

Editorial

Welcome to this the third issue of *The Journal of Undergraduate Nursing Writing*. In its third year, this journal continues with its tradition as a compilation of original articles written by senior nursing students in the Bachelor of Science in Nursing program at the University of Kansas School of Nursing. This year we are additionally proud to be able to say that this journal was recognized in 2008 with a Regional Excellence Award from Sigma Theta Tau International.

This third issue has strayed little from our initial conception for this journal. That is, to offer the seniors at the School of Nursing a showcase for their thinking and writing abilities. Over the last few years we have been increasingly impressed with the ability of the senior students. It is with great pleasure that we bring you this third edition.

With this issue, we followed the format of the first two issues by starting with a call for papers sent to the seniors explaining the idea and the requirements for contributing their articles. This year we received more than 20 articles. After a peer review, eight were selected that met the standard set for publication.

These articles originated as assignments given in two senior-level classes. The original call for papers did not limit their entries to any particular classes, but all papers received came from the Populations or Legal/Ethical Foundations of Professional Nursing courses. Thus, the content represented here deals with legal, ethical, or population issues.

Writing about these issues was not easy. These authors all showed an ability to describe these issues in their own manner while using sophisticated resources. Examples of topical choices include the savior child, mandating the HPV vaccine, bariatric surgery in children, use of forceps in labor, underreporting of suspected child abuse, open and closed adoption, sex education controversies, and opt-out testing concerns for HIV positive people. All of these articles contain the same element of being uniquely written in the style of today's graduating nursing student.

This endeavor would not have been possible without the support of several dedicated individuals and organizations. The Dykes Library staff at the University of Kansas Medical Center campus were wonderful, particularly Karen Cole and her staff for their vision, direction, & technical ability without which this project would never have happened. Of particular recognition is Jason Stirnaman, who has supported our efforts with his expertise in the use of the technology for distributing these articles. Delta Chapter of Sigma Theta International provided the financial support along with the positive encouragement of the Chapter Executive Board. Without this, the prizes each author received for the selection of their article would not have been possible. Lastly, we commend the faculty and staff at the University Of Kansas School Of Nursing for their patience and responsiveness as we sorted through all the issues necessary to make this happen. We would have been lost without their willingness to listen and share their own personal experiences.

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

Editor:

David Martin, RN, MN
Clinical Assistant Professor

Associate Editors:

M. Kathleen Brewer PhD, APRN,BC
Associate Professor

Lynne Connelly, PhD, RN
Assistant Professor

The Influence of Sex Education on Adolescent Health:

Abstinence-Only vs. Comprehensive Programs

Tara Blackburn

The University Of Kansas School of Nursing

About the author:

A native of Overland Park, Kansas, Tara plans to begin her career working with newborns with an emphasis in the Neonatal Intensive Care Unit. Her long-term plans include working in her dream job for a few years and eventually returning to school for a graduate degree in pediatric nursing.

The Influence of Sex Education on Adolescent Health: Abstinence-Only vs. Comprehensive Programs

We live in a time period of infinite debate and deliberation. From politics, to presidents, sex education, and sex preferences; individuals in this nation can't seem to just agree. The views of individuals in our nation are torn, each seeing the future in a different perspective and different colored light. But one thing many people do agree on is the need to improve the health and prosperity of the nation for the future. But how can this be done? One intense debate to improve future success along with mental and physical health of young adolescents involves contrasting sex education programs. Should today's youth be provided with information in school about safe sex practices in order to protect themselves from rising STD, HIV, and teenage pregnancy rates, or should they be taught that abstaining from sexual activity until marriage is the only way?

Abstinence-only education is a program that teaches adolescents to abstain from sexual activity until marriage, and restricts information about the use of condoms and contraceptive measures to only failure rates. Alternatively, comprehensive sex education informs youth that abstaining from sexual activity is the best preventative strategy, but still provides information on pregnancy, STD's, and the use of condoms and other contraceptive measures to promote safe sex practices (Masters, Beadnell, Morrison, Hoppe, & Gillmore, 2008). The purpose of this paper is to discuss these two diverse stances on sex education and identify the benefits that comprehensive sex education can have on the sexual activity and health of young adolescents. It is important to better understand the effects that differing types of sex education can have on adolescent health in order to improve primary prevention measures and teaching strategies and prevent harmful sexual consequences.

Review of Literature

According to the Center for Disease Control and Prevention (2008), birth rates and pregnancies among 15-19 year old teenage girls have declined 34 percent since 1991, but increased for the first time in 2006 by six percent. Reported HIV diagnosis in 15-19 year olds have also increased 34 percent from 2003 to 2006. Along with an eight percent increase in gonorrhea infection rates from 2004 to 2006, an estimated 19 million sexually transmitted diseases occur each year with a vast majority of those infected being adolescents (almost 50 percent) (Masters, Beadnell, Morrison, Hoppe, & Gillmore, 2008). These inclining rates of STD's and pregnancies in the youth population flame the debate regarding which type of sex education will improve these health outcomes.

In 1996, the government formed and initiated section 510 (b) of Title V of the Personal Responsibility and Work Opportunity Reconciliation Act. This act along with an Abstinence Education Grant Program and the Adolescent Family Life Act of 1981, require that sex educational programs focus on their eight point definition of abstinence in order to receive federal funding. Programs must also exclude any information about contraception in order to truly be abstinence-only-until-marriage based. There has been over one billion dollars spent on funding these programs in schools since 1996, despite little research done on the effectiveness of abstinence-only teaching (Lindau, Tetteh, Kasza, & Gilliam, 2008).

Supporters of abstinence-only education believe that teaching about contraceptive measures and pregnancy, will in turn promote adolescents to engage in sexual promiscuous behaviors. These supporters believe that teaching only about abstinence will delay the onset of sexual activity. Virginity pledges have been used in abstinence education as a tactic to influence students to make a pledge of abstinence. Bersamin, Walker, Waiters, Fisher, & Grube (2005) conducted a study which

examined the association between formal and non-formal virginity pledges and the effect these pledges have on sexual activity. The authors concluded that the formal virginity pledge did not appear to reduce the likelihood of abstaining from sexual intercourse or oral sex until one was older. Another study by Bruckner & Bearman (2005) revealed there was no significant difference between students who took a virginity pledge, and those that did not, and that the individuals who made the pledge were less likely to use contraception measures when engaging in sex. These results may indicate that in abstinence only programs, individuals who become sexually active will be uneducated about ways to protect themselves and will be at an increased risk to engage in risky and unprotected sex.

Kohler, Manhart, and Lafferty (2007) conducted a study to evaluate the effect of abstinence-only and comprehensive sex education on the initiation of sexual activity, risk of teen pregnancy, and prevalence of STD's. This study concluded that abstinence only education did not prevent adolescents from engaging in intercourse or delaying first sexual encounters as compared to comprehensive teaching. It also stated that adolescents with comprehensive sex education had a 50% reduced risk of becoming pregnant. Although there was no significant difference of STD rates in either program, an adolescent formally educated about STD's in a comprehensive program, might be more likely to get tested, diagnosed and treated.

Contraception use is an important aspect in sexually active individuals. In a 2004 congressional report, two thirds of abstinence only education programs were reported to have been giving teen's inaccurate information about contraceptive measures and the risks of abortion. Consequently, many states declined federal government funding for abstinence school programs (Kotz, 2007). As a result of this inaccurate information, many adolescents may abstain from using any type of birth control, condoms, or protection due to the implication that it is not very effective.

This type of inconsistent information can result in increased prevalence of sexually transmitted diseases.

A CDC reproductive health article states that “About one-third of girls in the United States get pregnant before age 20” (CDC, 2008, p. 1). It also states that teen girls who have a child when they are 15 to 19 years old are more likely to not finish school, live in poverty, and not receive proper prenatal care as compared to other adolescents. If approximately one third of adolescent girls become pregnant before the age of twenty, it seems obvious that many more are sexually active. Abstinence-until-marriage programs are designed to encourage adolescents to remain virgins until they are married, consequently, leaving out all of the teenagers who may already be sexually active. The decline in teen pregnancies has been primarily due to the fact that adolescents have been increasing their use of contraception and not because they are abstaining from sex (CDC, 2008).

In a study by Masters, Beadnell, Morrison, Hoppe, and Gillmore (2008), the researchers looked at what teenagers thought about abstinence instead of parent, teacher, or government views. Every adolescent has a mind of their own, and abstinence-only programs can affect these individuals in different ways. Abstinence-only education is deemed successful by evaluators of these programs, when it has impacted the “attitudes and intentions about abstinence.” This study found that many teenagers do not view abstinence and sexual activity as a black and white picture. An individual with a positive “attitudes and intentions” about abstinence will not necessarily abstain from sexual activity.

A study focused on sex education curriculums concluded that nearly one in three sex education teachers were not trained in sex education and many teachers were not comfortable discussing sexuality. These teachers often omitted important educational points because of the discomfort, lack of teaching materials, and lack of experience and skills (Lindau et al., 2008).

Physicians and nurses need to be aware that in any sex education program teens may be uninformed, misled, and lack the information they need to protect their health.

Conclusion

There have been many increases in the rates of negative sexual outcomes in the adolescent population. Rising STD rates and teen pregnancies are an indication that adolescents need more education, and need to be more aware of sexual consequences. Although remaining abstinent is strongly supported by both parents and adolescents alike, abstinence-only programs can provide inaccurate and misleading information that teens need in order to protect themselves. The literature that has been viewed in this paper shows that in order to decrease the rates of teen pregnancy, HIV, and other STD's children must be informed about the consequences of their actions and ways to prevent these through a comprehensive sex education program.

Although promoting abstinence and waiting to have sex until marriage is a very good and beneficial concept, abstinence-only programs are not the best way to protect all teens because not all teenagers are going to stay abstinent. In the perfect society, parents would discuss sexuality issues, values, and religion with their children so the curriculum would not be left up to the taxpayers to choose, but unfortunately, not all parents do. As a nurse it is essential to provide young patients the information that those parents, schools and the government try to leave out. As advocates for our patients, it is important to teach them the things they need to know in order to grow and develop into a healthy adult making healthy sexual choices.

References

- Bersamin, M.M., Walker, S., Waiters E.D., Fisher, D.A., & Grube, J.W. (2005). Promising to wait: Virginity pledges and adolescent sexual behavior. *Journal of Adolescent Health, 36*, 428-436.
- Bruckner H., & Bearman P.S. (2005). After the promise: The STD consequences of adolescent virginity pledges. *Journal of Adolescent Health, 36*, 271-278.
- Center for Disease Control and Prevention. (2008). Adolescent Reproductive Health: Home. Retrieved November 6, 2008, from <http://www.cdc.gov/reproductivehealth/AdolescentReproHealth/>
- Center for Disease Control and Prevention. (2008). Trends in HIV-and STD-Related Risk Behaviors Among High Schools Students---United States, 1991—2007. *Morbidity and Mortality Weekly Report, 57*(30), 817-822. Retrieved November 6, 2008, from <http://cdc.gov/mmwr/preview/mmwrhtml/mm5730al.htm>
- Kohler, P.K., Manhart, L.E., & Lafferty, W.E. (2007). Abstinence-Only and Comprehensive Sex Education and the Initiation of Sexual Activity and Teen Pregnancy. *Journal of Adolescent Health, 42*, 344-351.
- Kotz, D. (2007). A debate about teaching abstinence; Teen births have ticked up after a long decline. Is sex education the reason? *U.S. News & World Report, 143*(23), 28.
- Lindau, S.T., Tetteh, A.S., Kasza, K., & Gilliam, M. (2008). What schools teach our patients about sex: Content, quality, and influences on sex education. *American College of Obstetricians and Gynecologists, 111*(2), 256-266.

Masters, N.T., Beadnell, B.A., Morrison, D.M., Hoppe, M.J., & Gillmore, M.R. (2008). The opposite of sex? Adolescents' thoughts about abstinence and sex, and their sexual behavior. *Perspectives on Sexual and Reproductive Health, 40*(2), 87-93.

Santelli, J., Ott, M.A., Lyon, M., Rogers, J., Summers, D. (2006). Abstinence-only education policies and programs: A position paper of the Society for Adolescent Medicine. *Journal of Adolescent Health, 38*, 83-87.

Why Nurses Underreport Suspected Child Abuse Cases

Kidist Daka

The University Of Kansas School of Nursing

About the author:

A native of Addis Ababa, Ethiopia, Kidist received a Clinical Excellence Honorable Mention award from the School of Nursing for her exceptional work in interacting and meeting the health care needs of Pediatric patients. She is the recipient of the Goppert and Maude Landis Nursing Scholarship. Her long-term plans are to return to Ethiopia and work with children in orphanages or who have lost their parents. Short term, Kidist sees herself as working in a pediatric-oriented environment and furthering her education. She writes, "As a mother and a future nurse, I feel that we need to make our voices heard and become advocates for children who are abused every day. No child deserves to be abused, but should be safe, healthy, and happy."

Why Nurses Underreport Suspected Child Abuse Cases

In 2006, approximately 906, 000 children in the United States were victims of abuse and neglect, and an estimated 1,500 children died (Anonymous, 2008). Federal laws require each state to have their own definition of child abuse and neglect with an identified minimum set of actions or behavior. Federal law defines child abuse and neglect as any type of recent act by the parent or caretaker that results in death, serious physical or emotional harm, sexual abuse, and an act that presents an imminent risk of serious harm to a child. Child abuse can be classified as physical, sexual, and emotional. Child neglect is also a form of abuse (Anonymous, 2007).

Between the years 1963 to 1967, the federal government enacted the first mandatory reporting laws (Mathews & Kenny, 2008). This reporting duty was designated to health care professionals, social workers, teachers, and childcare providers who are likely to encounter children on a daily basis due to their nature of work. The purpose of this paper is to identify some of the factors that influence health professionals to underreport child abuse or neglect cases. This issue is particularly important in nursing because of nurses' close contact with children, parents, and family members.

Review of Literature

Any person can report child abuse and neglect. However, as mentioned above professionals who are in routine contact with children are legally mandated to report suspected child maltreatment. Typically, if a reporter in his or her official capacity suspects or has reasons to believe that a child has been abused or neglected, he/she should report the incident to Child Protective Services (CPS) immediately. The reporter should also report the source of suspected abuse (parent, adult caregiver, or legal guardian, and the types of abuse (physical, emotional, sexual, psychological and neglect) (Depanfilis, 2006).

Some states also require reports of other types of abuse to children like exposing children to illegal drugs, use of drugs by caregiver impairing ability to adequately care for child, exposing child to criminal distribution, production, and manufacture of drugs, etc. Reporters should contact the Child Protective Services (CPS), who initiates the assessment, investigation, and removal (if warranted) of the child. However, studies have shown that not all of the child abuse and neglect cases recognized by professionals were reported to CPS (Mathews & Kenny, 2008).

Issues with underreporting

Nurses' are key assets in the community in identifying child abuse and neglect cases. It is important to remember that nurses' are not only care providers, but also advocates and voices of the children who are victimized and neglected. In fact, Fluke, Shusterman, Hollinshead, & Yuan (2008) noted that initial reports made by health care professionals would be intervened swiftly by CPS. This agency more likely finds victimization in children that were reported by health care professionals. This illustrates the need for nurses' to be vigilant when dealing with suspected child abuse cases.

Several factors can be identified as to why health care professionals underreport suspected child abuse cases. The inexperienced nurse who lacks confidence and fears being wrong on his/her assessment of the suspected child abuse case may not intervene and report. The nurse may also feel guilty about the consequences of his/her report if the child is removed from home and put in foster care (Jones et.al).

Greipp (1997) found out that nurses often underreport because of their own personal history with child abuse. For example, if a nurse experienced abuse as a child or knows someone close who had been abused as a child may feel that it is "ok" and considers it as part of life. In addition, the perception that children who are abused will come forward and will reveal the fact

that he or she is being abused will alter the nurse's decision-making in reporting since children who are abused will simply hide their distress and may not open up.

Similarly, the nurse's personal biases or cultural experiences could lead to underreporting of child abuse cases. For example, if a nurse observes a child who is acting out and appears to be a "*brat*", then the nurse might ignore the bruises on the child's body thinking it was from the child's aggressive nature. Cultural experiences like believing that parents have full right to discipline, restrain, and punish their own children, could lead the nurse not to intervene in suspected child abuse cases (Greipp, 1997).

Sanders & Cobley (2005) found out that there is a "*culture*" of underreporting of non-accidental injuries in children in hospital emergency departments mainly because a significant number of medical or nursing staff do not have formal education in identifying potential indicators of child abuse. Therefore, many rely on the pediatrician or the medical doctor to assess and give his/her opinion about the case. The case may go underreported if there is no rapid access of pediatrician or medical doctor.

Jones et.al, (2008) conducted a study with primary care physicians on whether they reported suspected child abuse cases and found that only 73% of the injuries were reported to CPS even when the physician had the highest level of suspicion that there would be a possible child abuse. In this study, the physicians reported that they did not report the case to CPS because of anticipated negative child or family consequences of a report. They also reported, despite their report to the CPS, they have not taken action on the case or CPS may investigate but will close the file without further action.

Conclusion

In summary, child abuse is a global problem that is increasing in frequency. Here in the United States, thousands of children are abused and neglected each year. Although Federal law mandates health care professionals, teachers, social workers to report suspected child abuse cases, society as a whole should bear the responsibility of reporting cases of child abuse to the appropriate governmental agency. However, findings of this report demonstrate that there is significant lack of detection and underreporting among health care providers and nurses. Factors identified as reasons for underreporting include lack of knowledge in and assessment skills by nurses' when dealing with a suspected child abuse case. In addition, personal history and bias related to abuse, and the impression that CPS will not intervene as required are some of the other reasons of underreporting.

Reporting suspected child abuse cases is not only a legal obligation, but also an ethical and moral obligation. As future nurses, we all must remember that we are advocates for the children who are being abused and injured every day – we have to make sure it never happens again. The nurse is responsible for applying ethical principles as it relates to particular child abuse cases. A nurse who actively seeks to intervene in suspected child abuse cases has simply applied the ethical principle beneficence – that directs the nurse toward doing good for the client. To ignore a suspected abuse case would be a violation of non- maleficence – doing no harm to the client. By reporting a suspected child abuse case, the nurse will promote justice and follows mandatory reporting laws.

References

- Anonymous. (2007). Definitions of child abuse and neglect. Retrieved October 11, 2008, from http://www.childwelfare.gov/systemwide/laws_policies/statutes/define.cfm
- Anonymous. (2008). Preventing child abuse and neglect. Retrieved October 11, 2008, from <http://www.childwelfare.gov/pubs/factsheets/preventingcan.pdf>
- Depanfilis, D. (2006). Child neglect: A guide for prevention, assessment, and intervention. Retrieved October 18, 2008, from <http://www.childwelfare.gov/pubs/usermanuals/neglect/neglect.pdf>
- Fluke, D.J, Shusterman, R. G, Hollinshead, D.M, and Yuan, T. Y. (2008). Longitudinal analysis of repeated child abuse reporting and victimization: Multistate analysis of associated factors. *Child Maltreatment*, 13; 76. Retrieved October 15, 2008, from CINAHL with Full Text database.
- Greipp, M. (1997). Ethical decision making and mandatory reporting in cases of suspected child abuse. *Journal of Pediatric Health Care*, 11(6), 258-265). Retrieved October 18, 2008, from CINAHL Plus with Full Text database.
- Jones, R., Flaherty, E., Binns, H., Price, L., Slora, E., Abney, D., et al. (2008). Clinicians' description of factors influencing their reporting of suspected child abuse: Report of the Child Abuse Reporting Experience Study Research Group. *Pediatrics*, 122(2), 259-266. Retrieved October 15, 2008, from CINAHL Plus with Full Text database.
- Mathews, B. & Kenny, M.C. (2008). Mandatory reporting legislation in the United States, Canada, and Australia: A cross-jurisdictional review of key features, differences, and issues. *Child Maltreatment*, 13(1), 50-63. Retrieved October 11, 2008, from CINAHL Plus with Full Text database.

Sanders, T., & Cobley, C. (2005). Identifying non-accidental injury in children presenting to A&E departments: An overview of the literature. *Accident and Emergency Nursing*, 130(7). Retrieved October 15, 2008 from Expanded Academic ASAP. Gale. Kansas Univ Med Coll - Dykes Library.

The Savior Child: Having a Child to Save a Sibling...Is this Right?

Whitney Fasbender

The University Of Kansas School of Nursing

About the author:

A native of Cheney, Kansas, Whitney was inducted into Delta Chapter – Sigma Theta Tau International in May 2009. While at the KU School of Nursing, she received a Clinical Excellence Award for her work with a populations-based health care project. Whitney is the recipient of the AmeriCorps Education Award for Careers for the Common Good. She has also received the Goppert scholarships, The Lora C. And Sam R. Woods Scholarship and the KUMC Bookstore Scholarship. After graduation, she plans to work in the Surgical/Trauma Intensive Care Unit at Via Christi Regional Medical Center, Wichita, Kansas. In the future, Whitney would like to be able to merge her journalism interests with graduate education in advanced practice nursing.

The Savior Child: Having a Child to Save a Sibling...Is this Right?

Imagine you are a parent of a sick child who is dying from a severe medical condition and whose only chance of living is to find a near perfectly-matched donor for blood or marrow transplantation. Now, imagine you've been told there is a procedure which will allow you, as parents, to conceive another child that will be a perfect blood match to your sick child and will ultimately be able to save your child's life. Ethically, is this right?

Preimplantation genetic diagnosis (PGD) is a procedure that gives hope to desperate parents in the midst of losing a dying child. However, there are several ethical and moral issues concerning whether or not parents should be allowed to use PGD in order to create a child merely on the basis of saving the life of another child. This paper will examine the ethical issues surrounding using PGD in order to conceive a matched-donor child to save the life of a sibling.

Review of Literature

What is Preimplantation Genetic Diagnosis?

Preimplantation genetic diagnosis (PGD) is an early form of pre-natal diagnosis (Hashiloni-Dolev & Shkedi, 2007). It is a procedure in which a biopsy is taken from an embryo previously fertilized outside of a woman's womb to determine different characteristics about that embryo prior to in vitro fertilization and implantation. Its first reported successful use was in 1989, in a case in which it was used to avoid the implantation of an embryo that was "affected by a mutation or chromosomal abnormality associated with serious illness" (Wolf, Kahn, & Wagner, 2003, p. 327). Since then, PGD has controversially been developed and used for "family balancing" based on choosing the sex of a child and, most controversially, to "create a child who is Human Leukocyte Antigen (HLA)-matched with a preexisting sibling in need of stem cell transplants" (Wolf et al., 2003, p. 327). Using PGD in this fashion "allows a parent to

select an embryo free from serious genetic disease and simultaneously select for a tissue match so that the umbilical cord blood of the resulting baby can provide stem cells to treat a seriously ill sibling” (Spriggs, 2005, p. 341). Future marrow and tissue donation may also be expected from the donor child, which further intensifies the ethical debate.

Ethical Controversies Concerning PGD and the “Savior Child”

Wolf et al state that “PGD to avoid serious and early-onset illness in a child-to-be is widely accepted” (2003, p. 327). This is because the screening of an embryo will reduce the chances of parents having a child affected by a genetic or chromosomal disorder in which the parents may be faced with the decision of having to abort the child or live with the challenges associated with raising an ill or disabled child (Wolf et al., 2003). However, a controversy arises when using PGD solely for HLA typing because “when PGD is used to test for genetic diseases, that testing is done in the *best interest* of the embryo or the person it will become, whereas when PGD is used solely for tissue typing, the only benefit is for the existing sick child” (Devolder, 2005, p. 583). However, Devolder (2005, p. 583) believes, “PGD is not a cure, it is a selection procedure. An embryo is selected because of genetic characteristics it already had.”

The basis of creating a child to save the life of another child is that “transplantation from an HLA identical sibling is associated with a much higher success rate than a transplant from alternative donors” (Devolder, 2005, p. 582). The ethical debate regarding this issue incorporates the extent to which a child can be expected to be a “life long donor subject to repeated tests and procedures” (Wolf et al., 2005, p. 330), as well as the risks associated with procedures and the extent of bodily invasion. According to Devolder (2005, p. 584),

“...the standard employed is what would be acceptable if the donor child already existed. Umbilical cord blood harvest is widely accepted since it entails no physical intrusion. Bone marrow donations from young children to siblings are also widely accepted.

Harvesting vital organs from children is not acceptable in view of the risks involved for the donor child.”

To some, PGD to create a “Savior Child” is merely conceiving a child as an instrument to cure another child (Knoppers, Bordet, & Isasi, 2006). In today’s society though, parents have children for all different sorts of instrumental reasons. Some of these reasons include benefits to the couple’s marriage, continuity of the family name, economic and psychological benefits to the parents upon aging and providing a playmate for an existing child (Devolder, 2005). According to Knoppers et al. (2006, p. 212),

“...most parents have a broad range of reasons and expectations when they decide to have children, which also instrumentalizes them to a degree, leading some authors to conclude that, as long as the tissue donation would be ethical if performed on an existing child, bringing a child into the world to serve as a tissue donor is ethical if the child is also valued for him or herself.”

Those in favor of this practice ascertain it is acceptable “as long as the parents intend to rear and love the donor child” (Wolf et al., 2003, p. 330). “The fact that these parents make so much effort to try to save their child suggests they are caring and loving parents and makes it very unlikely they will treat the new baby as a ‘bred to order child’” (Devolder, 2005, p. 584).

Another ethical dilemma that has yet to be thoroughly investigated is the psychological ramifications to the donor child knowing he or she had been selected for the purpose of saving a life. Other psychological factors include “whether the child’s welfare is subordinated to that of the sick sibling, whether initial tissue donation is successful or further donations are required, and whether the sick child ultimately is cured or dies” (Knoppers et al., 2006, p. 212-213).

The Moral Issues

Because PGD involves the process of picking viable embryos and discarding unacceptable embryos, the question of abortion is ultimately raised in whether or not it is an

acceptable procedure. According to Knoppers et al. (2006, p. 203), two main points of view are debated. They are:

(a) the embryo is a new human life entitled to full moral status from the time of fertilization, because from that time it holds the potential to develop into a complete human being, or

(b) the embryo has some moral status from fertilization, but to a lesser extent than a born human being, and gradually acquires “full” moral status during development.

Wolf et al. (2003, p. 330) asserts that “creating and discarding healthy embryos for lack of HLA-compatibility with the affected sibling is consistent with currently accepted embryo practices”.

Hashiloni-Dolev and Shkedi (2007) believe there are three main objectionable moral issues concerning PGD. The first is from those people who think embryos are people and should have human rights at the earliest point of conception. These people oppose the selection and discarding of embryos as a whole. The second objection pertains to the act of “selecting” an embryo. Some people feel this process is unnatural and produces a “manufactured good”. The third objection deals with the future rights of the unborn child and how all children, once again, should “always be treated as an end in itself and never merely as a means” (p. 2082).

In defense to the abortion issue, Hashiloni-Dolev and Shkedi (2007, p. 2082) reported two arguments that “failure to implant a pre-embryo is morally preferable to killing a more developed fetus” and “since pre-natal diagnosis in general is widely accepted, there is no reason to single out PGD and ban it.”

Conclusion

Preimplantation genetic diagnosis is a procedure that, while associated with many ethical and moral controversies, could potentially be the future in changing the way certain fatal medical

conditions are treated where the life of a sibling is concerned. The positive aspects of allowing PGD to be used to ensure that a perfectly-matched embryo is implanted into the mother would have life altering effects for the parents and the child involved, including the possibility of curing the disease. However, ethical issues concerning the well being of the conceived child would always be at stake, including risks associated with the harvesting procedures, the future psychological health of the child, as well as the ethical and moral issues involving the procedure itself.

The intent of this paper was not to decide whether or not using PGD in hopes of producing a “savior child” is right or wrong, but was to make one aware of the controversies surrounding PGD and having a child to save the life of another child. I would like to see future research done on the psychological effects on the donor child when they become of age to fully understand the intentions of their parents when they were conceived. I, however, do believe that Spriggs (2005, p.341) stated a good point when he reported that the British Medical Association said, “As doctors, we believe that where technology exists that could help a dying or seriously ill child, without involving major risks for others, then it can only be right that it is used for this purpose.”

References

- Devolder, K. (2005). Preimplantation HLA typing: Having children to save our loved ones. *Journal of Medical Ethics, 31*, 582-586.
- Hashioni-Dolev, Y. & Shkedi, S. (2007). On new reproductive technologies and family ethics: Pre-implantation genetic diagnosis for sibling donor in Israel and Germany. *Social Science & Medicine, 65*, 2081-2092.
- Knoppers, B. M., Bordet, S., & Isasi, R. M. (2006). Preimplantation genetic diagnosis: An overview of socio-ethical and legal considerations. *Annual Review of Genomics and Human Genetics, 7*, 201-221.
- Spriggs, M. (2005). Is conceiving a child to benefit another against the interests of the new child? *Journal of Medical Ethics, 31*, 341-342.
- Wolf, S. M., Kahn, J. P., & Wagner, J. E. (2003). Using preimplantation genetic diagnosis to create a stem cell donor: Issues, guidelines & limits. *Journal of Law, Medicine & Ethics, 31*, 327-339.

Open versus Closed Adoption

Emily Gray

The University Of Kansas School of Nursing

About the author:

A resident of Olathe, Kansas, Emily is the recipient of a Level I Clinical Excellence Award from the School of Nursing and several School of Nursing Academic Scholarships. Following graduation, she plans to begin her career as a registered nurse on the Medical Transplant Intensive Care Unit at the University of Kansas Hospital. She later plans to pursue Nurse Anesthesia to become a Certified Registered Nurse Anesthetist.

Open versus Closed Adoption

As a nursing student, I have had the opportunity to speak with high school students about the issues of teen pregnancy and parenting. One student in particular confided that she was having trouble deciding whether she should put her unborn baby up for adoption. This conversation prompted me to investigate the legal and ethical issues facing parents who decide to give their child up for adoption. Primarily, I wanted to understand the options available to the birth parent, and also, to weigh these against the legal arrangements in the best interest of the child.

An adoption takes place for several reasons, as a result of an unwanted pregnancy, lack of a proper home environment or numerous other reasons. Three main steps are taken when a child is adopted: the child must be legally separated from their birth parents; the child is transferred to the custody of a qualified adoption agency; and the final step involves the transfer of parents' rights and responsibilities. Here a crucial decision must be made about open or closed adoption. With open adoption, the birth parents will have involvement in the raising of the child as well as communication with the adoptive family during the child's life (Adoption, 2008). If a closed adoption is chosen, the birth parents lose all custody and visitation rights. In this situation both sets of parents remain anonymous to each other and any documents from either set of parents are kept private (Clinton, 1996). A choice of open versus closed adoption must be carefully considered. Nurses may care for parents facing such a dilemma, and should be knowledgeable about both open and closed adoption. While a nurse is not directly involved in the adoption process, he or she is a constant and trusted caregiver with frequent direct contact with patients needing help in acquiring information to make a decision. The purpose of this paper is to discuss

the positives and negatives of placing a child in a closed adoption arrangement as opposed to an open arrangement.

Review of Literature

Open Adoption

Increasingly common nowadays is the open adoption process accounting for approximately 70% of domestic adoptions (Schwarzwald, 2008). An open adoption is one in which birth and adoptive parents interact during the adoption process. The degree of openness varies and usually is agreed upon by all of the involved parties (Schwarzwald, 2008). As a general matter, the birth parents have a voice in choosing their child's adoptive parents. Agencies give the birthparents biographies of prospective adoptive parents, and the birthparents pick the family with which they are most comfortable. Both sets of parents meet, and might be in touch frequently during the pregnancy. Many times the adoptive parents are able to witness their child's birth. Open adoption removes the mystery from the adoption process and can permit a greater degree of control in the decision-making (FindLaw, 2008). Little data is available regarding the impact of open adoption on the members of the adoption triad (adoptive parents, birth parents, and child), but advocates of open adoption argue that it helps the birth parent with grief and separation and diminishes the adoptee's identity crisis during adolescence (Schwarzwald, 2008). The open adoption process allows adoptive parents to better answer their children's questions about who their birth parents were, and why they were adopted. Open adoptions can also help the child come to terms with being adopted, because the child's concerns can be addressed directly by everyone who was involved in the adoption process (FindLaw, 2008).

There are downsides to open adoption. Many adoptive parents find the degree of openness to be a threat, fearing that the birthparents will intrude upon their lives, or even seek to

have the child returned to them (FindLaw, 2008). Consider the Debores family who adopted Jessica Schmidts when she was six days old. Some time after the adoption occurred, Jessica's birth parents married and decided that they wanted their child back. After a long court battle, the legal decision was to return Jessica to their birth parents. In this open-adoption scenario, a young child was taken from the only parents she knew and put in the custody of two strangers (Axness, 1997).

Closed Adoption

Closed domestic adoptions are decreasing, but were the norm until recently. The original birth certificate (if available) and adoption records are kept sealed by the courts and can be inspected only with court approval (Schwarzwald, 2008). Even if the adoptive parents and birthparents know of each other at the time of the adoption, they do not stay in touch after the adoption takes place. The child often will not know who his or her birthparents are, especially before turning 18 years of age (FindLaw, 2008). Closed adoption continues to be common when adopting internationally. According to the 2000 US census data, more than 250,000 (13 percent) of the country's two million adopted children were born outside of the United States (United States Census Bureau, 2000).

Some birth parents find a closed adoption arrangement appealing because of its private nature. Like the teenage mothers I spoke with in the high school, some pregnancies are unwanted and accidental. In a closed adoption setting, a mother would welcome the privacy of not having to share the embarrassment of becoming pregnant and lack of want or financial resources for the child. In addition, this arrangement gives birth parents a sense of closure and ability to move on with life. Of infants born to unmarried mothers aged 17 or younger, 8 % were placed for adoption (Chacko, 2008). Advocates for closed adoptions believe that birth mothers who have

continued contact with their children (as in an open adoption) have more difficulty with grief and separation; open adoption is more difficult for the adoptive parents and young adopted children (Schwarzwald, 2008). Adoptive parents might feel more comfortable in this setting as well.

There is no need to physically share the child with the birth parents, and it eliminates an intrusive-third party parent. Adoptive parents might also prefer the protection this setting provides their adopted child from unstable or emotionally disturbed birth parents (Child Welfare Information Gateway, 2008).

Interview

To gain further knowledge about both open and closed adoption arrangements spoke with a family about their recent adoption experience. Sherry Hanson (age 40) and her husband (age 60) brought home their adopted son, Sam, from China in August of 2008. Sam was born with a cleft lip and palate and consequently abandoned by his parents when he was less than 24 hours old. (personal interview with Sherry Hanson on October 19, 2008).

I asked Mrs. Hanson why her family decided to adopt internationally versus domestically and her opinion of the process and legal arrangements she and her husband endured. The Hanson's first contacted an international adoption agency. Each couple who is interested applies for a specific child, and as in the case with the Hanson family, they applied for Sam, knowing of his medical condition. Pediatric healthcare providers may be asked to review information concerning the health of a prospective adoptive child, then clearly and honestly apprise the prospective parents and the involved agency of any special health needs detected at the time of adoption or anticipated in the future. The potential adoptive parents are subject to an in-depth interview and must list a detailed plan for how they will care for the child (Schwarzwald, 2008). "We submitted all kinds of information about our finances and how exactly we would be able to

pay for the medical treatment Sam would need” (personal interview with Sherry Hanson on October, 19, 2008). Finally, potential parents are “logged-in” the system and the process of a closed adoption is started. In pursuit of an international adoption, most families will travel to their new child’s country of origin, each visit lasting from a few days to several weeks. Before an adoptee can be issued an entry visa for the United States, a medical examination is required to address the presence of potential health risks (Grogg, 2007).

The Hanson’s decided to pursue an international adoption for two ethical reasons. First, there was the ethical element of justice—not being viewed fairly as able parents. Because of their older age, the Hanson’s feared that they would have a disadvantage, and might be overlooked. “Being older than our 20’s and 30’s, we thought a mother might pass us up for a younger couple. We felt our chances would be better if we adopted internationally” (personal interview with Sherry Hanson on October, 19, 2008). Second, the Hanson’s did not want to be taken financially advantage of—paying for medical expenses of a birth mother and not having her follow-through. According to the Hanson family, the costs of an international adoption are less than had they chosen to adopt domestically for such reasons. The total cost of adopting varies from \$0 to more than \$40,000.00, depending on a number of factors (i.e. type of adoption, type of placement agency or facilitator, and the child’s age and circumstances). International adoptions can range from \$7,000.00 to \$30,000.00 (Adopting, 2008). “You would think that it might be more expensive internationally, but because the adoptive parents have no financial ties to the birth mother—they are not accountable for pre-natal or birthing health care that make up a significant part of the expense” (personal interview with Sherry Hanson on October 19, 2008).

Mrs. Hanson spoke about a family she knew in the process of an open, domestic adoption. This family felt more comfortable being somewhat involved in the mother’s life before

the child was born. They have paid for all of the birth mother's pre-natal care so far, and will be held responsible for hospital fees to come as well. The birth mother is not married, and lives in a lower socio-economic area. She calls frequently asking for money for personal needs, such as gas to drive to the doctor's office, groceries, etcetera, almost every week. The prospective parents in an open adoption agreement have no legal obligation to pay for personal expenses, but because a mother has up until 24 hours after the baby is born to change her mind about adopting, the prospective parents feel like they have little choice—they don't want the birth mother to become angry with them and take back her decision. "The friends in our support group are looking at spending at least \$30,000.00 for this adoption when it's all said and done" (personal interview with Sherry Hanson on October 19, 2008).

After discussing the ethical issues involved in their choice, I asked about the downsides of closed adoption, such as the loss of medical records. Mrs. Hanson replied that "... medical information would be nice to know, but anymore, you can find out about many of these things through DNA testing" (personal interview with Sherry Hanson on October, 19, 2008). DNA testing can be used in many situations surrounding adoption, as it provides indisputable answers. Adoption registries collect DNA profiles of adoptees and can be used to reunite adopted children with their biological families. In addition, adopted children can also learn about their families' medical history and determine the genetic health risks they may have (DNA Junction, 2008). As for being cut-off from his real family, Mrs. Hanson stated "I think it would be a great thing if Sam could be re-connected with his family, and should he chose to when he gets older, my husband and I will happily support him. I can't see this happening as there is nothing that ties him to his parents, but that would be a possibility in using DNA testing to see if he has siblings

who have been put up for adoption” (personal interview with Sherry Hanson on October 19, 2008).

Conclusion

As nurses, information and insight into both open and closed adoption is valuable when working in any healthcare setting where such a decision might arise. My experience speaking with the Hanson family face-to-face about the positives and negatives of each arrangement prepared me to aid a high school student in making an informed adoption decision. Adoption is no doubt an important decision for all parties involved, and therefore the legal arrangements should not be decided hastily. After completing this project, I feel closed adoption should be considered more seriously. The emotional being and stability of a child should be the priority. While open adoption provides easier access to medical information, it may not be worth the conflict at stake. Closed adoption gives the role of a parent to the parents who raise a child. No matter the decision, in the end, supporters of either open or closed adoption agree: a child's upbringing should be based on what is better for the child, not what is better for the parent.

References

- Adoption. Retrieved October 20, 2008, from: <http://www.adoption.com>
- Axness, M.W. (1997). *Painful Lessons: Adoption Assistance Information Support*. Bell & Howell Information and Learning, Ann Arbor, MI.
- Chacko, M. R. (2008). Pregnancy in Adolescents. Retrieved November 7, 2008, from http://www.uptodate.com/online/content/topic.do?topicKey=adol_med/4424&selectedTitle=5~114&source=search_result
- Child Welfare Information Gateway. (2008). Child Welfare Information Gateway: Adoption. Retrieved October 19, 2008, from <http://www.childwelfare.gov/index.cfm>
- Clinton, W. J., Executive Order, White House. "Steps to Increase Adoptions and Alternate Permanent Placement for Waiting Children in the Public Child Welfare System." December 14, 1996.
- Grogg, S.E. & Grogg, B.C. (2007). Intercountry adoptions: Medical aspects for the whole family. *The Journal of the American Osteopathic Association*, 107 (11), 481-489.
- No Author. (2008). DNA Junction. Retrieved November 8, 2008, from <http://www.dnajunction.com/uses/dna-testing-adoption>
- No Author. (2008). FindLaw: open vs. closed adoption. Retrieved October 20, 2008, from <http://www.findlaw.com/>
- Schwarzwald, H. (2008). Adoption. Retrieved November 7, 2008, from http://www.uptodate.com/online/content/topic.do?topicKey=gen_pedi/18620&selectedTitle=1~150&source=search_result
- United States Census Bureau (2000). United States Census Bureau: Adopted Children and Stepchildren. Retrieved November 7, 2008, from www.childwelfare.gov

The HPV Vaccine: Should Immunization be Mandated?

Katelin Karlin

The University Of Kansas School of Nursing

About the author:

A resident of Lawrence, Kansas, Katelin plans to start her career as a registered nurse on the Urology/ENT Nursing Unit at the University of Kansas Hospital after graduation. In the future, she plans to return to graduate school and pursue opportunities in the business management/nursing field.

The HPV Vaccine: Should Immunization be Mandated?

The Human Papillomavirus, otherwise known as HPV, is the most common viral Sexually Transmitted Infection (STI) in the United States (Zonfrillo and Hackley, 2008). Cervical cancer is the second most common cause of cancer mortality among women worldwide, causing approximately 10 deaths each day in the United States alone (Miksis, 2008). The HPV virus has been proven to be responsible for the occurrence of cervical cancers throughout the world (Vamos, McDermott, & Daley, 2008). The “etiologic link” between HPV and cervical cancer is one of the most firmly established relationships identified in cancer epidemiology. In a large, international study, the DNA for HPV was detected in 99.7% of cervical cancer samples (Miksis, 2008).

The HPV vaccine (Gardasil) has the potential to significantly reduce morbidity and mortality associated with cervical disease. This vaccine is designed to eliminate the possibility of acquiring the HPV virus, which can only be contracted from having sexual intercourse with someone who is already infected with the virus.

State legislatures across the nation have been considering whether to make HPV vaccination a prerequisite for school entry. This legislation has become a source of controversy between the legislators and the parents of school-aged girls (Vamos, 2008 & Stewart, 2008). This controversy has created a dilemma between the law, the right to personal autonomy, and the importance of public health (Stewart, 2008). The purpose of this paper is to discuss the implications of mandating the HPV vaccination.

Review of Literature

While most strains of HPV are harmless, some increase a women’s chance of developing cervical cancer (Casper & Carpenter, 2008). HPV infection has the highest incidence in the late

teens to early twenties and in the 5 to 10 year period following the first sexual experience (Ershler, 2007). An estimated 20 million Americans have been infected with HPV, with an estimated 6.2 million new infections each year (Vamos et al., 2008). Between 80-85% of sexually active people will contract HPV at some point in their life (Theroux, 2008). The majority of individuals (approximately 70%) with new HPV infections will spontaneously clear the virus within one year without significant immune system activation (Miksis, 2008). Those who fail to clear the infection are the ones who develop the persistent infection which can lead to cervical cancer (Gray, 2008). Infection with HPV normally develops within the first 2 years of sexual activity, and the majority of HPV infections are asymptomatic and transient. (Stewart, 2008; Miksis, 2008).

Although the most serious complication of HPV is the development of cervical cancer, other potential complications of HPV include the development of precancerous lesions of the cervix, vagina, or anal area (Ali & Forcello, 2008). Over 40 types of HPV have been linked to genital warts or cervical cancer (Zonfrillo & Hackley, 2008). These 40 types are divided into low-risk and high-risk groups. Low risk HPV causes genital warts, whereas persistent infection with high risk HPV is the primary cause of cervical cancer (Vamos et al., 2008; Miksis, 2008).

Cervical cancer is often detected only through routine screening, which many women cannot or do not receive, so prevention is critical (Casper & Carpenter, 2008). The groups most at risk for cervical cancer are Hispanics, followed by African Americans. It is believed these groups have the highest risk because both cultures tend to become sexually active at an earlier age than Caucasians (Casper & Carpenter, 2008). Other associated factors for the development of cervical cancer are persons with low socioeconomic status, those who are uninsured, those

with no regular healthcare access, and immigrants. The causal link is that these groups are less likely to receive routine pap smears (Vamos et al., 2008).

Gardasil, the HPV vaccine, was approved by the US Food and Drug Administration (FDA) in 2006 and has been found completely effective in preventing the development of 70% of cervical abnormalities and 90% of genital warts (Casper & Carpenter, 2008). Gardasil is given in three vaccines over the course of six months (Casper & Carpenter, 2008).

The Advisory Committee on Immunization Practices of Adolescents recommends the HPV vaccine be routinely administered to all 11-12 year old females as well as “catch-up immunizations” for 13-26 year olds who have not previously received the vaccine, regardless of sexual experience. (Rosenthal et al., 2008; Theroux, 2008). The recommended age for receiving the HPV shot is 11-12 because of their high levels of immunological antibody response, in comparison to older women because this population is most likely still attending a “well-child” clinic where they can receive the vaccine, they are still unlikely to become sexually active and thus more likely to be protected into their later teen years when they do become susceptible after initiation of sexual behaviors (Rosenthal et al., 2008). It is because studies show that by age 17, more than 60% of teenagers have had sex and that the vaccine is more efficacious among women who have not yet had intercourse, that the recommendation for earlier vaccination is made. The recommendation is further supported by the study finding that Gardasil was 99% effective in preventing cervical cancer and precancerous lesions in women who had never had vaginal sex, but only 44% effective in sexually experienced women (Casper & Carpenter, 2008).

There are relatively few side effects caused by the vaccine, and it has been found that the drug is well-tolerated without severe adverse effects. The side effects that do exist are minor and

include symptoms such as localized itching, swelling, headache, fever, nausea, or injection site soreness (Casper & Carpenter, 2008; Miksis, 2008).

The Gardasil vaccine should be required for all 11-12 year old girls to significantly reduce the incidence of cervical cancer. It is crucial that all girls in this age range capable of receiving the vaccine obtain it; even those sexually experienced, because these women are still likely to be susceptible to some, if not all vaccine-preventable types of cervical cancer (Rosenthal et al., 2008). The vaccine should be mandated since it has been found almost 100% effective in preventing the four strains of HPV responsible for 70% of cervical cancers and 90% of genital warts (Vamos et al., 2008).

The opposition of mandatory vaccination has referred to Gardasil as the “promiscuity vaccine,” and believes it “sabotages the abstinence message.” That view ignores that the vaccine is a preventive measure (Casper & Carpenter, 2008). Furthermore, one of the most important factors in influencing sexual activity among adolescents is parental acceptance. Parents are more influential than peers in determining the age of onset of intercourse (Vamos et al., 2008). The Center for Disease Control and Prevention (CDC) reports that it is unlikely that this vaccine will change the onset and frequency of sexual activity in girls, given that it is the parents, themselves, that impact the decisions to first have intercourse (Vamos et al., 2008).

The HPV vaccine itself is costly (about \$360 for the three shot series), yet could prove cost effective. Vaccinating all 11-12 year old girls in the country against HPV could prevent more than 1300 deaths. Another cost saved is the negative emotional and psychological reactions women experience from receiving an abnormal pap smear result and the invasive procedures they must then undergo to remove the precancerous lesions or cancerous cells (Vamos et al., 2008).

If the vaccine does become mandatory, parents will most likely have the option to “opt out” of the vaccine due to conscience, moral, or religious reasons. It is also imperative that should the vaccine become mandatory, it be accompanied by education, including that abstinence is the only 100% effective method of preventing pregnancy and STI’s (Vamos et al., 2008).

Conclusion

The HPV virus is the most common STI in the world, and the Gardasil vaccine can help to diminish this statistic. This HPV vaccine has the potential to assist in eradicating cervical cancer and most cases of genital warts. Girls ages 11-12 are the best candidates for receiving the vaccine, both because of their robust antibody response, in comparison to teenagers, and because they are more likely to be sexually inactive. The vaccine is given in three doses over six months and has very few side effects.

If this vaccine becomes mandatory, nurses providing the vaccine will need to educate their patients on sexual safety, including the fact that abstinence is the only absolute way to avoid pregnancy and contracting STI’s, as well as the importance of condom use for those who are sexually active. Nurses will also need to remind patients that they still need to schedule routine exams to screen for other gynecological conditions.

This paper has forced me to learn how important the Gardasil vaccine is and what an advancement its mandatory use would potentially provide in the ongoing cure for cancer. After reading several articles surrounding the HPV vaccine debate, it has become clear that there should be mandated immunization for all 11-12 year old girls. Before reading the articles, the only reason I knew for not mandating the vaccine was the risk it would spur the early onset of sexual activity in girls. Since the CDC has found this is a highly unlikely proposition, I now completely support a mandate of the HPV vaccination.

References

- Ali, R. & Forcello, L. (2008). HPV Vaccine. *Oncology Nursing Forum* 35(5) 515-516. Retrieved October 27, 2008, from CINAHL database.
- Casper, M.J. & Carpenter, L.M. (2008). Sex, drugs and politics: The HPV vaccine for cervical cancer. *Sociology of Health and Illness*, 30(6) 886-899. Retrieved October 27, 2008, from CINAHL database.
- Ershler, W.B. (2007). An analysis of HPV vaccine efficacy in preventing cervical cancer. *Clinical Oncology Alert* 23(7) 49-50. Retrieved October 27, 2008, from CINAHL database.
- Gray, S. (2008). Delivering the HPV vaccine in primary care. *Practice Nursing* 19(10) 482-484. Retrieved October 27, 2008, from CINAHL database.
- Miksis, S. (2008). A review of the evidence comparing the human papillomavirus vaccine versus condoms in the prevention of human papillomavirus infections. *Journal of Obstetric, Gynecologic, and Neonatal Nursing* 37(3) 329-337. Retrieved October 27, 2008, from CINAHL database.
- Rosenthal, S.L., Rupp, R., Zimet, G.D., Meza, H.M., Loza, M.L., Short, M.B., & Succop, P.A. (2008). Uptake of HPV vaccine: Demographics, sexual history and values, parenting style, and vaccine attitudes. *Journal of Adolescent Health*, 43(3) 239-245. Retrieved October 27, 2008, from CINAHL database.
- Stewart, A. (2008). Childhood vaccine and school entry laws: The case of the HPV vaccine. *Public Health Reports* 123(6) 801-803. Retrieved October 27, 2008, from CINAHL database.

- Theroux, R. (2008). The HPV vaccine: Rates, attitudes, and acceptability. *Nursing for Women's Health* 12(5) 423-426. Retrieved October 28, 2008 from CINAHL database.
- Vamos, C.A., McDermott, R.J., & Daley, E.M. (2008). The HPV vaccine: Framing the arguments for and against mandatory vaccination of all middle school girls. *Journal of School Health* 78(6) 302-309. Retrieved October 27, 2008, from CINAHL database.
- Zonfrillo, N.J. & Hackley, B. (2008). The quadrivalent human papillomavirus vaccine: Potential factors in effectiveness. *Journal of Midwifery and Women's Health* 53(3) 188-194. Retrieved October 27, 2008, from CINAHL database.

The Use of Forceps during Labor

Marianna Reasons

The University Of Kansas School of Nursing

About the author:

A native of Overland Park, Kansas, Marianna was the recipient of the Trinity Lutheran Hospital School of Nursing Scholarship. After graduation, she will start her career in the Neonatal Intensive Care Unit at Saint Joseph Medical Center, Kansas City, Missouri. Her long-term goals are to positively impact others by progressively growing her knowledge and technical skills with an interest in women's health.

The Use of Forceps during Labor

When it comes to giving birth, there are several different methods to choose from, such as vaginal delivery, assisted vaginal delivery with a vacuum, assisted vaginal delivery with forceps, cesarean deliver with no labor, and cesarean deliver with labor (Thompson, Roberts, Currie, and Ellwood, 2002). Additional methods that are a possibility during labor are an episiotomy, artificial rupture of membrane, elective induction of labor, and fundal pressure to shorten the second stage of labor (Simpson and Thorman, 2005). Many people have their own opinion as to which is the best and safest method. One method that brings up some controversy and ethical discussion, regarding beneficence and nonmaleficence, is whether or not it is more harmful or helpful to the mother and/or baby to have assisted vaginal delivery with forceps.

Hudelist et al (2005) described how forceps delivery is a delicate method that requires precise understanding of the station and presentation of the descending caput and that poor training and knowledge of this method can lead to a higher risk of perineal damage. So it is very important that proper teaching and understanding of how to use forceps is achieved. This may be a possible contributing factor as to why the research by Caughey et al (2007) described how obstetric forceps has decreased in its use since the late 1980s. Simpson and Thorman (2005) stressed the importance of mothers clearly knowing the full benefits, risks, and alternatives of obstetrical interventions, such as with the use of forceps, and practicing their autonomy in making their own decisions, with the father, regarding childbirth. The purpose of this paper is to outline the ethical dilemma of whether forceps delivery is beneficent and nonmaleficent to the mother, or not, through the description of risk factors and benefits of forceps delivery. The parents' use of autonomy in deciding which method is best for them, as well as describing the nurse's role as the patient advocate are other topics discussed in this paper.

Review of Literature

A forcep delivery involves the usage of an instrument that grasps, holds firmly, or exerts traction upon the object especially during a delicate operation (Forceps, 2007-2008). Obstetric forceps are used for grasping the fetal head to facilitate delivery during complicated labor (Obstetric forceps, 2007-2008). Indications for the use of forceps during labor are when the fetal head is engaged and the cervix is fully dilated, but it is more often used for convenience to shorten the second stage of labor (Simpson & Thorman, 2005). Guido (2006) described autonomy as an individual freedom, self-determination, and the right to choose what happens to one's self, beneficence as actions that should promote good, and nonmaleficence as the result of beneficence with the aim of doing no harm, as well as not inflicting pain or suffering on others.

Simpson and Thorman (2005) discussed the many risk factors associated with the use of forceps as increased maternal perineal trauma with tearing of soft tissue tears, third and fourth degree perineal lacerations, anal sphincter disruption, and pelvic floor injuries. Risk factors for the infant discussed include scalp lacerations, cephalohematoma, subgaleal hematoma, intracranial hemorrhage, hyperbilirubinemia, retinal hemorrhage, corneal abrasions, external ocular trauma, and neurologic abnormalities.

Other risk factors are outlined in a study with 2,075 (50.4%) women who delivered by forceps and 2,045 (49%) delivered by vacuum-assisted, third or fourth degree laceration rates were higher (36.9%) in forceps deliveries compared with vacuum-assisted deliveries (26.8%). In the same study it was found that vaginal lacerations, cervical lacerations, and facial nerve palsy were higher among the women who had forceps deliveries (Caughey et al, 2005). Thompson et al. (2002) explained how there is an increased risk for perineal pain and sexual dysfunction, thus resuming sexual intercourse much later compared with other methods, with the use of forceps

during delivery. The use of forceps, perineal trauma, increasing age, primiparity, heavier and longer babies, longer labors, and epidural are listed, by Williams, Herron-Marx, and Knibb (2007), as risk factors of stress urinary incontinence in women. The results of this study, were that women following forceps deliveries experienced more perineal pain, continual urinary incontinence, stress urinary incontinence, urge urinary incontinence, loss on sensation urinary incontinence, flatus incontinence and liquid fecal incontinence. In the conclusion of this study it was stated that instrumental births, such as forceps, should be avoided whenever possible.

Benefits of forceps delivery, as researched by Caughey et al (2005), found that amongst 2,075 (50.4%) women who delivered by forceps and 2,045 (49%) who delivered by vacuum-assisted, shoulder dystocia of the infant was lower with women who underwent forceps delivery (1.5%) compared to the women who underwent vacuum assisted vaginal delivery (3.5%).

Damron and Capeless (2004) concluded in their research that forceps correlated with higher success rates compared with vacuum-assisted delivery for occupant anterior and posterior cases.

Nurses play an important role as the patient advocate. They are there to help the mother and father with any questions or concerns they may have and to provide clear information and guidance. After the mother and father have made their decision, as the advocate, the nurse is there to respect their decision and to support them through promoting autonomy and ensuring beneficence and nonmaleficence are carried out for their patient. Simpson and Thorman (2005) stated that, "There is a complex interrelationship between all parties involved in the labor and birth process, including the primary care providers (physicians and nurse midwives), staff nurses, the institution, and mothers and infants" (p. 134). They also go on to stress the importance of how safe care, assurance of beneficence and nonmaleficence, for mothers and infants should be a combined goal and priority and that obstetrical procedures and interventions should include clear

benefits for mothers and infants. Simpson and Thorman (2005) addressed how the nurses can be advocates for their patients during labor. They describe this by explaining how if a situation or problem should arise concerning a certain procedure that is about to take place, the nurse should practice beneficence and suggest to the primary care provider that they first talk to the patient before the procedure is initiated. Even though this may seem like a difficult task, it is important for the laboring mother who may not have the opportunity to do this herself.

Research performed by Scott, Klaus, and Klaus (1999) showed that the presence of a doula significantly increases the well-being of the mothers and their infants and reduces the need for obstetrical interventions during labor. Having someone there during labor, who had no previous relationship with the mothers, decreased duration of labor, need for pain relief medication, use of forceps or vacuum, and a five-minute Apgar score of less than seven. It is very important that women obtain support from a trained caregiver, such as nurses or midwives, so that each and every mother can profit from constant emotional and physical support during their labor process.

Conclusion

Amongst this research, there appears to be more risk factors than there are benefits to the use of forceps during delivery. But ultimately it is the mother and/or father's decision, through autonomy, as to which method they believe to be best for them in their given situation. It is very important that mothers and fathers research benefits and risk factors of each method carefully to ensure that they make an informed decision that is right for them. It is also important that doctors practice veracity by telling the patients the truth about each method as well as discussing their medical practices concerning each method.

Nurses play a very important role as the mothers' advocates concerning any questions they may have as well as providing information and guidance regarding the several methods and procedures available during labor and delivery. Nurses are also there to support and respect the parents and to initiate change when needed, as well as promote autonomy in the patients and ensure beneficence and nonmaleficence are followed out in the mother and baby's care.

Future research that would be helpful and informative in the area of forceps during delivery would be more studies that address the ethical issues of whether the use of forceps during labor is beneficent and nonmaleficent to the mother, through the research of potential benefits as well as more risk factors. This is especially important for the parents who want to know more about this specific area. There is still a lot of potential for future research and new findings in this area that would better inform parents as they practice autonomy, making their own decisions, concerning which method of labor and delivery they choose and decide works best for them.

References

- Caughey, A., Sandberg, P., Zlatnik, M., Thiet, M., Parer, J., & Laros, R. (2005). Forceps compared with vacuum: Rates of neonatal and maternal morbidity. *Obstetrics & Gynecology*, *106*(5 Part 1), 908-912. Retrieved November 12, 2008, from CINAHL Plus with Full Text database.
- Damron, D., & Capeless, E. (2004). Operative vaginal delivery: A comparison of forceps and vacuum or success rate and risk of rectal sphincter injury. *American Journal of Obstetrics & Gynecology*, *191*(3), 907-910. Retrieved November 10, 2008, from CINAHL Plus with Full Text database.
- Forceps. (2007-2008) In *Merriam Webster's Medical Dictionary* online Retrieved November 12, 2008, from <http://medical.merriam-webster.com/medical/forceps>.
- Guido, G. (2006). *Legal and Ethical Issues in Nursing* (4th ed.). New Jersey: Pearson Education, Inc.
- Hudelist, G., Gelle'n, J., Singer, C., Ruecklinger, E., Czerwenka, K., Kandolf, O., et al. (2005). Factors predicting severe perineal trauma during childbirth: Role of forceps delivery routinely combined with mediolateral episiotomy. *American Journal of Obstetrics & Gynecology*, *192*(3), 875-881. Retrieved November 10, 2008, from CINAHL Plus with Full Text database.
- Obstetric forceps. (2007-2008). In *Merriam Webster's Medical Dictionary* online Retrieved November 12, 2008, from <http://medical.merriam-webster.com/medical/obstetricforceps>
- Scott, K., Klaus, P., & Klaus, M. (1999). The obstetrical and postpartum benefits of continuous support during childbirth. *Journal of Women's Health & Gender-Based Medicine*, *8*(10), 1257-1264. Retrieved November 12, 2008, from CINAHL Plus with Full Text database.

- Simpson, K., & Thorman, K. (2005). Obstetric conveniences: Elective induction of labor, cesarean birth on demand, and other potentially unnecessary interventions. *Journal of Perinatal & Neonatal Nursing, 19*(2), 134-144. Retrieved November 12, 2008, from CINAHL Plus with Full Text database.
- Thompson, J., Roberts, C., Currie, M., & Ellwood, D. (2002). Prevalence and persistence of health problems after childbirth: Associations with parity and method of birth. *Birth: Issues in Perinatal Care, 29*(2), 83-94. Retrieved November 11, 2008, from CINAHL Plus with Full Text database.
- Williams, A., Herron-Marx, S., & Knibb, R. (2007). The prevalence of enduring postnatal perineal morbidity and its relationship to type of birth and birth risk factors. *Journal of Clinical Nursing, 16*(3), 549-561. Retrieved November 11, 2008, from CINAHL Plus with Full Text database.

Legal and Ethical Considerations of Bariatric Surgery in Children and Adolescents

Allison C. Taylor

The University Of Kansas School of Nursing

About the author:

A native of Topeka, Kansas, Allison will graduate from the University Of Kansas School Of Nursing with Nursing Honors. She is the recipient of the Arthur and Leona Peck Nursing Scholarship Award. She was inducted into Delta Chapter, Sigma Theta Tau International in May 2009 and is also a member of Phi Kappa Phi Honor Society. Allison is also the recipient of a Delta Chapter STTI Honors Research Project Award. Her plans for the future are not fully confirmed, but Allison sees herself as having a career as a Registered Nurse in an acute care setting and eventually pursuing an advanced degree in Nursing.

Legal and Ethical Considerations of Bariatric Surgery in Children and Adolescents

Obesity is the most common disease of childhood and adolescence among developed nations (Paoletti, 2007). Over the past 30 years, the prevalence of overweight children in the United States has nearly tripled. Current estimates are that 17% of American children and adolescents are now either overweight or obese (Paoletti, 2007), with a disproportionately high prevalence in ethnic minorities (Cuttler, Whittaker, & Kodish, 2005).

As the waistlines of today's youth expand, questions arise about what needs to be done to combat this obesity epidemic in the pediatric population. Will the childhood obesity resolve itself over time? Does childhood obesity need a lifestyle intervention, or are more aggressive treatments, such as surgical intervention, appropriate.

Bariatric surgery is an intense obesity treatment that raises several legal and ethical issues for the pediatric population. It is important for nurses to be knowledgeable about these issues because of the huge prevalence of obesity in the general population so that nurses can better understand and educate others about obesity issues. It is important for nurses to implement preventive measures to combat obesity and to address the needs of those children and adolescents who are already obese and help them explore their treatment options and lifestyle changes. This paper will examine the topic of overweight and obesity in the pediatric population and the associated legal and ethical issues of bariatric surgery.

Review of the Literature

Overweight and obese children and adolescents are at risk for numerous health problems, including hypertension, hyperinsulinemia, dyslipidemia, Type 2 diabetes, psychosocial dysfunction, venous stasis disease, fatty liver disease, and other serious co-morbidities (Haynes, 2005). Furthermore, many diseases associated with overweight/obese individuals have serious

complications. For example Type 2 diabetes has related cardiac, renal, and ophthalmic complications for young adults (Inge, Krebs, Garcia, Skelton, Guice, Strauss, et al., 2004).

A number of professional organizations recommend childhood obesity treatment programs include lifestyle modification, family education, and a focus on gradual long-term changes (Cutler et al., 2005). In the adult population lifestyle-based treatment for obesity is generally unsuccessful, while treatment guidelines for pediatric obesity have focused almost exclusively on lifestyle intervention. The current literature suggests that childhood obesity be addressed through population-based preventive measures because it is much easier to prevent obesity than to reverse it. However, this does not account for children who are already obese and in need of intervention.

Surgery has been established as a more effective treatment than conservative weight management approaches in obese adults. There has also been evidence for the efficacy of surgical intervention in the pediatric population (Cutler et al., 2005). It could be considered unethical to deny children and adolescents, based on age, those treatments that have been found beneficial for adults. However, treatments for children require specific evaluations of safety and efficacy. While surgery is an extreme measure to deal with childhood obesity, it may be warranted in some cases as the consequences of obesity may severely affect health and quality of life in the child if left untreated.

Several ethical issues emerge when discussing bariatric surgery in the pediatric population. One is the controversy over the best time to surgically intervene in pediatric obesity cases. Optimal timing often depends on the severity of the patient's obesity-related co-morbidities, whether the patient's health is being compromised by severe obesity, and whether the patient has failed more conservative options. The longer an individual is obese, the higher the

risk of co-morbidities. Since many obesity-related diseases take years to develop, the suggestion exists of a need for earlier intervention (Foster, 2007). However, according to Cuttler et al. (2005), childhood obesity becomes the dominant predictive factor for adult obesity after age 10 years, with approximately 80% of children 10 years or older with a basal metabolic index (BMI) above the 95th percentile carrying their obesity into adulthood. Cuttler et al. (2005) suggested that since the link between pediatric and adult obesity is age-dependent and particularly strong after the age of 10 years.

Much of the controversy over the timing of bariatric surgery is due to the potential compromise of growth and development in children who undergo this procedure too young. There is rapid neuroendocrine, skeletal, and psychosocial maturation during adolescence, and according to Inge et al. (2004), it is unknown how these growth processes are affected by restrictive or malabsorptive surgical procedures. The accelerated growth of adolescence requires adequate nutrition, and bariatric surgery performed before the growth spurt could potentially compromise growth. While bariatric surgery is not considered to drastically impair linear growth if at least 95% of adult stature has been attained, it is not yet known whether and to what extent bariatric surgery may adversely affect bone mineral density and increase the risk of brittle bone fractures later in life (Inge et al., 2004). Additionally, while some adolescents may be considered physiologically mature enough to undergo bariatric surgery, psychological readiness is not as easy to assure.

A second legal and ethical issue raised is whether the patient has decisional capacity and is able to participate in autonomous decisions. According to Inge et al. (2004), decisional capacity is not determined strictly by chronologic age. Many agree that children under age 13 years do not have the capacity to make decisions regarding such a complicated serious

intervention as bariatric surgery. Assent for surgery must be obtained from the child/adolescent patient, and informed permission must be obtained from the parents/guardians before surgery. Most experts generally consider the age range of 8-14 years to be appropriate for assent, with younger children incapable of meaningful participation in medical decisions and older individuals capable of providing true informed consent (Cuttler et al., 2005). These ethical considerations regarding developmental capacity to give assent and consent suggest that intensive treatments should focus on older children and adolescents and that all decision-makers (parent, child, and physician) need to reach a consensus before beginning intensive treatment.

Additionally there is concern over insurance coverage that is often unavailable or inadequate for obesity services, even if recommended by professional and governmental organizations (Cuttler et al., 2005). This issue raises questions of distributive justice, since barriers preventing payment may intensify existing sociodemographic disparities in obesity.

Another ethical matter is the need to put young female patients on contraception after bariatric surgery. Parents/guardians may be apprehensive of their child's use of contraception because of the associated perception that it condones sexual activity. Neglecting contraception after the surgery is of greater ethical concern because as Inge et al. (2004) stated, "reliable contraception must be used for at least the first 1 year after the operation because of the increased risk to the fetus posed by the rapid weight loss" (p. 221).

Also of concern is the ethical decision of which surgical procedure is best for the pediatric patient. Gastric bypass is the most common bariatric procedure performed in the United States, but because of its irreversibility, there is concern regarding chronic malabsorption in the pediatric population that has directed surgeons to consider laparoscopic adjustable gastric banding (LAGB) (Zitsman, 2006). However there are few centers that are currently approved for

LAGB, and there are ongoing studies to determine the efficacy and applicability of LAGB in adolescents. There is also a paucity of pediatric endosurgical literature that compares open and minimally invasive procedures (Zitsman, 2006).

Conclusion

The childhood obesity epidemic requires a two-pronged approach of preventive measures combined with interventions for those children already obese. Surgical intervention for children and adolescents raises many legal and ethical issues that need to be recognized and addressed, including but not limited to optimal timing of surgery, determining decisional capacity, and which bariatric surgical procedure is best for pediatric patients.

Nurses need to be aware of these legal and ethical issues related to pediatric obesity interventions to be able to help patients and families fully explore treatment options. Nurses also have an important role in implementing preventive measures by promoting wellness through education and by providing early intervention for at-risk children in a number of settings including clinics, pediatricians' offices, hospitals, schools, and out in the community. Nurses need to recognize barriers families may encounter that could make healthy eating more of a challenge, such as a lack of knowledge about healthy food options or limited resources.

The long-term effects of bariatric surgery in the pediatric population have not been well characterized (Inge et al., 2004). Further investigation of this topic is needed, including more longitudinal studies on bariatric surgery in pediatric patients and close monitoring and follow-ups throughout these patients' lives to ensure optimal health post-operatively. It is important that nurses become more aware of the legal and ethical implications posed by bariatric surgery in the pediatric population.

References

- Cuttler, L, Whittaker, J.L, & Kodish, E.D. (2005). The overweight adolescent: Clinical and ethical issues in intensive treatments for pediatric obesity. *The Journal of Pediatrics*, 146(4), 559-564.
- Foster, R. K. (2007). Major obesity surgery for children—what's it all about? *Nutrition Bulletin*, 32(2), 109-112.
- Haynes, B. (2005). Creation of a bariatric surgery program for adolescents at a major teaching hospital. *Pediatric Nursing*, 31(1), 21-25.
- Inge, T.H, Krebs, N.F, Garcia, V.F, Skelton, J.A, Guice, K.S, Strauss, R.S, et al. (2004). Bariatric surgery for severely overweight adolescents: Conclusions and recommendations. *Pediatrics*, 114(1), 217-223.
- Paoletti, J. (2007). Tipping the scales: What nurses need to know about the childhood obesity epidemic. *RN*, 70(11), 35-41.
- Zitsman, J.L. (2006). Pediatric minimal-access surgery: Update 2006. *Pediatrics*, 118(1), 304-308.

Ethical Concerns with Opt-Out Testing in Comparison to Voluntary Counseling Testing

Monica White

The University Of Kansas School of Nursing

About the author:

A native of Kansas City, Kansas, Monica was the recipient of a Level II Clinical Excellence Award for her abilities to recognize and assist pediatric patients with their unique health care needs. In early 2009, Monica traveled with a group of students from the University Of Kansas School Of Nursing to Malawi Africa to provide medical and nursing care to the children and staff of an orphanage in Bangula Malawi. Monica is the recipient of the Mattie Ely Nursing Student Scholarship awarded by the Greater Kansas City Black Nurses Association, the David A. Junge Memorial Scholarship, and the Arthur S. & Leora J. Peck Scholarship Awarded by the KU School of Nursing. After graduation, she will start her nursing career on the Medical Oncology Unit at Truman Medical Center, Kansas City, Missouri as a Registered Nurse. Her long-term plans include pursuing an advance degree in nursing with an interest in Public Health and Organizational Leadership.

Ethical Concerns with Opt-Out Testing in Comparison to Voluntary Counseling Testing

Human Immunodeficiency Virus (HIV) continues to be a prevailing epidemic in the United States (US). Early diagnosis and counseling about high risk behaviors is a major prevention strategy. The Centers for Disease Control (CDC) has recommended testing guidelines to decrease the number of people in the US who are unaware they are living with this disease (Donoghoe, Lane, & Wolf, 2007). Opt-out testing is the new routine testing strategy that does not require a specific consent for testing, but rather consent to opt-out of testing. An ethical concern with current testing methods of voluntary counseling and testing (VCT) is the provider missed opportunities to test. These missed opportunities may be associated with the time required for pretest counseling and signing informed consent (Burman, Cohn, Gardner, Jenkins & Thrun, 2006). Researchers have explored the benefits, risks, and ethical issues associated with this new strategy as opposed to the old strategy of VCT over the last decade.

HIV testing is now placed under the general consent to treat. What is not clear are the cost and consequences that accompany these CDC recommendations (Holtgrave, 2007). Written informed consent promotes patient information and awareness, while protecting patients and physicians; omitting counseling and disclosures may eliminate patient education about HIV and high risk behaviors (Donoghoe, Lane, & Wolf, 2007). The ethical issue with routine testing is the elimination of HIV test specific written consent and pretest counseling. The lack of adequate information related to patients rights to refuse testing along with the risks and benefits are also ethical concerns. Routine testing may be met with barriers from individual states. Most states have pretest counseling incorporated in their HIV testing laws (Donoghoe, Lane, & Wolf, 2007). Opt-out testing may come with consequences such as failure to reduce high risk behavior (Holtgrave, 2007).

Literature Review

CDC recommendation of opt-out testing occurred in 2006 which warrants testing in all health care settings for ages 13-64. Due to time limitations inherent in the HIV counseling and pretest counseling process, the testing process could become obscured (Holtgrave, 2007). Individuals who engage in high risk behavior will be offered testing annually, whereas routine testing may be discontinued in areas with a seroprevalence of less than 0.1% (Holtgrave, 2007). HIV/AIDS advocates argue that counseling and testing are crucial for the complete comprehension of the psychosocial risk, stigmas, and discrimination that may accompany positive results (Donoghoe, Lane, & Wolf, 2007).

Routine testing is not a new practice. The CDC recommended universal screening for pregnant women in 2001. This recommendation was endorsed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (Bayer, & Fairchild, 2006). These authors also reported that “some pediatricians asserted that babies had a right to be tested because, if infected, they required vigilant medical care before they became sick—a right that trumped the mother’s right to privacy” (pg 648). A pregnant woman not recommended for prenatal HIV testing who has an infected child, will have a valid malpractice suit (Lo, Sengupta, & Wolf, 2000).

The new CDC recommendations may meet resistance from state laws that have been in standing since HIV testing was initiated decades ago. The CDC is a federal agency but its weighty recommendations do not have the power to force states to changes its laws (Donoghoe, Lane, & Wolf, 2007). “The regulations of health and public health are recognized as state

issues” (Donoghoe, Lane, & Wolf, 2007 pg. 3). Several states will have to rewrite their laws just to comply with CDC recommendations. According to Donoghoe, Lane, and Wolf (2007):

The amended statute ties state recommendations on HIV testing to the CDC’s “most current guidelines,” but it explicitly rejects essential components of the recommendations, stating that the CDC’s guidelines “shall in no event be interpreted or implemented in a manner inconsistent with the minimum informed consent standards of this [statute]. (pg 2)

HIV advocates and lawmakers presume that the lack of disclosure that accompanies the CDC recommendations is inadequate for making informed decisions about testing (Donoghoe, Lane, & Wolf, 2007).

The new testing guidelines may include many patients whose opportunity to test was missed in emergency departments and urgent care clinics. A retrospective review in Denver’s health system explored these opportunities in a study between September 2001 and December 2003 (Burman, Cohn, Gardner, Jenkins & Thrun, 2006). The study showed that “one hundred and twenty of 348 newly diagnosed HIV cases had medical care within our system in the 3 years prior to diagnosing” (pg 329). The study also showed that “one hundred and five of 120 had at least one prior encounter in the emergency department or urgent care center” with thirty two noted to have a CD4 count signifying AIDS (pg 331). The report also noted that obstacles associated with the CDC recommendations in an Emergency Department (ED) or Urgent Care Clinic (UCC) settings are “provider time constraints, expense, and logistics of follow-up and medicolegal implications” (pg 332). The lack of testing in these settings prevented early diagnosis which could have anticipated early treatment and reduce the occurrences of high risk behaviors.

Voluntary counseling and testing has been a proven prevention method in the HIV epidemic and was the technique commonly used before the opt-out approach. VCT aides in the prevention of new HIV occurrences and provides access to HIV- positive appropriate care

(Coates, Collins, Spielberg, & Summers, 2000). “VCT is effective in reducing unsafe behaviors; although brief didactic counseling is often the norm, it is not as effective as client-centered counseling” (pg. 129). A comparison was made between no screening, voluntary screening, and “universal” screening, and it was determined that universal screening was the most cost effective (pg. 133).

There is an estimated 250,000 people who are unaware they are infected with HIV living in the US alone (Holtgrave, 2007). The question that has been presented by many researchers is does VCT or Opt-Out testing have the best patient and public health outcomes. In a study that used scenario analysis and cost-effectiveness analysis; it was shown that targeted counseling and testing would hold the best outcomes (Holtgrave, 2007). The study reported “opt-out testing may reach 23% of people who are infected with HIV unaware, and prevent 9% of 40,000 new HIV infections that occur each year in the U. S.; whereas targeted counseling and testing might identify about 75% of unaware HIV positive individuals, and prevent 36% of new HIV infections” (pg 1018). The preclude cost with the testing was a difference of \$175,000 for one new infection (Holtgrave, 2007, pg 1018).

Conclusion

The CDC recommends that VCT is the appropriate method in the prevention of new HIV cases and the spread of the disease to others. Opt out testing is a less time consuming method but the possible liabilities associated with the lack of counseling may prove expensive for patient, provider, and the public. Providers have a moral and ethical obligation to warn patients of risks that accompany testing; such as the behaviors that place patients at risk for the disease and the possible discriminations and stigmas that may come with a positive test result. Along with

informing patients of any risk associated with testing, they must also be informed that they have a right to refuse the test. Under the basic concept of informed consent a patient has the right to control what is done to his/her body. CDC recommendations may need to be enhanced to incorporate a productive relationship between federal and state statutes in this matter.

CDC recommendations of opt-out testing have intent to discover more HIV positive patients and raise awareness and provide early diagnosis, but the investment must be made to include counseling in these recommendations. My opinion in this matter is that both the testing and counseling options must be supported to gain control over the spread of HIV and maximize the health of individuals dealing with this virus. Time constraints may place physicians in a position to resist recommending testing. However, through prevention training and accessibility of a HIV specialist in all ER and UCC specific education associated with testing may ease physicians concerns. The ethical issues associated with the new testing strategies leads for further evaluation and discussions related to this matter.

References

- Bayer, R., & Fairchild, A. (2006, August). Changing the paradigm for HIV testing-The end of exceptionalism. *New England Journal of Medicine*, 355(7), 647-649.
- Burman, W. J., Cohn, D. L., Gardner, E. M., Jenkins, T. C., & Thrun, M. W. (2006, May). Risk-based human immunodeficiency virus (HIV) testing fails to detect the majority of HIV-infected persons in medical care settings [Electronic version]. *Journal of American Sexually Transmitted Diseases Association*, 33(5), 329-333.
- Coates, T., Collins, C., Spielberg, F., & Summers, T. (2000, December). Voluntary counseling, testing, and referral for HIV: New technologies, research findings create dynamic opportunities. *Journal of Acquired Immune Deficiency Syndromes*, 25, s128-s134.
- Donoghoe, A., Lane, T., & Wolf, L. E. (2007, October). Implementing routine HIV testing: The role of state law. *Plos One*, (10), 1-5.
- Holtgrave, D. R. (2007, June). Costs and consequences of the US centers for disease control and prevention's recommendations for opt-out HIV testing. *PLOS Medicine*, 4(6), 1011-1018.
- Lo, B., Sengupta, S., & Wolf, L. (2000, December). Ethical issues in early detection of HIV infection to reduce vertical transmission. *Journal of Acquired Immune Deficiency Syndromes*, 25, s136-s143.