Gardasil is to educate both parents and adolescents. This would include the protection it offers, and the age at which vaccination is advised. Education needs to be done to inform parents of the targeted age group, as it is most successful if given before one becomes sexually active. Adolescents need information on the vaccine's protection limits -- they need to know that it will not protect them against all types of HPV or sexually transmitted infections, and therefore safe sex practices still need to be used as a preventative measure. Pap smears are another form of primary prevention for females who are at least 21, even if they are not yet sexually active. Finally, Gardasil, as a vaccine, is a form of primary prevention itself against two strains of HPV and two strains of genital warts.

Secondary

Secondary interventions include annual Pap Smears for women that are sexually active. Adolescents are at risk for HPV and sexually transmitted infections once they have had intercourse. A second prevention would be to do DNA testing for HPV if a Pap smear came back abnormal and, if indicated, the removal of pre-cancerous lesions.

Tertiary

Tertiary interventions would be to administer Gardasil to females that currently have HPV, but not a strain targeted by the vaccine. This will help them to be protected against other types that cause the majority of cervical cancer. Another intervention would be Pap smears on a more frequent basis, or as ordered by their physician, to closely follow the individual after the removal of abnormal cells. Even with a normal Pap smear result, it is still important to educate women on the importance of routine Pap smears and protection against other sexually transmitted infections.

Role of the Population Health Nurse

The first role of the population health nurse (PHN) is education of both adolescents and their parents. Parents need to be educated about HPV and their adolescent's susceptibility once they begin sexual activity with emphasis on understanding that the vaccine provides the greatest benefits if initiated beforehand. Adolescents need to understand that the vaccine does not provide unlimited protection and need to be encouraged to engage in safe sexual practices. Adolescents also need to be informed that it is critical to continue routine Pap smears.

Secondly, the PHN needs to be involved with facilitating access to care. The vaccine may be costly, but is frequently available for free through the Public Health Department. The role of the nurse is to spread this information so that families are aware of the accessibility and affordability of the vaccine.

It is also important to gather data on those who are at an increased risk for contracting HPV but who are not receiving the vaccine. Research shows that African and Asian Americans are the least likely to give consent for vaccination, yet they are most at risk for mortality due to HPV. A lack of willingness to have their daughters receive the vaccine may be due to religious reasons or because it is not found culturally acceptable (Kahn, 2007). The PHN needs to be aware of cultural differences and be able to discuss these in relation to the vaccine.

Conclusion

The Gardasil vaccine is a form of primary prevention against two strains of HPV that cause 70% of cervical cancer and two strains that cause 90% of genital warts. While it is an excellent new form of protection, success depends on early vaccination. It is critical that health care providers have the ability to reach across age groups and cultures to educate, inform, and convince the public of its safety, preventive capabilities, affordability, and availability.

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Inheriting Breast Cancer:

Genetic counseling for the BRCA 1 and BRCA 2 genes

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Inheriting Breast Cancer: Genetic counseling for the BRCA 1 and BRCA 2 genes

Introduction

Breast cancer is the second leading cause of cancer-related death in women in the United States, and it will take the lives of approximately 40,460 women in 2007 (American Cancer Society, 2007). Positive family history is known to increase risks of breast cancer, but only 5% to 10% of cancers are genetically inherited (MacDonald, 2002). The most common causes of this hereditary breast cancer comes from mutations in the BRCA1 and BRCA2 genes which increase a woman's risk of breast cancer to as high as 85% (MacDonald, 2002). In 1996, the availability of commercial testing to screen for these gene mutations brought new risk management options to the general population and a new set of ethical issues to ponder (MacDonald, 2002). As medical professionals, it is important to understand the implications that this kind of genetic testing has on the client and on health care. The purpose of this paper is to provide the reader with information about the implications of having an increased risk for breast cancer, the risk management options that genetic counseling provides, and the professional's role in genetic counseling.

Review of Literature

In order to understand the importance of genetic counseling for BRCA1 and BRCA2, we must look at how having a family history of breast cancer affects the individual. Women who have a family history of breast cancer often overestimate their own risk of developing breast cancer (Matloff, Moyer, Shannon, Niendorf, & Col, 2006). These high risk individuals live in a state of "chronic risk" that can have many "physical, social, cultural, financial, and medical meanings and can affect feelings of self-worth as well as interpersonal relationships" similar to individuals suffering from an actual chronic illness (Kenen, Arden-Jones, & Eeles, 2003, p. 316).

Most of these women with a strong family history of breast cancer have experienced the agonizing effects of cancer on a loved one, so it is easy to see how these life experiences would have a profound effect on their health risk perceptions and behaviors (Matloff et al., 2006). Genetic counseling provides a technological advantage that can allow for increased screening and preventative interventions for those identified as carriers of a BRCA1 or BRCA2 mutation gene, as well as freeing those identified as non-carriers from the stress of intensive medical screening or prophylactic surgery (Claes et al., 2005). Once the carrier status has been established, decisions must be made about risk management options which are discussed as part of the genetic cancer risk assessment (MacDonald, 2002).

Options for risk management of breast cancer include screening, chemoprevention, and prophylactic surgery (MacDonald, 2002). Screening methods used for early detection of breast cancer include mammograms annually after age 40, annual clinical breast exams, and monthly self breast exams. For individuals identified as having a high risk for breast cancer, these screening methods are started at younger ages and may include an ultrasound or MRI with the annual mammogram (American Cancer Society, 2007). Chemopreventive agents such as tamoxifen are now available to reduce the risk of breast cancer by as much as 50% in healthy high risk women. However, this drug carries risks of its own ranging from vaginal discharge and hot flashes to side effects as severe as increased risk for endometrial cancer and thromboembolic events (Matloff et al., 2006). In one study, over 90% of the women who qualified for chemopreventative medication declined with adverse reactions as the most commonly cited reason (Matloff et al., 2006). Prophylactic surgery is also an option including bilateral mastectomies and prophylactic oophorectomies to minimize the risk for ovarian cancer that is also associated with the BRCA1 gene mutation; although it is important to note that these

surgical procedures may not eliminate the risk in these genetically predisposed women (MacDonald, 2002). Clearly these are not easy choices. This puts the healthcare professional in a unique role in this decision-making process.

Genetic counseling has traditionally consisted of a nondirective approach wherein the counselor provides all the information for the client to interpret and use in their “autonomous decision making” (Evans, Bergum, Bamforth, & MacPhail, 2004, p. 461). Despite the healthcare provider’s obligation to respect the client’s autonomy, studies show that many women desire recommendations from their physician in this delicate matter. Some women want to be given a specific course of action while others want to be presented with all the options (Geller, Strauss, Bernhardt, & Holtzman, 1997). These findings indicate the need for an adaptation of this traditional nondirective approach to a holistic approach in which there is an active dialogue between the client and the healthcare provider thereby enhancing both autonomy and beneficence (Evans et al., 2004). This approach requires healthcare providers to “disclose their own motivations, beliefs, and values” and ask their clients questions that yield insight into their health beliefs, practices, and experiences (Geller et al., 1997, p.31). This does not mean that the provider should exercise paternalism or try to influence the client’s decision, but rather strive to see the client as a unique and whole person who is not just another client with the BRCA mutation gene (Evans et al., 2004).

Genetic counseling in this particularly vulnerable population involves the timing of the genetic testing and sensitivity when providing information and counseling. Women who had been diagnosed with breast cancer indicated that they did not want to handle both their diagnosis and genetic testing at the same time because they would feel overwhelmed by the information and therefore be more likely to rush towards a decision that they are not yet ready to make and

may later regret (Arden-Jones, Kenen, & Eeles, 2005). Occasionally women with a family history of breast cancer choose to have prophylactic mastectomies regardless of the outcome of their genetic testing (Geller et al., 1997). Studies show that there is “no perfect time” to offer genetic testing, and that the “right time” only occurs when the client is ready for the information (Arden-Jones et al., 2005, p. 275).

Another issue debated by both clients and professionals is who should handle the genetic counseling. Women as a whole seem to feel that it is best to have the genetics department handle the counseling so they would know that they are dealing with an expert who can offer plenty of time to ensure that the client is comfortable, accurately informed, and not rushed (Arden-Jones et al., 2005). In contrast, medical professionals generally agreed that this counseling should be handled by the breast surgeons or the oncologists. Surgeons feel that there was no need for women to see the genetics department when they already are interacting with a surgeon who was quite familiar with the genetic aspect of this disease (Arden-Jones et al., 2005). Other healthcare professionals, including breast cancer nurses, did acknowledge the time constraints at busy clinics. They felt that it was more important to make sure that the client knew the testing was available and then provide answers to any questions that the client might have (Arden-Jones et al., 2005). It is clear from these differing opinions that the delicate matter of genetic counseling must be handled on an individual basis and not generalized.

Conclusion

Nurses must take into consideration that clients with a family history of breast cancer often overestimate their own risks leading to a “chronic risk” lifestyle that can affect many aspects of their lives (Kenen et. al., 2003, p. 316). For these women, the BRCA1 and BRCA2 genetic testing offer a sense of “certainty” about their high risk status and provides them with the

information necessary to make informed decisions about their risk management options (Claes et al., 2005, p.102). These options, which include screening, chemoprevention, and prophylactic surgery, are not without their own risks and therefore require careful thought and consideration. The professional's role in genetic counseling is a very valuable one involving a balance between respecting the client's autonomy and maintaining beneficence. Generating a counselor-client relationship that fosters an open dialogue and provides the client with the support necessary to deal with this life-altering issue is vital. The timing of the genetic testing and the type of professional that provides the counseling are two ways in which this process can be tailored to the client's individual needs for improved comfort and effectiveness.

The prevalence of breast cancer in our society today makes nurses responsible for understanding these issues and exploring our own opinions. Regardless of their specialty, nurses will encounter a woman with a family history of breast cancer and have the opportunity to meet that woman's needs by having adequate, accurate, and thorough information to assist her in the decision-making processes (MacDonald, 2002). As a future nurse and a woman with a family history of breast cancer, this issue holds both professional and personal relevance and I value the insight gained from reviewing the literature and writing this paper. As nurses we pride ourselves on being patient advocates, and so we must assist these high risk women by making sure they know genetic testing is available and the various risk management options as well as ensuring that their needs are met throughout the genetic counseling process. Ultimately this makes us better nurses and increases the overall health of our clients and the population as a whole.

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Disapproval, Prejudice and Adequate Care; Can They Coexist?

Homosexuality and Health Care

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About the author:

A long time resident of Minneapolis, Minnesota. Jenna is member of the National Society of Collegiate Scholars. She graduates with Honors from both University of Kansas and the School of Nursing. After graduation she will start her career as an RN in the Emergency Department at Stormont-Vail Medical Center in Topeka, Kansas. She believes her future is as a Nurse Practitioner in a Women's Health Care environment. Her passion for this topic developed from her observations of the many subtle methods by which healthcare providers demonstrate their biases and the potential effect these could have on individuals.

Disapproval, Prejudice and Adequate Care; Can They Coexist? Homosexuality and Health Care

Introduction

Assumptions, discrimination and years of classifying homosexuality as abnormal have lead to increased fears surrounding the health care system. "Literature reveals that many [homosexuals] deeply distrust health care providers and that this mistrust is often well founded" (Hughes, 2005, p. 301). Societal views have a considerable influence on the medical world and the views of many health professionals. "The interplay between medicine and society has meant that heterosexuality as the 'norm' underpinned all medical and scientific attempts to understand homosexuality" (Hinchliff, Gott & Galena, 2005, p. 346). Society has made many changes to improve the treatment of several minority groups yet homosexuals often believe that these improvements have failed to apply to them. Many people continue to disapprove of the lifestyle and sexual behavior that is associated with homosexuality. If health care providers disagree with a patient's lifestyle should they be obligated to care for that individual? Should health care providers set aside their own standards and values to care for individuals they feel are morally inapt? How should one tell certain patients that you do not desire to care for them? Is ignorance impeding health care providers' ability to treat their patients? Do homosexuals receive inadequate care due to prejudice, insensitivity and stigma? Delivering respectful and conscientious care to all patients is important in ensuring adequate health care and safe practice. Examining current research is essential to understanding the differing views concerning the health care of homosexual patients.

Review of the Literature

Disadvantages and Discrimination of Homosexuals

“Lesbians and gay men suffer from discrimination in housing, employment, and basic civil rights. In addition, they frequently feel uncomfortable with or rejected by their families of origin and often lose traditional social support when they disclose their sexual identity” (Hughes, 2005, p. 301). Society has often failed to remove barriers for homosexual individuals consequently, one can imagine that many barriers continue to exist within the health care system. Rondahl, Innala and Carlsson (2004) defined homophobia as “an irrational fear, aversion or discrimination of homosexuality or homosexuals” (p. 19).

Homophobia has adversely affected many in the gay and lesbian communities. Rondahl et al. (2004) add that, “homophobia [is] reflected in how people *think* about homosexuality, which in turn reflects their attitudes and knowledge about homosexuality” (p. 20). Many homosexual patients reported anxiety, insecurity, feelings of discomfort and fear of hostility or even physical harm when interacting with health care professionals (Rondahl et al., 2004). Reinforcing the concept of homophobia McAndrew and Warne noted that “*The Diagnostic and Statistical Manual of Mental Disorders* ceased to define homosexuality as pathological in 1973 replacing it with a new ‘illness’ of ‘gender identity disorder’” (2004, p. 428).

Many people believe that homosexuality is considered a separate entity in terms of discrimination. Daniel Pollack stated, “in the *Code [of Ethics]*, discrimination based on sexual orientation and discrimination based on religious beliefs are equally condemned, and respect is equally endorsed. Neither one is the ‘first among equals’” (2007, p. 179). Although many believe that homosexual individuals are to be treated equally and respectfully, discrimination and prejudice still abound. In a study conducted by Rondahl et al. (2004) the research team asked

nurses and nursing students whether they would refrain from treating a homosexual patient if they had the option. Results showed that 36% of the nursing staff and 9% of student nurses indicated they would chose the option to refrain from treating homosexual patients (Rondahl et al., 2004). One nurse stated, "I think if you choose to live with the same sex you are going against God" (Rondahl et al., 2004, p. 23). A nursing student openly expressed his/her disdain for homosexuals saying, "I would be disgusted. You can't care for 'something' that you hate" (Rondahl et al., 2004, p. 23). It is alarming to note that individuals whose career is based on the concept of caring made these statements. "Health care providers are not immune from societal prejudices, and their personal beliefs and attitudes toward homosexuality can influence the quality and type of health care they provide to clients who are members of those populations" (Hutchinson, Thompson & Cederbaum, 2006, p. 397). Martino Maze (2005) implied that, "caring for members of disenfranchised groups instills fear at some level in nurses who are working with these individuals" (p. 546). If one does not approve of another's lifestyle should they be obligated to work with them? According to the American Nurses' Association (ANA), "the nurse should reject any assignment that puts patients or themselves in serious and immediate jeopardy" (Martino Maze, 2005, p. 550). The ANA is safeguarding nurses and patients alike but in this safeguarding practice are they creating more harm than harmony? Is the ANA encouraging prejudice based on sexual orientation, among other things, by allowing the rejection of patient assignments? These are important questions to consider when addressing homosexuality and the health care system.

Advances and Changes In Policy and Health Care Attitudes

Although many research findings suggest negative outcomes for homosexual patients some advances are being made to improve health care for this population. According to

O'Hanlan, Dibble, Hagan & Davis (2004), "research confirms that homosexuality is a normal expression of human sexuality" (p. 227). There are many promising statistics for the improvement of cultural competency regarding homosexuality. O'Hanlan et al. (2004) cited The Kaiser Family Foundation whose research demonstrated that, "66% believe that homosexual behavior is a normal part of some people's sexuality. Americans (56%) support U.S. military service for gay men and lesbians...and 88% say they would accept a lesbian, gay or bisexual family member or friend" (p. 231-32). O'Hanlan et al. (2004) indicated that work is being done to include marital status, sexual orientation, gender, or perceived gender in nondiscrimination statements. Some people believe that having nondiscriminatory policies may be endorsing homosexuality but, "it should be noted that similar policies issued regarding race, religion, and ability are not seen as endorsements of a particular race, religion, or ability" (O'Hanlan et al., 2004, p. 232-33).

Health care providers that have trouble relating to homosexual patients should be encouraged to provide the best care possible. McManus, Hunter & Renn (2006) recommends that, "health care providers should be aware of the challenges they will face and be informed of options available to them" (p. 19). Health care providers are not expected to know everything in relation to a certain type of patient but they should remain respectful and open to new experiences and challenges. "Health care providers do not need to know the answers to all of the questions that the [gay/lesbian] couple may have, but they are obligated to be aware of resources available to answer any questions that may be beyond their expertise" (McManus et al., 2006, p. 19). Health care providers may look to colleagues for advice on how to work with homosexual patients. A nurse involved with research conducted by Rondahl et al. (2004) stated, "all patients have the right to equal nursing care. My personal opinion/values do not influence my work" (p.

23). A student participating in the Rondahl et al. (2004) study said, “it doesn’t matter what you *really* think about homosexuals, they have the same right to equal care as you do” (p. 23).

O’Hanlan et al. (2004) cited The American Medical Association and The American Medical Women’s Association as they urged:

national, state, and local legislation to end discrimination based on sexual orientation in housing, employment, marriage and tax laws, child custody and adoption laws; to redefine family to encompass the full diversity of all family structures and to ratify marriage for lesbian, gay and bisexual people...creation and implementation of educational programs...in the schools, religious institutions, medical community, and the wider community to teach respect for all humans (p. 232).

Conclusion

There are many contrasting opinions on the sensitive topic of whether to treat and care for homosexual patients. McAndrew and Warne (2004) found that, “subjects classified as gay, lesbian or bisexual were found to be at an increased lifetime risk of suicidal ideation and behaviour, major depression, generalized anxiety disorder, conduct disorder and nicotine dependence” (p. 431). McAndrew and Warne (2004) also noted that, “to enjoy mental health one needs to be true to one’s own identity and develop a positive self concept” (p. 432). Although many homosexual patients have had negative experiences advances are being made to increase awareness of their unique needs and concerns within the health care system. The question remains whether prejudice, discrimination and adequate care can coexist. Increased education about homosexuality is needed in order for individuals to maintain their personal values and deliver quality care.

Hutchinson et al. (2006) emphasized that:

it is the responsibility of all health care providers...to be knowledgeable and sensitive to the health care needs and issues, competent and skilled in interacting and providing

appropriate care, and able to provide practice environments that convey a sense of respect, acceptance, and welcome to all [people], regardless of sexual orientation (p. 398).

Exploring the topic of homosexuality and health care has improved my ability to be tolerant of all people, including those who are intolerant to homosexuality. Although it is not ideal to be intolerant of certain issues one must realize that everyone holds their own opinions and it is how we handle the difference between these opinions that counts.

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Secondhand smoke: Who's autonomy are we willing to negate?

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Secondhand smoke: Who's autonomy are we willing to negate?

Introduction

In 1976, a New Jersey Superior Court judge presided over the landmark case of *Shimp vs. New Jersey Bell Telephone Company*. The judge ruled that the evidence was clear and overwhelming that cigarette smoke contaminates and pollutes the air, creating a health hazard not merely to the smoker but to all those around her who must rely on the same air supply. The right of an individual to risk his or her own health does not include the right to jeopardize the health of those who must remain around him or her in order to perform properly the duties of their jobs (Sweda, 2004, p. 61).

This case elicited numerous questions on the effects of secondhand smoke (SHS) causing many non-smokers to defend their rights to breathe clean air.

Even though the case mentioned above was geared toward smoking in the work place, the issues of SHS reach much farther. The main purpose of this paper will be to address the effects SHS has on the human body and the benefits of smoke-free environments for adults and children. The issue of SHS is important for the nursing profession to examine because chronic diseases present in hospitals are often associated with SHS.

Review of Literature

Secondhand smoke, also known as environmental tobacco smoke, is a complex mixture of gases and particles which includes smoke from the burning cigarette, cigar, or pipe tip and exhaled mainstream smoke. SHS contains at least 250 chemicals known to be toxic, including more than 50 that are known carcinogens (National Toxicology Program, 2005). Some of the chemicals contained in SHS include formaldehyde, cyanide, carbon monoxide, ammonia, and nicotine. Fortunately, exposure of adults to SHS is declining as smoking becomes increasingly

restricted in workplaces and public places. Unfortunately, children continue to be exposed in their homes by the adults around them that choose to smoke (U.S. Department of Health and Human Services, 2006).

The overwhelming body of medical evidence clearly demonstrates the direct causes and linkages between exposure to second-hand smoke and serious health effects among non-smokers. The adverse health effects of SHS exposure in non-smokers have been documented since the early 1970s, yet the exposure still exists in many public places across the United States. Each year, there are 3000 lung cancer deaths and at least 35,000 coronary heart disease deaths attributed to SHS exposure in US non-smokers (Pickett, Schober, Brody, Curtin & Giovino, 2006).

Secondhand smoke is a pollutant that causes serious illnesses in adults and children. Adults exposed to SHS are more susceptible to heart disease and lung cancer. Children that are exposed to smoke are at increased risk for sudden infant death syndrome, middle-ear disease, worsened asthma, respiratory symptoms, and slowed lung growth. The children of parents who smoke have an increased frequency of a variety of acute respiratory illnesses and infections, including chest illnesses before 2 years of age and physician-diagnosed bronchitis, tracheitis, and laryngitis, when compared with children of non-smokers (U.S. Department of Health and Human Services, 2007). There is strong evidence that SHS may be associated with stroke, spontaneous abortion, negative effects on the development of cognition and behavior in children, exacerbation of cystic fibrosis and cervical cancer (California Environmental Protection Agency, 1997).

Scientific evidence has determined that a safe level of exposure to SHS does not exist. Non-smokers who are exposed to SHS at home or work increase their heart disease risk by 25-30 percent and their lung cancer risk by 20-30 percent (Department of Health and Human Services,

2006). Pickett, Schober, Brody, Curtin and Giovino (2006) conducted an investigation of the relationship between smoke-free law coverage and SHS exposure in the United States non-smoking adult population. These researchers found that, as of January 2006, there were 440 local laws and 15 state laws that require smoke-free air in at least one of three locations (workplaces, restaurants, and bars), covering 39% of the total US population. Also, up to a 90% reduction in the odds of SHS exposure for adults residing in counties that enacted smoke-free air laws, compared to those without smoke-free policies was found. Smoking bans and restrictions in workplaces in the United States, Australia, Canada, and Germany have lead to 3.8% reduction in smoking prevalence among employees (Fichtenberg & Glantz, 2002).

Adolescents who work in smoke-free workplaces are significantly less likely to be smokers than adolescents in workplaces with no smoking restrictions or a partial work-area smoking band (Farkas, Gilpin, White & Pierce, 2000). In another study investigating the factors contributing to smoking behavior of adolescents, researchers found having parents and best friends who smoked increased the susceptibility of adolescent, who had never smoked, initiating smoking (Pierce, Choi, Gilpin, Garkas & Merritt, 1996).

Conclusion

Shimp vs. New Jersey Bell Telephone Company was instrumental in paving the way for researchers and doctors to take a closer look at the harmful effects associated with SHS. Once the Surgeon General published the 1986 report, *The health consequences of involuntary smoking*, SHS became linked to an endless list of serious health problems ranging from sudden infant death syndrome to lung cancer. It has also been found that exposure to SHS in the workplace, home and public only exacerbates one's health problems. It is widely known that health problems associated with SHS can be avoided by eliminating passive smoking exposure, whether

it exists. With all of this information at our finger tips, what has prevented a national ban on smoking from being implemented?

Implementing 100% smoke-free environments is an effective way to protect the population from exposure to SHS. This may seem like a drastic measure, but the increase in the last 10 years of the known diseases associated with SHS shows that not enough is being done to stop the exposure. By decreasing the public exposure to SHS there should be a decline in the occurrence of lung cancer and heart disease leading to an increase in the health of future generations.

As a member of the nursing profession we must advocate for smoke-free policies. Secondly, we need to routinely screen children to identify household members who smoke and advise parents to take steps to eliminate children's smoke exposure. Thirdly, we need to provide information to smokers about the benefits of quitting. However above all this, as a nurse we must always remember, we are role models and our actions speak loudly.

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Ending a Life in the Beginning: An Informative Analysis of Pediatric End-of-Life Palliative

Care

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Ending a Life in the Beginning: An Informative Analysis of Pediatric End-of-Life Palliative Care

An Introduction to Palliative Care

After months and years of loving, caring, worrying, and anticipating the arrival of a new life, how can one decide to end that young life just as quickly as it arrived? This is the dilemma some families are forced to face when they have a child with life-ending complications. Is it fair to out live one's child? Is it fair to play God and decide to end that child's life? These questions are only a few questions families are forced to face. Behind all of these questions, however, lie the deeper issues of morality and ethicality.

Addressing morality and ethical elements are often focused on in end-of-life care. This is especially true when the life that is ending is that of a child. To end a life that has yet to flourish forces one to face morality and question its ethical acceptability. Palliative care nursing helps one face these issues. Palliative care is a specific area of nursing that focuses on providing holistic comfort to those in the end stages of life, while maintaining ethically acceptable care (American Academy of Pediatrics [AAP], 2000). Choosing to provide palliative care is not an easy decision, especially when the patient is a child. The purpose of this paper is to examine the ethical involvement in pediatric palliative care. This is an important issue because providing ethically sound care is a priority in the nursing profession.

The Decision Process

A family's decision to change the plan of care from curative to palliative care can be the most difficult decision that family makes. This decision comes after an emotional rollercoaster of highs and lows full of uncertainty the family has already had to endure (Romesberg, 2007). Parents, mothers in particular, often face an ethical dilemma regarding their obligations to care

for their seriously ill child (Corkin, Price & Gillespie, 2006). Their first reaction is to do anything to make their child live, "...we didn't care, we just wanted her to live...I was determined that my daughter would not die." (Berg, 2006, p. 239). However, this attitude can only last for so long. When one begins to see the suffering, pain, and discomfort their child is facing just to live, the attitude often changes. Hannan & Gibson (2005) reported that parents of seriously ill children with incurable diseases change their attitude in the plan of care, leading them to seek palliative care. The reason behind this change is the parent's wishes to provide continual comfort care for their child, while allowing them to enjoy & value the little time they have left with them. The ethical dilemma however, arises with this new plan of care due to the inevitable loss of their child's life. For that reason, reaching this final decision is a long and heartbreaking process. As commented by one mother;

"If clinicians think that parents can be presented information just once about life or death decisions and then expect parents to say "yes" or "no," it won't happen. As a parent, this type of decision is an evolving process. You need to be presented with information compassionately, have a chance to ask questions, then develop your thinking as a parent..." (Dokken, 2006, p. 175).

To make this life ending decision, parents must be well informed, have compassionate caregivers, and trust those involved in the care of their child (Dokken, 2006).

Goals and Principles of Palliative Care

Caring for a child is the primary goal in any pediatric nursing care. However, when the focus of care is palliative, the outcomes in the plan of care are augmented. The goal of palliative care is care focused on alleviating symptoms without curing (Romesberg, 2007). As supported by the American Academy of Pediatrics, to provide this type of care and accomplish the goal ethically, certain principles are necessary (AAP, 2000). These principles include respect for the

dignity of patients & families, access to competent & compassionate palliative care, and support for the caregivers (AAP, 2000).

Respect for the dignity of the patient & family is the cornerstone principle in providing ethically sound palliative care (AAP, 2000). Without respect, the basic Standard of Care for nursing is being breached therefore; ethically, the care given cannot be described as ethically acceptable, and the goal of palliative care cannot be met.

Access to competent & compassionate palliative care is another keystone principle necessary in providing ethically acceptable care. Included in this are various therapies such as, “education, grief & family counseling, peer support, music therapy, child life intervention or spiritual support for parents & siblings, and appropriate respite care” (AAP, 2000, p. 351). By providing such therapies, it allows families time to absorb the situation at hand, coordinate care necessary for the patient, prepare for the future, and maintain a quality of life as close to normal as possible (Institute of Medicine of the National Academies, 2002).

The final principle necessary in accomplishing the goals for providing ethically acceptable palliative care is support for the caregivers (AAP, 2000). Parents and family members are not the only ones involved in the care of the patient. Most of the nurses that care for these palliative care patients develop a special bond with them, and as a result, they too need support just like the family. These health care professionals require support from their colleagues, institutions, and other health care providers (AAP, 2000). This is so that the providers can provide proper care for their patients, without breaking down themselves, physically and emotionally. Together, all of these principles help accomplish the goal of pediatric palliative care.

Barriers Nurses Face

Understanding the necessary principles for palliative care may be easy to comprehend, however providing the actual care can be difficult due to barriers nurses face. Many undergraduate programs lack the proper environment and necessary preparations needed to help teach their students how to provide optimum palliative care for their pediatric patients (Malloy, Ferrel, Virani, Wilson & Uman, 2006). This lack of proper training has lead nurses to many barriers in providing proper care, which forces them into many ethical dilemmas (Malloy et al., 2006). These ethical dilemmas and barriers are the components that have made pediatric palliative end of life care an ethical issue today. Barriers nurses are facing in providing ethical care vary from personal morals, values & emotions, practicing beneficence & nonmaleficence, nurse exposure to death & stress, and grief (Kain, 2006).

In the beginning of one's career, nurses are encouraged to develop their own personal morals, values, and emotional coping mechanisms. The hope is that by doing so, it will help nurses cope with the death of pediatric patients in their own way. The issue however, is that no matter how comfortable one is with their morals, values, and coping mechanisms, providing any type of pediatric palliative end-of-life care leads to a negative experience for the nurse (Kain, 2006). The care provided still leads to the death of a child, which by societal norms is "unnatural", making it more difficult to understand (Kain, 2006). With this known negative experience, nurses are led to question whether they should or should not provide pediatric palliative care, given the possibility that the evolving modern technology may someday provide a solution to allow the child to live.

Practicing beneficence & nonmaleficence also is cited as a barrier to providing ethical pediatric palliative care (Kain, 2006). Defined, nonmaleficence is the requirement to "do no

harm”, while beneficence is not only the preservation of life, but also understanding that preserving life is not always in the best interest of the patient if the quality of life suffers (AAP, 2000). These principles often come in conflict in regards to dying children and pain. Pediatric palliative care nurses face a moral dilemma when they deal with this situation of inflicting pain; does the “potential of maleficence outweigh beneficence” if quality of life suffers in the situation at hand (Kain, 2006, p. 389)?

Another barrier is the nurse’s exposure to death (AAP, 2000). With cumulative exposure to pediatric death, nurses are more vulnerable to anxiety and trauma, making them “psychologically unable to support dying babies and their families” (Kain, 2006, p. 389). In addition, the continuing exposure to death is personally emotionally difficult for the nurse causing distress that cannot be avoided, which leads to an increase in stress (Romesberg, 2007). If one is stressed and unable to support one’s patients, how can they focus and provide proper ethically sound care?

The final barrier is grief (Kain, 2006). Grief experienced by pediatric palliative care nurses is complex, especially if they were not prepared for the death and if there was pain & anguish during the death of the patient (Romesberg, 2007). In particular, it is known that the death of a child causes “more intense and complicated feeling than that of an adult” due to the unnatural event of a young life being lost (Kain, 2006, p. 390). In addition to these feelings of grief, pediatric palliative care nurses are prone to additional distress due to the training they received. Nursing is geared towards helping cure a patient in distress therefore; death of a patient may be viewed as a failure (Romesberg, 2007). The grief and emotional distress due to experiencing repeated deaths of children can lead to guilt and times of depression. This can lead to a nurse encountering personal psychological issues. Can this nurse adequately provide

ethically sound-nursing care when he or she is actually harboring unresolved grief himself or herself?

A Final Thought

From these cited barriers, providing ethically sound pediatric palliative care can be difficult to accomplish. However, the need for pediatric palliative care is essential, and for that reason, these barriers should not get in the way of providing the care needed. Pediatric palliative care is a special field of nursing, and as with other fields, ethical dilemmas will arise. It is one's job as a nurse to critically think through each situation and reason the ethically appropriate way of providing care. After all, it is the innocence and vulnerability of a child the pediatric nurse is trying to preserve; while it is the holistic comfort to those innocent and vulnerable children the pediatric palliative care nurse is trying to provide.

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Responsible Sexual Behavior in Adolescents Through Comprehensive Sex Education

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Responsible Sexual Behavior in Adolescents Through Comprehensive Sex Education

Introduction

As a population, adolescents are known to partake in risky behaviors, but few risky behaviors result in consequences as damaging to the overall health and well-being of teenagers as unprotected sex. The federal government has recognized the urgency of this public health concern, and as part of its *Healthy People 2010* initiative, has prioritized the prevention of sexually transmitted diseases (STDs) and pregnancy within the adolescent population through education about responsible sexual behavior. Although the teen pregnancy rate in the United States has been declining during recent years, the U.S. “continues to have the highest teen pregnancy rate of all industrialized nations” (Perrin & Bernecki DeJoy, 2003, p. 445). Furthermore, according to the Kaiser Family Foundation, sexually active “young adults under the age of 25 are at higher risk for acquiring STDs for a combination of behavioral, biological and cultural reasons,” and “one in four sexually active young adults ages 15 to 24 contracts an STD” yearly (2006, p. 2). Alarming, adolescents and young adults within this age group in the United States acquire “half of all new sexually transmitted disease infections, but represent only about 25% of the sexually active population” (Bleakley, Hennessy, & Fishbein, 2006, p. 1151). When adolescents have unprotected sex, it is also expensive in terms of the costs to society because “direct medical costs associated with the 9 million STD infections, including HIV, among this age group in 2000 were estimated at \$6.5 billion, which is likely an underestimate” (Bleakley, Hennessy, & Fishbein, 2006, p. 1151). All of this information emphasizes “the relevance of timely and informative sex education in middle and high schools as an important component to the public health goal of promoting safe behaviors and preventing additional infections and unintended pregnancies” (Bleakley, Hennessy, & Fishbein, 2006, p. 1151). Therefore, as patient

advocates and population-health nurses, it is essential that nurses prioritize the prevention of sexually transmitted diseases and teen pregnancy through comprehensive sex education as they care for adolescents.

Determinants of Health

Nurses have a great potential to effect change, and promote effective methods of preventing STDs and pregnancy in the adolescent population. These include “promoting abstinence or delaying sexual initiation” as well as “fostering safer sex messages that promote the use of condoms” through sex education (Allender & Spradley, 2005, p. 655). When educating students about sex, nurses must consider adolescents’ attitudes about abstinence, contraception, monogamy, and the consequences surrounding sexual activity. Although the federal government financially supports abstinence-only education programs, research has overwhelmingly shown that abstinence-only programs are ineffective and out of sync with the societal trends in the United States, where “premarital intercourse is the norm,” and “no evidence suggests that this 80-year trend is likely to be reversed by an educational intervention” (Kantor & Bacon, 2002, p. 40). In the past, sexual activity outside of marriage was considered taboo, but today “the reality is that more than 80% of Americans have intercourse before marriage, and more than half of teens are sexually active by the age of 18” (Perrin & Bernecki DeJoy, 2003, p. 450). Additionally, the majority of Americans feel that informing teens about contraception would “not encourage them to have sexual intercourse earlier than they would otherwise,” and 77% say arming adolescents with “such information makes it more likely the teens will practice safe sex now or in the future” (Kaiser Family Foundation, 2004, p. 2).

While adolescent sexual activity may seem mostly like a behavioral concern, nurses must also consider how the biological dimension of adolescent development contributes to the issue.

According to the Kaiser Family Foundation, “males are slightly more likely than females to report having sex,” and “the median age at first intercourse is 16.9 years for boys and 17.4 years for girls” (2006, p. 1). As teens undergo puberty and mature physically, their hormones are raging and their curiosity about sex is piqued before they may be cognitively prepared to make responsible choices about sex.

There is a gap that exists during the time between adolescents’ physical and cognitive maturity. While their physical development is nearing completion, their cognitive and emotional maturity may still have some catching up to do. Although it is important to teach young people how to avoid pregnancy and STDs because of physical concerns, “many parents say they are most worried about the effects of sexual activity on their child’s psyche” (Kaiser Family Foundation, 2004, p. 3). The psychological stressors involved with adolescent sexual activity must not be discounted. When teens have sex before they are psychologically equipped to deal with the consequences of that action, they put themselves at risk for emotional distress. Furthermore, if a pregnancy or STD results, the stigma attached with either of those outcomes in the high school setting is a major psychological stressor.

Sociocultural factors are important to consider when determining the best way to encourage responsible sexual behavior in adolescents. Examining the typical family structure within the target population is critical in providing teens with culturally sensitive sex education. The family’s attitudes and values surrounding sex often have a strong effect on all members of the family. Whereas one family might believe in abstinence until marriage, another family may live in a community where getting pregnant and starting a family at an early age is considered normal. Furthermore, “not all parents are equally knowledgeable about sexuality or feel comfortable discussing it with their children,” but “schools can provide the consistency and

medically accurate information that many students do not receive at home” (Perrin & Bernecki DeJoy, 2003, p. 453). In fact, “one-quarter of teens ages 15 to 17 have not had discussions with a parent or guardian about how to say no to sex or about birth control, condoms, or STDs” (Kaiser Family Foundation, 2006, p. 2).

The physical environment contributes to the sexual health of adolescents as well. Research has shown that “young people, particularly minors, face a host of barriers to health care, including limited access to transportation, lack of confidentiality and youth-friendly service delivery environments, fear about seeking care, and lack of information about services available” (Kaiser Family Foundation, 2006, p. 2). Teens need to know that there are safe environments available where they can confidentially ask questions and get the sexual health care they need.

Some adolescents are unaware of the services available to them, regardless of whether they have insurance causing a health care barrier; “among sexually active teens ages 15 to 17, only six in 10 have ever seen a health care provider about their sexual health” (Kaiser Family Foundation, 2006, p. 2). As a population, teens have a tendency to be mistrustful of health care providers regardless of the fact that “21 states explicitly allow all minors to consent to contraceptive services,” and “most other states allow minors to consent only under certain circumstances, such as marriage or risk to health” (Kaiser Family Foundation, 2006, p. 2).

Interventions

The focus of primary interventions surrounding responsible sexual behavior in the adolescent population should be education. It is critical to educate teens about their sexual health, contraception, and available resources “to prevent exposure to and acquisition of STDs” and pregnancy (Allender & Spradley, 2005, p. 213). Abstinence-only approaches have not been proven to have “any significant impact on participants’ initiation of intercourse, frequency of

intercourse, or number of sex partners,” but comprehensive programs “have been shown to help young people abstain or increase contraceptive use” (Kantor & Bacon, 2002, p. 39).

Furthermore, comprehensive, “theory-driven, school-based, multi-component programs with a clear message can enhance psychosocial variables and reduce sexual risk behaviors related to HIV, other STDs, and pregnancy prevention among high school students” (Coyle, et al., 2001, p. 92).

Sex education is not a burden that should be placed only on school nurses. As an additional primary intervention, nurses must educate parents as participants in their teen’s sex education because “studies have suggested that parent-child conversations about sexual matters are associated with delays in initiation of sexual activity and with increased use of contraceptives by adolescents who engage in sexual intercourse” (Allender & Spradley, 2005, p. 213).

An important secondary intervention is to screen teens to make sure that if they have an STD, that it is caught early and treated promptly. To do this effectively, “the number of clinics offering STD screening, diagnosis, treatment, counseling, and referral services should increase substantially to improve access to comprehensive services” (Allender & Spradley, 2005, p. 213). At the tertiary level, it is important to intervene on behalf of those adolescents who need follow-up care after contracting an STD or getting pregnant. Staffing a clinic with health care providers who are specially trained to meet the health care needs of adolescents would help meet these teens tertiary care needs (Allender & Spradley, 2005, p. 213).

Nurse’s Role

In exploring how best to encourage responsible sexual behavior in teens, populations-health nurses must consider that “teen sexual activity is driven by a complex interplay of forces, including social, familial, economic and educational factors,” and we have the greatest potential

to prevent the negative consequences of sexual activity through comprehensive health education efforts (Perrin & Bernecki DeJoy, 2003, p. 446). Nurses have to work in conjunction with teens, their parents, their schools, and even the government to promote sexual health and link teens to their available resources. Above all, populations-health nurses must advocate for the members of the adolescent population and strive to equip them with the knowledge they need to make responsible sexual health care decisions.

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Nurses and MRSA: Stopping the Spread

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Nurses and MRSA: Stopping the Spread

Methicillin-resistant *Staphylococcus aureus* (MRSA) may seem like the newest epidemic spreading around communities, long-term care facilities, and hospitals, but in reality it has been lingering around since the 1940's. The first strain of MRSA was discovered over 60 years ago, not long after penicillin was introduced into the medical world. Penicillin was found to be highly effective against infections from the *Staphylococcus* family, but strains of *S. aureus* found a way to beat the antibiotic. The resistant strains of *S. aureus* produce the enzyme beta-lactamase, which destroys the beta-lactam ring that surrounds the penicillin molecule, thus inactivating penicillin (Bissett, 2005). *S. aureus* may sound like a genius bacterium to be able to develop this beta-lactamase and resist antibiotics, but hospitals and healthcare workers lent an unwitting hand by acting like a Petri dish for this organism. The development of MRSA, or the resistant *S. aureus*, is mainly due to several findings in hospitals that are highly common. Researchers believe MRSA has developed due to poor hand hygiene, overcrowded hospitals with sicker patients, and heavier nursing loads (Bissett 2005). Additionally, the increasingly unnecessary use and overuse of antibiotics exacerbated the spread of MRSA (Rao, 1998).

MRSA is probably the most common antibiotic-resistant bacterium found in hospitals throughout the world (Rao, 1998). MRSA is mainly seen in the nasal area of patients, but it is also seen in the groin, axilla, and gut (Sheff, 1999). The risk factors, which are not uncommon findings in patients, include frequent and extensive use of broad-spectrum antibiotics, prolonged hospitalization, and the presence of a decubitus ulcer or prosthetic intravascular device (Rao, 1998). Many patients who are admitted to hospitals arrive with at least one of these risk factors, and once a single patient contracts MRSA, it is easily spread from room to room. These issues make the need for nurses to take action to reduce MRSA cases in hospitals incredibly pertinent.

The following research articles make several suggestions to decrease the spread of MRSA that are realistic to implement in the hospital.

Review of Literature

Although MRSA has numerous causes, one individual is uniquely empowered to stop its spread: the nurse. MRSA most commonly spreads through hand contact (Kilpatrick, 2006). The amount of skin-to-skin contact nurses have with a given number of patients a day makes MRSA spread from one patient to another easily. Good hand hygiene is the single most important measure in preventing the transmission of MRSA and all nosocomial infections (Winter, 2005). With each patient visit, the nurse should wash his or her hands before and after entering the room. This should be common practice, but shockingly, “hand hygiene compliance is low...in health services,” (Knifton, 2005, p. 40). MRSA can live on hands for up to three hours if nurses do not wash their hands or do not wash them properly (Sheff, 1999).

Many hospitals have started to use alcohol-based hand gels and disinfectants as a simple way to disinfect hands without employing soap and water. This speedy solution is also exceedingly effective at eradicating germs and bacteria on hands if they are not visibly soiled. Some are reluctant to abandon soap and water, but a recent three-year study found that alcohol-based disinfectants are just as effective and easier on the staff to use. The study showed that hand hygiene compliance improved from 48% to 66% among health care workers with access to alcohol-based disinfectants. Most importantly, this increase in hand hygiene coincided with a reduction in MRSA’s transmission (Winters, 2005, p. 18). This study highlighted how easily MRSA spreads and how simple it is to decrease it. Everyone that comes into direct contact with patients must practice proper hand washing techniques.

Given MRSA's prevalence, universal MRSA screening is a hotly debated issue in hospitals. Universal screening is tremendously appealing, but can be prohibitively expensive. Routine post-admittance screening is ineffective because colonized patients can become recolonized following treatment within a short amount of time (Bissett, 2005). Screening completed upon admission may prove beneficial.

There are measures nurses can take before they start giving care if they know their patients have MRSA. Interventions such as private rooms and contact isolation precautions are effective methods for decreasing the transmission of MRSA (Bissett, 2005). Keeping all the patients with MRSA in the same area with the same nurse is another successful, but difficult strategy to implement. (Sheff, 1999). A nurse with a single MRSA-infected patient runs the risk of spreading it to the others, especially if they have open wounds, which are easy targets for MRSA. Once placed in a room, a patient with MRSA should never be transferred to a different ward. Patients commonly go from ward to ward as they improve or need additional attention, but sending a MRSA-positive patient around the hospital begs for the infection to spread to even more patients (Rao, 1998).

A huge factor in the increasing cases of MRSA is the overuse and improper use of antibiotics; unfortunately, this is the hardest factor to resolve. When patients use antibiotics for extended periods of time or take their prescriptions improperly, it allows the drug-resistant infections to arise. This happens because "with the improper use of antibiotics, weaker bacteria are killed, but stronger, more resilient ones live on and reproduce" (Stirling, Littlejohn, & Willbond, 2004, p. 19). In today's medical environment, medical personnel commonly treat patients with a disease caused by a virus with an antibiotic. All cases of the antibiotic-resistant bacteria around the world are connected to "indiscriminate antibiotic prescribing practices, poor

compliance and the unregulated availability of these drugs” (Rao, 1998, p. 328). Worse yet, this careless practice cannot be remedied as easily as hand hygiene problems or stricter isolation precautions. The real solutions are developing new antibiotics or looking into alternatives like vaccines (Rao, 1998). If new antibiotics are discovered, extra precautions should be taken to ensure that history does not repeat itself; *S. aureus* has the ability to build-up resistances to even the newest and strongest antibiotics.

Nurses have the ability to help with drug noncompliance by educating their patients about their medications. Many patients will be discharged from the hospital while using antibiotics and nurses need to stress the importance of using them correctly. It is the nurse’s responsibility to ensure that patients leaving the hospital know how to take their prescription properly, on time, and until the end of their prescribed dosage. Drug noncompliance is an enormous factor in the spread of antibiotic-resistant bacteria; patients must be educated on their prescriptions, not just treated for their infection.

Conclusion

MRSA is a growing problem and it is imperative that nurses act immediately to stop it. It is treatable currently with vancomycin, but recently strains of *S. aureus* have even become resistant to this antibiotic. Nurses must remember the importance of hand hygiene, isolation precautions and antibiotic education. These tasks, though simple, will greatly reduce MRSA’s spread.

Without serious interventions implemented in hospitals, it will be nearly impossible to stop this powerful bacterium. For this reason, it is important to remember that, “As known organisms mutate and unfamiliar ones emerge, nurses are the healthcare professional in the best

strategic position to respond” (Stirling et al., 2004, p. 20). The steady incline of MRSA is eye-opening, but nurses are uniquely empowered to confront it.

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