THE JOURNAL OF
UNDERGRADUATE NURSING WRITING

UNIVERSITY OF KANSAS SCHOOL OF NURSING BACHELOR OF SCIENCE IN NURSING PROGRAM
and DELTA CHAPTER OF SIGMA THETA INTERNATIONAL

http://archie.kumc.edu/handle/2271/237

VOLUME 4, ISSUE 1

July 2010

Editorial

Female Circumcision
................................................................. Barbagiovanni, C

Legal and Ethical Considerations on Consent for Minors
................................................................. Fogleman, C

Pediatric Cochlear Implants: Medical Miracle or Cultural Genocide?
................................................................. Heffley, H

Physician Assisted Suicide: Right to Life or Right to Death?
................................................................. Ku, S

Adolescent Sexual Health Education
................................................................. Moyer, J

State Mandated Childhood School Entry Immunizations: A Public Safety Issue
................................................................. Smith, M K

The Rise of Cesarean Sections
................................................................. Spaeth, T
Editorial

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

The articles presented in this volume originated as assignments given in the students’ 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 Nursing courses. Thus the content represented here deals with legal, ethical, or population issues.

Writing about these issues was not easy. These authors all show an ability to describe these issues in their own manner while using sophisticated resources. Examples of topical choices this year include mandated childhood immunizations and pediatric cochlear implants, female circumcision, consent issues with minors, physician assisted suicide, adolescent sexual health and the ongoing rise in cesarean section. Their ability to sort through the piles of information available on each of their topics and emerge with a perspectives of what is the best way to proceed so that they can provide better care to their clients should give us all a positive uplift about the future of nursing.

This endeavor would not have been possible without the support of several dedicated individuals and organizations. The Dykes Library staff at the University of Kansas Medical Center campus was wonderful. Delta Chapter of Sigma Theta International provided the financial support along with the positive encouragement of the Chapter Executive Board. 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 fourth volume and await your feedback. Let us know what you think.

Editor:

David Martin, RN, MN
Clinical Assistant Professor

Associate Editors:

Dr. Martha Baird, PhD, ARNP
Clinical Assistant Professor

Dr Nelda Godfrey, PhD, ARNP, BC
Associate Dean for Undergraduate Programs
Clinical Associate Professor

Jo Ellen Greischar-Billiard, MS, RN
Clinical Assistant Professor

Dr. Vicki Ross, RN, PhD
Research Assistant Professor
Female Circumcision

Claudia Barbagiovanni

University of Kansas School of Nursing

Claudia Barbagiovanni is a native of Los Angeles, California, and the first in her family to attend college. She earned a BA in finance with highest honors from Loyola Marymount University, where she was the recipient of the program scholar award distinguishing her as the top of the graduating class. She is a member of the Jesuit honors society Alpha Sigma Nu, the national honors society Phi Kappa Phi, the business honors society Beta Gamma Sigma, and the nursing honors society Sigma Theta Tau. Claudia is beginning her career at the University of Kansas Hospital and plans to pursue graduate level studies. She would like to thank her mother and father for their support and guidance. She would like to recognize Arthur S. & Leora J. Peck, Charles H. & Viola Loomis, the Shutz Nursing Scholarship, and all the charitable individuals and foundations that generously support education, hers in particular, in the health sciences.
Female Circumcision

Introduction

The thought of circumcising a girl may seem like a perplexing and abhorrent practice for most American citizens, but for many cultures it is a celebrated right of passage for women. While this custom has since been outlawed in the United States, it is still commonplace in other countries. The World Health Organization estimates that female circumcision, also referred to as female genital mutilation (FGM), has been performed on approximately 100 to 140 million girls and women, predominantly in Africa (WHO, 2008). It is also prevalent in the Middle East, Asia, South American and Pacific countries. With the growing rate of immigration to the United States, health professionals are encountering more patients who have undergone this procedure. A lack of education has left many clinicians unprepared to manage some of the physical and psychological sequelae of female circumcision.

Health care professionals have a duty to provide culturally competent care to individuals of diverse backgrounds. Despite the legal and ethical questions surrounding female circumcision, every individual is entitled to the same care and respect. Learning about the cultural beliefs and practices behind this tradition is mandatory to providing culturally competent care. The purpose of this paper is to educate the healthcare workforce about female circumcision and establish a culturally competent foundation for serving patients. Understanding the beliefs of a particular culture allows for the establishment of a respectful, nonjudgmental and trusting relationship between the provider and their patient.

Review of Literature

Female circumcision began centuries ago, predominantly as an attempt by men to exert control over women (Whitehorn, Ayondrine, & Maingay, 2002). Four major types of
procedures are performed. Type I entails removing the clitoris, also known as clitoridectomy. Type II involves the removal of the prepuce, clitoris, and parts of the labia. Type III combines clitoridectomy with infibulation. The majority of the labia is excised, then the vulva is sutured back together, leaving a single small hole for urine and menstruation. Type IV is rare and consists of manipulations such as burning, piercing, or stretching the labia (Morris, 1999). These rituals are commonly performed between the ages of four and twelve as a rite of passage into womanhood (Morris, 1999). A woman in the community, usually with no medical knowledge, oftentimes performs the procedure without anesthesia or sterile instruments. (Whitehorn et al., 2002).

The health consequences of female circumcision vary depending on the type of procedure performed, sterility of the instruments, and skill of the woman performing the circumcision. Complications immediately following the procedure can include hemorrhage, hypotension, shock, acute infections, abscess, cellulitis, gangrene, tetanus, sepsis, oliguria, and urinary retention. Laceration of the urethra, bladder, or vagina can also occur. Injured organs or fractured bones occur secondary to restraining the child during the procedure (Nour, 2004). Long term complications that can occur after a type II or III circumcision are urinary scarring, pain, infertility, sexual dysfunction and dyspareunia (Nour, 2004). Women who have undergone infibulation may be at increased risk for obstetrical difficulties such as fetal complications, perineal tears, wound infections, and episiotomy separation (Nour, 2004).

In addition to the physical complications that can result from female circumcision, various degrees of psychological problems can develop. Some consequences of this traumatic experience include post-traumatic stress disorder, chronic anxiety, depression, loss of sexuality, low self-esteem, fear of conceiving, and loss of sleep (Morris, 1999). Because of the social
rejection that would result from not undergoing the procedure, “authors argue that not to be 
circumcised in certain communities has a greater psychological impact than the trauma caused 
by the circumcision itself” (Whitehorn et al., 2002, p. 165).

Despite the complications that can occur, many cultural rationales encourage women to 
undergo this procedure. Girls view this ceremony as a rite of passage signifying their 
womanhood. The young female undergoing circumcision is given special food and clothing, 
then educated on her expected role as a woman (Gibeau, 1998). Female circumcision ensures 
the virginity of the girl, therefore resulting in a high bride price. Many men will not marry an 
uncircumcised woman. This practice is also viewed as making a woman more sexually 
attractive, ensuring fidelity, maintaining sexual harmony, preventing stillbirths, and as an essential part of overall health (Morris, 1999).

This medically unnecessary procedure originated as a means of controlling female 
sexuality and is perpetuated by women who believe in its necessity to ensure social acceptance 
and marriage. The eradication of these rituals and beliefs demands a combination of community 
education and legislation. In 1958, the United Nations urged the World Health Organization 
(WHO) to carry out studies about the harmful cultural practices done to females. Both the WHO 
and the International Planned Parenthood Foundation condemned female circumcision in 1986 
(Morris, 2008). In 1994, “UNICEF declared that female circumcision constituted both a health 
risk and a violation of human rights for girl children” (Gibeau, 1997, p. 89). According to the Center for Reproductive Rights (2009), the U.S. Congress declared the practice of female 
circumcision on a minor a criminal offense in 1996. Subsequently 16 states have passed 
legislation relating to female circumcision, many following the example of criminalizing this practice.
Women’s health and social rights are international concern. Other countries, including Britain, Sweden, and some African nations, have outlawed this practice. Legislation may not be the best means to enact change because it can result in underground practices. “Education also helps, but simply explaining the medical hazard is not enough” (The unkindest cut, 2004, p.1). Legislation in addition to providing culturally sensitive education may be a more effective solution to eradicating this practice.

Many organizations have worked to abolish female circumcision on the basis that it is a violation of female human rights. “It seems easy to resolve an ethical dilemma by providing a legal solution” (Gibeau, 1998, p. 89), but legislation does not account for ethical issues such as autonomy and patient rights. While female circumcision is viewed as a form of mutilation and abuse in western cultures, it is important to consider the egocentrism of such judgments. If a woman requests this procedure in America, her autonomy and cultural beliefs should be respected. Alternatively, the provider has a right to preserve his/her integrity and refuse a procedure he or she deems unethical, according to Provision 5.4 of the ANA code of Ethics (2005).

While Western cultures may find female circumcision to be an unethical practice, health professionals have a duty to provide culturally competent care when working with patients. Women have reported feeling distressed, resentful, and hurt when their providers react with pity or disgust upon seeing the infibulated scar (Nour, 2004). “Women have described being left in stirrups while residents and medical students are brought to view the scar” (Nour, 2004, p. 277). Experiences such as these discourage circumcised women from visiting health care providers in America for fear of being judged and humiliated.
It is essential for providers to be educated about the cultural beliefs underlying female circumcision in order to provide culturally competent care for their patients. By understanding the practice of female circumcision, health care providers can respond more sensitively and respectfully. For example, speculum examinations are not routinely performed in some countries, therefore the provider should prepare the patient by explaining the procedure, showing the tools that will be used, and if necessary, using a smaller speculum (Nour, 2004). By recognizing diverse cultural values and beliefs, educating staff about the various forms of female circumcision, using the patient’s terminology in regards to their specific case, and acknowledging personal discomfort, health care professionals can provide culturally competent care with a nonjudgmental approach.

Conclusion

Although female circumcision is no longer legal in most developed nations, the increasing number of immigrants utilizing their healthcare systems has drawn attention to this abolished practice. Ignorance in regards to this procedure results in an unfriendly and resentful healthcare experience for circumcised women. Regardless of the legal and ethical implications surrounding female circumcision, each patient has a right to respect and culturally competent care. Health care staffs that are knowledgeable about the beliefs of other cultures can more easily establish a trusting relationship with their patients.

Patient trust can allow for valuable education to take place, and possibly alter attitudes and beliefs regarding female circumcision. In order for the practice to be eliminated, “there must be fundamental changes in both the attitudes of men and women and in attitudes about women and female sexuality across cultures” (Whitehorn et al., 2002, p. 165). With cultural knowledge and the establishment of a trusting relationship, health care professionals can educate
circumcised women and their spouses about the implications of female circumcision in an effort
to eradicate this suppressive female practice.
References


Legal and Ethical Considerations on Consent for Minors

Christy Fogleman

Legal/Ethical Foundations for Professional Nursing

The University of Kansas School of Nursing

About the Author:
Christina Fogleman is a native of Olathe, Kansas. While at the KU School of Nursing she received a Clinical Excellence Award for her work in her Medical Surgical clinical courses and Honorable Mention for Clinical Excellence in the Foundations clinical course. She has accepted an invitation to join Delta Chapter – Sigma Theta Tau International, Nursing’s’ Honor Society. She will graduate with distinction in the top 10% of her class. After graduation she plans to begin her career on the Neuroscience Progressive Care Unit at The University of Kansas Hospital. Her long range plans include returning to school to pursue a masters or doctoral degree in nursing. She is also looking forward to using her nursing knowledge and ability to make a positive impact in the lives of her patients, co-workers, friends, and family. She wishes to acknowledge her faith in God for “giving me the talents I have”, along with her family and friends for “the support they continuously provide to me in order to succeed in my current endeavors”.

Legal and Ethical Considerations on Consent for Minors

Introduction

People considered of minor age are a vulnerable group. Minors are viewed by society as having little autonomy and are largely controlled by the wishes of their parents or legal guardians. This lack of autonomy is due to society’s view that adolescents have a limited knowledge and experience base. Many times this deems them unfit to participate in self-determination. When minors enter the health care arena a problem is presented about who is best suited to determine which procedures and treatments the minor receives.

Healthcare providers must obtain consent before performing any procedure or providing treatment to an individual. The defining lines of consent begin to gray when a child shows competency and understanding of a treatment or procedure and has different wishes than their guardians. This raises many legal and ethical dilemmas for healthcare providers who must determine which decision to uphold. This paper will examine the definition of a minor and the legal and ethical challenges associated with who has permission to give consent for a child of minor age.

Review of Literature

Legal challenges

In the United States, individual states hold the power to determine the age at which a child is no longer a minor. For the majority of states, this age is eighteen years old, stating that anyone younger than eighteen must have parental or guardian consent before any type of medical therapy is performed. Exceptions to this law apply when there is an emergency and no guardian is present, the child has been emancipated or fits within the mature minor criteria, there is a court order to initiate or proceed with therapy, or the law recognizes the minor as having the ability to
consent to therapy. Further exceptions include situations where minors would be more willing to seek medical care and assistance if parents or guardians were not involved. These situations include the diagnosis and treatment of certain infectious diseases, drug addiction, obtaining contraception, and treatment during a pregnancy (Guido, 2006).

The exception criterion of a mature minor is a stumbling block for many parents, practitioners, and children. A mature minor is defined as an older adolescent who can demonstrate maturity and decision making skills to the healthcare provider through conversations pertaining to the anticipated treatment options. This is different than the definition of a legal minor which is anyone under the legal age of eighteen. Once it is determined that an adolescent is a mature minor, a practitioner may treat the minor without parental consent on procedures which fall within mainstream medical treatment and have minimal risk. This exception is based on common law and is used to defend practitioners in non-negligent cases (Berlan & Bravender, 2009). This exception allows increased autonomy for children before the age of eighteen that prove themselves able to fully comprehend the risks and benefits of a treatment or procedure. The added autonomy will help an adolescent voice their wishes and concerns, and become more in control of their treatment. When one refuses treatment and healthcare providers go against that person’s wishes, the right to autonomy is disrespected and true paternalism is displayed. This puts the nurse in a legal and ethical dilemma because it is the nurse’s responsibility to advocate for the patient and assess whose rights they are trying to uphold (Vasey, 2008). A parent’s role is not negated with a mature minor, but rather there is a greater need

Ethical Challenges
In the treatment of a minor patient, the family becomes the patient. At times, this family system forgets to include the minor child who is the subject of the treatment. It is the nurse’s moral and ethical obligation to respect and advocate for the child so the child is included in the communication and decision making process. Minors in the United States are raised to abide by their parents’ and authority figures’ decisions. When decisions are being made regarding treatment, minors might agree only because they fear what might happen if they were to oppose their parents’ decisions (Allen & Marshall, 2008).

Allowing children to have a voice in their own care allows them to feel in control of their situation and has many therapeutic benefits for the child. The child that is able to express their wants and needs, will feel more like a person with rights and less anxious about their current situation (Batson, 2008). Obtaining consent from the child and parent has both clinical and legal implications. From a clinical perspective, a procedure will be more accepted if there is cooperation from the patient. From a legal perspective, it becomes a defense against crime and tort of trespass (Griffith, 2008). For healthcare providers a controversy arises when parents intentionally fail to disclose information to their children about treatment. In some pediatric HIV and AIDS cases, parents intentionally keep troubling information from their child about how the disease was transferred or the process it will take. This allows for a great disruption in the flow of care for the child by remaining silent when children benefit from open discussions about their illness and treatment options (Allen & Marshall, 2008). Parent’s that feel disclosure is not the best option, may need to have additional support and counseling from nurses or other health care providers to understand the profound benefits that communication has in the treatment process.

Adolescents are at the age of curiosity and defiance. A teenager needs to feel safe when disclosing risk taking behavior and mental health needs with health care providers. By providing
a place where confidentiality is upheld, adolescents will be more apt to share important information (Berlan & Bravender, 2009). In order to obtain confidentiality with a minor, there are situations outlined where parental or guardian consent is not necessary. Many adolescents that are sexually active seek reproductive services that provide birth control, condoms, and other contraceptive items. Numerous teenagers have reported that they would stop using contraception and seeking medical advice if their parents were notified. Although parents do not like to have information withheld when medical professionals are working with their children, many parents view confidential time between healthcare provider and minor as necessary to obtain the best care. For those that are initially opposed to confidentiality, it has been shown that their opinions can be changed if written material and education is provided to explain the importance of confidential time (Berlan & Bravender, 2009).

New advances in technology are opening up a realm of possibilities for confidentiality. A new program to allow patients easier access to their medical records is the patient-controlled health record. This medical record is a comprehensive record of all health care interactions over a life time. While the patient-controlled health record is controlled by parents for very young children, it has different privacy options for the various developmental periods of a child’s life. Each data field of the record is controlled by access codes to determine if the minor, parent, or both can view the content. Even with these technological advances, adolescents continue to voice fears over how their confidential information will be kept confidential. Consequently, parents voice fears over being kept out of the loop with their child’s care (Berlan & Bravender, 2009).

Conclusion

The majority of states uphold that a person eighteen years and older has the right to consent. There are specific exception criteria where children under the age of eighteen are
allowed to consent for themselves such as the diagnosis and treatment of certain infectious diseases, drug addiction, obtaining contraception, and treatment during a pregnancy. Because people differ greatly with various levels of competence, maturity, and behaviors; the lines which are drawn for consent become very gray. Due to this variability, nurses and other healthcare providers are placed in a position with potential for legal and ethical dilemmas.

Consent must be obtained before any procedure or treatment is performed, presenting great challenges for nurses. In order to address these challenges, a nurse must be educated on the different exceptions for consent. Adhering to these exceptions will allow the nurse to give the most comprehensive care and serve as a true patient advocate. Knowing the current ethical and legal requirements on consent for minors, will help nurses provide the best of care to minor patients and their families. Additionally, remaining current and providing quality care can serve as a defense if a nurse is placed in a lawsuit position over consent. The nurse must also educate patients and families on their options with consent and facilitate communication in order to arrive at the option that is best for the patient. For a nursing student, the review of credible sources regarding consent for minors provides a foundation of current practice and familiarity with the various outcomes that may be achieved regarding who provides consent.
References


Pediatric Cochlear Implants: Medical Miracle or Cultural Genocide?

Holly Heffley

University of Kansas School of Nursing

Holly Heffley is a native of Lawrence, Kansas. While at the University of Kansas School of Nursing she was the recipient of the Arthur S. and Leora J. Peck Scholarship and the Arlene Roberts Schaake Memorial Scholarship. Following graduation Holly will start her nursing career in the Neonatal Intensive Care Unit at Children’s Mercy Hospital in Kansas City, Mo. From here, she hopes to gain the expertise necessary to further her dream of becoming a Pediatric Nurse Practitioner.
Pediatric Cochlear Implants: Medical Miracle or Cultural Genocide?

Introduction

Hearing is a complex sense that is paramount to a child’s cognitive, linguistic, and social development. In the United States, nearly 20 million people and 3 out of every 1,000 children are born deaf or hard-of-hearing every year. As of April 2009, 25,500 children in the United States have received cochlear implants (National Institute of Deafness and Communication Disorders, 2009). The cochlear implant is a surgically implanted device that bypasses the outer ear and is directly inserted into the cochlea. The implant electrically stimulates the auditory nerve fibers, which translate impulses into sound (Berg, Herb, & Hurst, 2005). This breakthrough technology was first approved for trial in 1985 and approved by the FDA for surgical implantation in children two years or older in 1990 (Berg et al., 2005). The invention of this device was viewed as a miracle by the medical community for the ability to cure the deaf. However, to the deaf community, the cochlear implant was a direct attack against deaf culture. With the use of cochlear implants, it is feared that the deaf way of life will disappear. Due to the success of implantation, the criteria have broadened to consider children as young as 18 months and at various testing centers, only 6 months (Berg et al., 2005). This puts parents in a unique position of deciding what is in the best interests of the deaf child. Pediatric nursing is likely to see an increase in patients undergoing cochlear implant surgery due to the rise in technology, and it is imperative for nurses to understand the implications, both physical and mental, of this controversial procedure.

This controversy has created an ethical dilemma between the deaf cultures ability to thrive, paternalism, and acting in the best interests of the child. The purpose of this paper is to discuss the implications of pediatric cochlear implantation.
Review of Literature

To understand the turmoil that underlies this heated controversy, it is important to look at deafness as a minority culture within the hearing world. A culture consists of members with a “shared history, social life and sense of identity” (Hyde and Power, 2000, p.118). The deaf community shares their own form of communication, American Sign Language, and a shared set of values centered on autonomy and independent living. The members of the deaf world believe that the absence of hearing is far less important than the ability to share a culture and language (Berg et al., 2005). Being deaf carries the same disadvantages as does any other minority group, including discrimination, a lower level of education, reduced life expectancy, and higher rates of unemployment (Levy, 2002). The increased use of cochlear implants means a decrease in the use of American Sign Language and the values of deaf life. This is a view that many people from the hearing community are unable to comprehend because many are taught that being deaf is the absence of a physical trait and considered a disability.

If deafness is a genuine culture, and not a disability, then allowing medical intervention to correct the problem may be viewed as unethical and could lead to the demise of the deaf world. The medical model views deafness as something that can be cured. This view contrasts with the social-cultural model, which sees a viable future as a deaf person (Hyde & Power, 2000). Members of the deaf culture believe that being deaf is a “good thing and would like to see more of it” (Lane & Grodin, 1997, p. 234). To those, being deaf is a way of life and not a disability. When defined as a disability, deafness is something that should be repaired, fixed, altered, or improved. By implanting young children with cochlear implants, society is sending the message that the child needs to be ‘fixed’ to be normal and live in today’s world (Delost & Lashley, 2000). Levy (2002) states that trying to fix the deaf sends the wrong message that “we want no
more people of ‘your kind’, no more disabled people, no more Deaf people” (Levy, 2002, p. 142). Most deaf children are born to hearing parents. Cochlear implants allow a quick fix that makes it possible for the deaf child to participate in the hearing family and culture. The idea of a quick solution could lead hearing parents to unrealistic expectations of their child’s social, development, and linguistic future (Berg et al., 2005).

Cochlear implants involve serious medical and surgical risks. The surgery involves drilling into the temporal bone and includes complications such as infection, damage to facial nerves, and increased risk of otitis media and meningitis. Children with cochlear implants are not able to participate in contact sports, play in pits of plastic balls, or slide down plastic slides due to the risk of injury and electrostatic discharge (Delost & Lashley, 2000; Okubo, Takahashi, & Kai, 2008). In a study following 300 pediatric cochlear implantations, conducted by Nottingham University Hospital, seven (7) experienced major complications and forty eight (48) resulted in minor complications. Research about the lasting effects of cochlear implants is still yet to be conducted (Okubo, Takahashi, & Kai, 2008).

Those who advocate for cochlear implants have a compelling argument about how living in a world of sound could benefit deaf children. Perceived benefits of implantation include auditory improvement and speech production (Okubo, Takahashi, & Kai, 2008). Oral speech alone leads many families toward cochlear implants because of the ability to interact with hearing society, respond to the environment, and reduce social stigma. The problem arises with the efficacy of cochlear implants. Effectiveness of the implant is variable and dependent on many things including non-modifiable factors such as IQ, socioeconomic status, gender, family size, and educational program (Berg et al., 2005). Implants do not guarantee the ability to hear and acquire spoken language. Lane’s 1995 study of children born deaf and implanted at an early
age showed that the majority of implanted children were unable to follow instructions or answer any oral questions correctly on a test after 5 years of implantation (as cited in Lane and Grodin, 1997).

After surgical implantation, the child does not hear immediately. It can take anywhere from two weeks to two years before the child begins receiving auditory input (Delost & Lashley, 2000). Implantation is typically followed by extensive language therapy with speech pathologists, special teachers, and requires hours of commitment (Lane & Grodin, 1997). Cochlear implant surgery is not approved by the FDA under the age of 12-18 months and is then typically followed by an additional silent period where the device cannot be used (Berg et al, 2005). This time gap puts the child at a significant language delay compared to their hearing and deaf peers. By waiting to acquire a language, mastery often decreases and can lead to altered “intellectual, social and psychological development” (Lane & Grodin, 1997, p. 236).

The true issue that lies behind the implantation of children is the violation of autonomy. Advocates of the cochlear implant state that the most effective outcomes are achieved at the youngest age of implantation (Berg et al., 2005). However when young children are implanted, residual hearing is permanently destroyed, as are the possibilities of future technological applications (Berg et al., 2005). Parents must sign an informed consent for this complicated surgery stating they understand all benefits/risks associated. This decision, made for the child but not by the child, violates personal autonomy and determines the child’s future.

The decision to implant a child can result in negative psychosocial effects. Although cochlear implantation might improve hearing or allow for the acquisition of spoken language, the child is still truly deaf. This places the child without a true identity in society. To the hearing world, they are abnormal, and to the deaf world, they are hearing (Okubo, Takahashi, & Kai,
Implantation could be viewed as a paternalistic action, which enforces a particular way of life upon children (Berg et al., 2005). Parental surrogacy is approved for many medical instances in which the lives of children are threatened. However in the case of cochlear implants, being deaf is not life threatening. Deaf children are not in immediate danger. One should have the right to preserve one’s body and determine personal identity, this is why deaf advocates argue that cochlear implantation should be withheld until a child is able to request and understand the full consequences of that decision. This prevents paternalistic actions that are made with intent to do what is in the best interest of the child (Berg et al., 2005).

Conclusion

The cochlear implant is a medical invention that is now the center of a swirling controversy. The cochlear implant was created to enlighten the deaf with the joy of hearing. It was not until after the FDA approval of this small device, did the medical community realize that many deaf are happy being deaf. Cochlear implants not only degrade the deaf and force a feeling of inadequacy, but they also undermine the deaf way of life. Due to increased effectiveness of early implantation, several ethical issues are now at the center of this debate. Arguments have emerged over parental surrogacy and trying to preserve the individual’s right to autonomy. To prevent cochlear implant complications, negative psychosocial effects, delayed language acquisition and possible resentment toward a forced way of life, cochlear implants should only be allowed when one is old enough to request and understand the consequences of such action. With increasing technology, nursing is likely to see advances in cochlear implants and hearing aids in the future. By understanding what lies behind the decision to receive a cochlear implant, the nurse will be able to provide appropriate care to deaf families and children.
References


Physician Assisted Suicide: Right to Life or Right to Death?

Sarah Ku

University of Kansas School of Nursing

Sarah Kathleen Ku is from Overland Park, Kansas. While attending the KU School of Nursing she was the recipient of the Brisley Scholarship. She has also been named to the Dean’s honor roll for the University of Kansas for all eight semesters. She hopes to begin her career in an acute care medical surgical environment in the Kansas City area. Her career goals include completing graduate degrees in nursing with an eventual long range plan of becoming an undergraduate nursing educator. I would like to acknowledge David Martin, my legal/ethical class professor. If it were not for this individual, I would have never written this paper. This professor encouraged me to explore the legal and ethical implications associated with the nursing profession. I am very grateful that I was required to do this assignment, and I think that my patients will benefit from the knowledge that I have gained.
Physician Assisted Suicide: Right to Life or Right to Death?

Introduction

In 1997 the Death with Dignity Act was implemented in the state of Oregon. This piece of legislation enables a competent adult who desires to end their life access to a lethal dose of medication. In order for a person to qualify for assisted suicide under this act, they must be 18 years or older, a resident of Oregon, able to verbalize and understand the consequences of their decision, have a prognosis of six months or less to live due to a terminal illness, and convince a physician of their desire to end their life (Volker, 2007).

Although the Death with Dignity Act empowers individuals to control the timing of their death, physician assisted suicide still remains a controversial topic in today’s society that raises many ethical questions. These questions include: Who is the true owner of our lives? Should relieving suffering always be the highest priority or does suffering occur for a reason? Is suicide a purely individual choice (Mathes, 2004)?

The answers to the above questions are subjective, yet healthcare workers deal with the difficult issues associated with end-of-life care on a daily basis. Since patients and families frequently ask nurses to provide information about support in dying, it is important for nurses to thoroughly understand the topic of physician assisted suicide regardless of whether it is legally permitted within the State where they are working (Ersek, 2004). The purpose of this paper is to describe benefits and disadvantages of assisted suicide and to discuss the ethical reasoning behind both of these opposing viewpoints.

Review of Literature

Throughout the literature, there are many arguments that support the prohibition of physician assisted suicide. One of the most obvious arguments is that health care providers are
supposed to save lives—not take them. (de Vocht & Nyatanga, 2007). This principle of nonmaleficence can be traced back in time to Hippocrates, a Greek physician, who states this duty as “I (healthcare provider) will use treatment to help the sick according to my ability and judgment, but I will never use it to injure or wrong them” (Beauchamp & Childress, 2009, p. 149). In other words, this statement can be interpreted as “do no harm”. The American Nurses’ Association supports the notion that active participation in assisted suicide goes against the ANA Code of Ethics for Nurses (2001). Helping a client take their own life is not only in contrast with ethical traditions of nursing but it could also discourage clients from seeking out medical care due to fear (Ersek, 2004).

In response, proponents for assisted suicide argue that it is well within the patient’s right to decide whether he or she lives or dies. Emphasizing the importance of the principle of autonomy, they feel that quality of life is a very personal opinion. By preventing clients from taking their life, they feel healthcare providers are being paternalistic and imposing their views onto their patients. Some also feel that it is pride, not altruism, which inhibits healthcare workers from supporting assisted suicide. They argue medical professionals do not like to admit that they cannot fix a situation, because it causes them to acknowledge their own limitations and evokes a feeling of failure. (de Vocht et al, 2007).

Another reason many dislike physician assisted suicide is their belief that it might eventually lead to involuntary euthanasia. This slippery slope conjecture is based on the idea that small steps will eventually lead to an inevitable chain of events that cannot be stopped once started. This notion is supported by statistics gathered from the Netherlands that state “roughly 1,000 patients die due to the result of an end-of-life decision made without their explicit consent”
Therefore advocates of this theory feel that the best way to prevent the establishment of involuntary euthanasia is by barring assisted suicide.

In contrast, supporters of physician assisted suicide feel that the slippery slope argument is an exaggeration. Since the passage of the Death with Dignity Act in Oregon, involuntary euthanasia is far from being a reality of the status quo in the United States. This is a living example that demonstrates assisted suicide can be passed without spiraling out of control. Therefore support of the slippery slope argument is closed minded and shows little faith in human nature (Dieterle, 2007).

However, the possibility that patients might be coerced into participating in assisted suicide against their will is very concerning to many people. Opponents to legalizing assisted suicide fear that patients could be persuaded by their family or insurance companies into requesting support in dying. A specific concern exists for vulnerable populations which include the elderly, poor, and minorities. These groups of people may be easily manipulated and lack the means to defend themselves. In summation, it is very possible that abuses of law could occur (Dieterle, 2007).

The argument also exists that legalizing assisted suicide would make it easier to regulate these practices. One result of not legalizing assisted suicide could be that people might utilize the “euthanasia underground” as a source of relief. These people are very determined to die and may go to other countries or fall back on illegal methods to reach their goal. This not only makes it hard to control what is happening, but some people are also dying in ways that they do not prefer (de Vocht et al, 2007).

Since assisted suicide is a complex issue, many feel that forming comprehensive legislation that is safe is an impossible task. The current Death with Dignity Act uses many terms
which are subjective. For example, there is no definite way to determine the exact time and date when a person will die. Therefore the 6-month prognosis is not reliable even if it is agreed upon by two different physicians. In addition, mistakes in assisted suicide are permanent and cannot be corrected (Gannon & Garland, 2008).

Conversely, assisted suicide supporters argue physicians are already familiar with facilitating the death of their patients. Currently, “In all 50 states in the US, patients have the right to refuse treatment and be allowed to die. Furthermore, all 50 states have procedures in place for allowing substituted judgments for the refusal of treatment” (Dieterle, 2007, p. 132). Although end-of-life issues are complex, legal support for physicians comfortable with this process should continue.

Another argument against assisted suicide is that it could encourage people to give up and take the easy way out. By allowing a person to take their life when they feel hopeless, it might give off the wrong impression to the public that when life becomes hard it is acceptable to quit. (Dieterle, 2007). Instead of focusing on ending life, emphasis should be put on how to enhance palliative care.

On the contrary, proponents for assisted suicide argue that the people who are requesting it are not hopeless and depressed. The clients who utilize the Death with Dignity Act in Oregon, Linda Ganzini states, “are not so much depressed as determined” (Schwartz & Estrin, as cited in Dieterle, 2007, p. 134). Ironically, these people say that assisted suicide actually instills hope in people because they feel they have a way of controlling their life if it becomes too unbearable.

Conclusion

While there many arguments for and against assisted suicide, the answer to the question of whether it is right or wrong remains ambiguous. One reason for the lack of clear cut answers
is that assisted suicide is an ethical issue which is dependent on a person’s values, morals, religion, and experiences. In general, the topic of end-of-life decision making is very sensitive and evokes strong emotions and opinions. Instead of debating the issues involved with assisted suicide, this paper merely describes pertinent arguments that have been presented by both sides.

There are many nursing implications that are associated with assisted suicide. Among these is the importance for nurses to be aware of their own beliefs about end-of-life care. Self-awareness will prepare nurses for obstacles they will face when dealing with death. Another implication is that nurses need to be cognizant of politics and legal authority. Becoming active in political processes, nurses can work to ensure that they will not be forced into doing procedures that come in direct conflict with their beliefs.

Writing this paper has taught me that autonomy is a very controversial issue in the health profession. I have also learned that there is a fine line between being a patient advocate and acting paternalistically. There is also a very fine line between providing a patient with information and influencing their decision making process. I plan to use this knowledge in my practice by being aware of my own biases and respecting the beliefs of my patients. I have come to the conclusion that facing ethical issues is inevitable part of a nurse’s professional practice.

References


Jenna Moyer is a native of Olpe, Kansas. She is a member of Kansas University Student Nurses Association, the National Student Nurses Association, and Sigma Alpha Pi (The National Society of Leadership and Success). Following graduation from the University of Kansas, School of Nursing, she plans to pursue her career in the Neonatal Intensive Care Unit at Saint Joseph’s Medical Center in Kansas City, Missouri. Her future plans include returning to pursue an advanced degree in Pediatric Nursing. In addition to school, she is a caregiver and sitter for a teenage boy with Cerebral Palsy. She wishes to thank her husband, parents, and siblings for their endless patience, love, and support. She states: “I am so fortunate to have such wonderful family and friends. I am also thankful for my faith, the Good Lord, and all of His blessings throughout my life.”
Adolescent Sexual Health Education

Introduction

Patient education is one of the most important components in the nursing profession, as it facilitates expansion of the patient’s knowledge base and promotes optimal health. Not only is it crucial that the teaching be effective, but it is equally important for the patients to receive the most timely and most valuable health information as evidenced by research literature. Nurses are often faced with situations in which the teaching topic may be part of a legal or ethical argument. It is not uncommon for nurses to have a personal difference in opinion with the literature, particularly because of religious beliefs. Regardless, nurses are responsible for providing information that is most beneficial to the health of all patients.

One highly controversial and highly debated topic regarding sex education is which educational approach is most beneficial to both the sexual and overall health of adolescents. The two opposing outlooks are known as abstinence-only and comprehensive sex education. This is a topic of concern to all nurses, not only in the school setting, but also in the community, clinics, and hospitals. It is important for adolescents to receive accurate sexual health education because it can have a major impact on numerous aspects of their life, such as education, health, relationships, and future. The use of research studies and literature reviews as the basis for the most effective sex education methods can be helpful because they demonstrate the most successful methods used previously and they display the areas in need of improvement. In addition, they help to establish a more uniform standard for adolescent sexual health education.

The purpose of this paper is to discuss the two conflicting methods of adolescent sex education and to identify the viewpoints established by each side. The author will explore the
impact of sex education on the health and sexual practices of adolescents. The government’s involvement in support and funding of sex education programs will also be reviewed.

Review of Literature

Abstinence-only sex education is a method of teaching which promotes abstinence from sexual activity until marriage, adding that it is the only proven method to prevent sexually transmitted infections (STIs) and premarital pregnancy (Stammers & Ingham, 2000). It includes discussion of values, character building, and refusal skills. Comprehensive programs encourage abstinence from sexual activity until marriage as well; however, they also teach about condom use, contraception, safe sex practices, abortion, and prevention of STIs and HIV (Bleakley, Hennessy, & Fishbein, 2006).

Those in support of abstinence-only education argue that condoms and contraception are not “fool-proof” in preventing pregnancy or STIs and that abstinence is the only fully effective method of prevention (Stammers & Ingham, 2000). Advocates of abstinence-only also feel that comprehensive sex education actually encourages early sexual activity among adolescents. Those on the side of abstinence believe that morals, values, and religious beliefs should be a significant deciding factor among adolescents and sex related decisions, specifically, waiting until marriage to have any type of sexual activity (Santelli et al., 2006).

Comprehensive program supporters believe that it is important to provide sexual health education in order for adolescents to protect themselves in sexual situations (Collins, Alagiri, & Summers, 2002). They deny that providing contraceptive information encourages early sexual activity, but instead they believe it equips adolescents with the information they need to make healthy sex decisions when they decide they are ready. They too believe that abstinence should
be primarily encouraged, but feel that it would be an injustice not to inform adolescents about contraception and STIs (Collins et al., 2002).

The study by Kohler, Manhart, and Lafferty (2007) reported that teens who received comprehensive sex education were significantly less likely to report teen pregnancy while there was no significant effect found in those that received abstinence-only education. It also found that abstinence-only education did not reduce the likelihood of adolescents engaging in vaginal intercourse whereas the comprehensive approach was associated with a lower report of having engaged in vaginal intercourse (Kohler et al., 2007).

The method supported by the United States Federal Government for over a decade has been abstinence-only sex education. In order for schools to receive Federal funding, they have had to follow the eight central abstinence program components outlined in the Social Security Act of 1996 (Bleakley et al., 2006). Surprisingly, even with governmental support and funding, the number of studies assessing abstinence-only education is very few in comparison with those evaluating comprehensive approaches.

The study by Collins et al. (2002) stated that there is no reliable evidence that the millions of dollars spent by the federal government on abstinence-only education has had any positive effect. As a result of this and numerous other studies, President Obama has proposed a shift from abstinence-only education to a comprehensive approach including teen pregnancy prevention, which would allocate 178 million dollars for education and community-based programs (Jayson, 2009). Obama’s proposal would include discussion about abstinence but would not initially set funds aside to support abstinence-only education.

Even more recently, however, the Senate voted to pass an amendment to Obama’s proposal in order to restore Title V of the Welfare Reform Act which includes 50 million dollars
in grants for abstinence-only education programs (Kliff, 2009). Although many thought that Obama’s plan would make abstinence-only education a topic of the past, this move by the Senate proves that the debate is not yet over.

One nationwide poll conducted among middle school and high school parents found that 90% believed it was very or somewhat important to have sex education taught in school and of those parents, only 15% wanted it to be abstinence-only teaching (Santelli et al., 2006). The shift in Obama’s proposal would provide the funding and new teaching approach that the majority of the parents in this study support. The other 15% would also still have the option of abstinence-only and some funding available to them through the amendment by the Senate.

One primary weakness has been identified in both of the opposing sex education approaches. The study by Beshers (2007) pointed out that not only is the topic of sex education controversial, but the terms “abstinence-only” and “comprehensive” also create confusion. Abstinence can have a variety of definitions and generally each individual decides what it means to him or her. Some see abstinence as not having sexual intercourse while others view it as not engaging in any sexual activities (Beshers, 2007).

It is also unknown what exactly the comprehensive programs include since there are no universal standards. For example, some programs include condom-use instruction and demonstration while others simply encourage condom use (Santelli et al., 2006). There are also some that address the topic of abortion, another highly controversial subject. No matter which program is in place, this lack of standards and consistency is creating an inadequate learning environment for adolescents receiving sexual health education.
Conclusion

It is important for adolescents to receive instruction on all sexual health topics from abstinence to contraception, to pregnancy and STI prevention, especially since they are faced with a vast number of risks related to sexual health. The greater their knowledge base, the more likely they are to make educated decisions in relation to sexual activity. Regardless of personal opinion or religious beliefs, nurses are responsible for acting as patient advocates and providing adolescents with the most current, evidence-based sexual health information.

Although supporters of both abstinence-only and comprehensive programs agree that the objective of sex education is to reduce the risk of STIs and teen pregnancy as well as delay initiation of sexual activity, both sides feel strongly that their method is the superior approach. The proposed changes by President Obama would create a move away from the method funded and supported over the past decade; however, the amendment by the Senate reinstates some of the abstinence-only approach. Because there is currently not a unanimous agreement, both approaches still need further study to evaluate their effectiveness, especially since each side offers pros and cons. As a result of the ongoing disagreement at both the public and governmental levels, the topic of adolescent sexual health education will continue to be one of ethical controversy.
References


State Mandated Childhood School Entry Immunizations: A Public Safety Issue

Mallorie K. Smith

University of Kansas School of Nursing

Mallorie Smith is a native of McPherson, Kansas. While at the KU School of Nursing she received the Goppert Scholarship, a Jayhawk Assistance, and a KU Tuition grant. After graduation she hopes to begin her career in Labor and Delivery Unit for a central Kansas hospital. Her future plans include returning to a graduate program where she can obtain a master’s degree in advanced practice. She wishes to acknowledge her parents, Mike and Michelle Smith. They have been so supportive of me and always pushed me to do my best. I attribute my high standards for myself to them; for they have always held me to high expectations and insist on nothing less than what they know to be my very best efforts”. She also acknowledges the support of her fiancé Brian. “He has encouraged me for the past five years to accomplish my goals and become the nurse that I aspire to be”.

State Mandated Childhood School Entry Immunizations: A Public Safety Issue

Introduction

In February 2008, a measles outbreak threatened citizens from San Diego, California to Hawaii. Cheryl Clark (2008) from SignOn San Diego writes that, “in less than a month, the outbreak…began in Switzerland and has spanned about half the globe. The case demonstrates how quickly, extensively and silently the potentially lethal virus can spread.” Clark explains that a 7-year-old boy contracted the disease while vacationing with the family. This child then spread the disease to his two siblings and one classmate. After exhibiting symptoms of the disease, the child was taken to a clinic, where four other children were potentially infected. Clark states that “all these children, from infants to a 9-year-old, were not vaccinated because they were younger than 1 – the minimum age for measles inoculation – or because their parents objected to having them vaccinated.” These four other children that were potentially infected at the clinic could have then infected another 60 individuals with the disease (Clark, 2008)!

Every child, before school admittance, is asked to provide proof of immunization against certain diseases. These immunizations are given periodically, throughout a child’s pre-school years, in order to enhance and improve their immunity. However, although proof is requested, not all children are receiving these vaccines. Some are exempt for medical reasons; some are exempt for religious reasons; but, others are gaining exemption status for personal reasons. Salmon and Siegel (2001) explain in their article, that nonmedical exemptions are very easy to acquire and, for some, healthcare personnel need not be involved; merely a parent’s signature will suffice. If it were not for the history of immunizations, diseases like Polio would not be eliminated from the United States, and Smallpox would not be eradicated from the world. Nies and McEwen (2007) cite statistics from the Center of Disease Control about Measles and
Pertussis, both preventable by immunization. These statistics show that since 2003, there have only been 56 cases of Measles reported in the United States in comparison with over 11,000 cases of Pertussis reported that same year.

Diseases, like Polio, Pertussis, and Measles, are still endemic to certain areas of the world. It is important to understand that shifts in vaccination status among our children can have dire effects on the health of our country; or, as Salmon and Siegel (2001) state, “history tells us that such a shift can result in resurgence of disease and needless morbidity and mortality” (p. 294). These diseases can still be transmitted and infect those in this country. This paper will explain the importance of immunization in personal health as well as public health. It will also focus on why the state governments can, and should, step in to mandate that children are receiving the required immunizations to help protect themselves as well as those that are exempt for medical reasons. This is an important issue due to the increasing popularity of children who are not being vaccinated due to nonmedical exemptions.

Review of Literature

Vaccines are recommended to protect us from diseases. Salmon et al. (2004) describe vaccines as “one of the greatest achievements in medicine and public health during the past century (p. 553). Some of the diseases that are vaccine preventable carry debilitating side effects, miserable symptoms, and can even cause death. However, most individuals do not associate these diseases as risks for people today. Therefore, instead of considering the benefits of the immunizations, people have been trying to identify faults associated with them. Benjamin Levi (2007) explains in his article, that the media is in part responsible for this misconception. The media has begun inquiring about the importance and safety of vaccines. Levi (2007) also explains that some of the resistance to childhood immunizations also stems from the lack of
knowledge or inaccurate ideas that parents have when it comes to the benefits and risks of getting vaccinated.

We have seen a surge of questioning in regards to even the seasonal flu vaccines provided every year. In a study of nonmedical exemption rates in schools, the results of another case-control study were reported to identify vaccination safety as the top concern of parents that chose not to vaccinate their children. This study of nonmedical exemption rates in schools also showed the lack of vaccination among the children with nonmedical exemptions leads these children to an increased risk of contracting disease, as well as an increased risk of transmission among the community (Omer, Pan, Halsey, & et al., 2006).

Public health programs have been in place to fight vaccine preventable diseases for over a century. Mariner, Annas, and Glantz (2005) tell of a case that occurred in 1905. The Massachusetts Supreme Judicial Court tried the case Jacobson vs. Massachusetts regarding the Board of Health mandating immunizations for everyone against smallpox, which was endemic at the time. There was a monetary fine associated with declining the vaccine. The decision was upheld, that the states had the authority to “police their internal affairs,” which was found to include the health of the people (Mariner, Annas, & Glantz, 2005). Some would argue that this is a violation of one’s right to decline medical treatment. Others, who opt out of immunizations for religious reasons, would argue that this is a violation of the First Amendment and the right to practice religion. However, the article over religious and philosophical exemptions from vaccination explain that the Court recognizes laws must be religiously neutral, and that this right to practice does not allow for parents to put their children at risk or the community at risk to a communicable disease. Salmon and Siegel (2001) explain this further with the explanation that
“parents are free to become martyrs themselves. But it does not follow that they are free in identical circumstances, to make martyrs of their children” (p. 291).

With regards to protection of the community, vaccination is explained to be the ‘duty of the citizens’. This article describes vaccination in respects to male citizenship and war. Like those who were drafted and expected to fight for their country, so should we fight the war against disease. To gain religious sanction for war is described as a very lengthy process (Salmon & Siegel, 2001). To think of vaccination as a duty to serve and protect, maybe we should re-evaluate the ease of claiming exemption. This process should be more than a signature or a written statement; it should be an equally lengthy process to determine one’s sincerity in refusing to vaccinate their child.

This issue becomes a matter of the rights guaranteed to all by the laws of the country. Is it a fundamental right to choose whether or not children get vaccinated? Mariner et al. (2005) help define those rights that are considered fundamental. In the article covering the Jacobson vs. Massachusetts case, the fundamental rights have been listed as: freedom of speech, voting, freedom from arbitrary physical restraint, marriage, contraception, procreation, family relationships, raising children, and education. This article goes on to explain that schools have the right to require immunizations among their students as long as two conditions are satisfied, the first being that the disease still exists in the population, and the second being that there is a safe immunization that can prevent the spread of the disease to others (Mariner et al., 2005). There are some individuals, children and adults, who have medical conditions that do not allow for them to be immunized. Therefore, it is the responsibility of the rest of us to make sure that we are immunized in order to protect those that cannot be. Omer, Pan, Halsey, and et al (2006) state this concept perfectly in their article, when they say “states must balance parental autonomy
with the tremendous public health benefit of vaccines when considering the types of exemptions allowed…” (p. 1763).

Nonmedical exemptions increase the risk for everyone not immunized against certain diseases; whether it be a medical exemption, religious exemption, personal exemption, or the fact that a child is not old enough to be immunized. The risk for these groups increases by having someone that could be immunized, not vaccinated. The study of nonmedical exemptions to school immunizations requirements describes the trend of nonmedical exemption as being “geographically clustered.” This clustering is said to increase the risk for a mass susceptibility in an area, which in turn, increases the risk for a disease outbreak. This study also states that as of 2006, 48 states allowed for religious exemptions, and 19 states allowed for personal exemptions (Omer et al., 2006). The ease of claiming exemptions has an impact on the number of nonmedical exemptions experienced in that state. For example, in this study of nonmedical exemptions to school immunization requirements, it was concluded that states that have easily achievable exemptions have a higher mean of nonmedical exemptions than those that have a medium or difficult way of achieving exemption. It was also found that there is an association with easily obtained nonmedical exemption and an increased incidence of pertussis (Omer et al., 2006). Therefore, we can conclude that the rate of disease is inversely proportioned with the rate of vaccination.

Children naturally acquire immunity from exposure to toxins and disease. This can be done through experiencing the disease process and developing immunity, or from receiving vaccination and developing immunity. For those that cannot receive vaccinations, or those that choose not to receive vaccinations, there is another type of immunity called herd immunity. Herd immunity, Nies and McEwen (2007) explain, is the immunity one receives indirectly, not
through the vaccination of themselves, but through association to a population where at least 80-percent of the population is immunized. However, if we continue to easily allow nonmedical exemptions for the vaccination of children, we see the proportion of those vaccinated to those not vaccinated slowly even out closer to a 1:1 ratio. Keeping in mind the need for at least 80-percent of the population to be vaccinated in order to maintain herd immunity, we would need at least four vaccinated individuals for every one unvaccinated individual.

Conclusion

The future of vaccinations is uncertain at this point. Mariner et al. (2005) note that public health is no longer a concern only at the local level; it has now manifested into the duty of the state and federal government. Medical technology is surging and new treatments are available. But it is important to remember the power of vaccinations and the devastating diseases that we have eliminated from our country because of immunizations. Jennifer Steinhauer (2008) of the New York Times states that children that are not vaccinated are “unnecessarily susceptible” and that they pose a threat to those children that are vaccinated because some of the vaccinations are not 100-percent effective at preventing the illness. It is the job of parents to protect their children. If parents choose to not vaccinate their children, they are endangering not only their own child, but they are also endangering the children that cannot get immunized for medical reasons as well as those that take the responsibility to get vaccinated. With the rise in the number of nonmedical exemptions, the states should step in and mandate the vaccination of children before entry to school to ensure the safety of the public.
References


The Rise of Cesarean Sections

Tracy Spaeth

University of Kansas School of Nursing

Tracy Spaeth is a resident of Eudora, Kansas. While at the School of Nursing she received the Visiting Nurse Association Scholarship and the Maud Landis Nursing Scholarship. After graduation she plans to start her career on the Neonatal Intensive Care Unit at the University of Kansas Hospital in Kansas City, Kansas. Her future plans include pursuing graduate education in nursing. She thanks her husband for all his support, encouragement, and patience. As a mother of two young boys she appreciates their giving up some of their “mommy time” so she could finish her education.
The Rise of Cesarean Sections

Introduction

Over the past several years, there has been much discussion and debate concerning the steady rise in the rate of cesarean section births. The number of cesarean sections being performed has increased every year, with data from the National Vital Statistics System showing that in 2006, 31% of births were performed by c-section (CDC, 2006). Much of the discussion centers on the safety of cesarean sections versus vaginal deliveries for both maternal and neonatal outcomes. However, another topic being hotly debated is the underlying cause of the increasing rate. Many point to “cesarean delivery on maternal request” as the prime reason the rate has skyrocketed. This is a topic of great importance. It is quite surprising that most medical personnel accept that up to 31% of babies are being delivered via a major abdominal surgery simply due to mothers requesting. This paper will review the ethical implications of elective cesarean sections, specifically the issues of patient autonomy and beneficence/nonmaleficence, and how they relate to cesarean delivery on maternal request (CDMR).

Review of Literature

When considering the ethical aspects of elective cesarean deliveries, it is necessary to first determine if the procedure is any safer or riskier than vaginal deliveries. In a large, multicenter study in Latin America, researchers concluded that cesarean deliveries do reduce overall risk in breech presentations. However, in cephalic presentations, c-section deliveries significantly increase risk of both maternal and neonatal morbidity and mortality. The researchers’ overall conclusion from their study was that the “increase in rates of cesarean delivery at an institutional level is not associated with any clear overall benefit for the baby or mother but is linked with increased morbidity for both” (Villar et al., 2007, p. 1025).
Similar results were seen in the study conducted by Kolas, Saugstad, Daltveit, Nilsen, and Oian (2006). After comparing planned cesarean births with planned vaginal births, they found that infants born via c-section had a significantly higher risk of being transferred to the neonatal intensive care unit and had significantly more pulmonary disorders. They went on to further analyze the data to determine if high-risk pregnancies may adversely skew the results of the planned c-section group by excluding data from c-section deliveries which were planned due to fetal indicators. This re-analysis showed no significant difference from the original results.

It has been suggested by some that the reason cesarean sections “appear” less safe than vaginal deliveries in some studies is due to the inclusion of emergency c-sections which are known to have more complications than planned c-sections. To address this, Quiroz, Chang, Blomquist, Okoh, and Handa (2009) conducted a study to compare vaginal delivery outcomes with both c-section deliveries performed before the onset of labor (UCD – unlabored cesarean delivery) and those performed after the onset of labor (LCD – labored cesarean delivery). They concluded that both the LCD (labored) and vaginal delivery groups had a higher risk of bleeding than the UCD (unlabored) group but that the UCD (unlabored) group had significantly more neonatal complications than either of the other two groups. When adjusting for fetal indications for cesarean delivery in the UCD (unlabored) group which could be risk factors for neonatal complications, it was found that there was no significant difference in neonatal complications between the UCD and LCD groups. However, the odds of experiencing complications were 37% lower for neonates born vaginally (Quiroz, et al., 2009).

All three of the studies discussed acknowledge that much more research needs to be done to better understand the risks and benefits of cesarean deliveries. None of them, however, concluded that cesarean deliveries are safe enough to be routinely offered. What, then, is leading
to the record high rate? One possibility is simply that more women need cesarean sections due to complications encountered with their pregnancy. This could be due to more women waiting until they are older to have children or because of the increased incidence of multiple births. Declercq et al. (as cited in “Why does the cesarean section rate keep going up”, 2007), however, found that the rate of c-sections has gone up in all groups of women “regardless of age, the number of babies they’re having, the extent of health problems, their race/ethnicity, or other breakdowns (para. 6)”. It seems, from this information, that maternal health considerations are not the cause of the increase.

Many practitioners and lay persons interested in the topic have come to accept that the true reason for the increase in c-section rates is due to an increase in elective cesarean sections, specifically cesarean delivery on maternal request (CDMR). The National Institutes of Health State-of-the-Science Conference Statement (2006, p. 1386) defines cesarean delivery on maternal request as “a cesarean delivery for a singleton pregnancy on maternal request at term in the absence of any medical or obstetric indications”. In other words, CDMR is elective surgery without medical necessity.

The American College of Obstetricians and Gynecologists published a committee opinion, “Surgery and Patient Choice” (2003), which addressed ethical considerations of such elective surgeries as CDMR. They sought to guide OB/GYN physicians in making decisions regarding patient requested surgeries when medical indication is lacking. The committee appropriately asked the question “should health care options be regarded in the same way as choice of cereal in the supermarket” (ACOG, 2003, p. 188). One of the central issues involved is patient autonomy. Patients should be the ones to determine what is done to their own bodies, including having the choice to have or not have a surgical procedure such as a cesarean section.
How is autonomy handled, however, when it conflicts with other ethical elements such as beneficence and nonmaleficence? The ACOG committee recognized that, in decision making, physicians must “consider the maintenance of the dignity and honor of the discipline of obstetrics and gynecology and its standards of care”, and that “even though the decision of the patient should be respected, this might not include supporting the decision, particularly when doing so is in direct conflict with other guiding ethical principles” (ACOG, 2003, p. 189).

The other guiding principles involved are beneficence, promoting the health and well-being of the patient, and nonmaleficence, doing no harm to the patient. Cesarean births have not been proven to be of any benefit to mother or child in uncomplicated pregnancies. Therefore, a physician may actually be violating the principles of beneficence and nonmaleficence when agreeing to an elective c-section request by putting the mother and child at unnecessary risk of harm. The ACOG committee determined that when patient autonomy and beneficence/nonmaleficence are in conflict, “the patient has the right to refuse unwanted treatment…she does not, however, have a parallel right to demand treatment that the physician believes is unwise or overly risky” (2003, p. 189).

Conclusion

It is clear from the above information that there are many different variables to consider when deciding on a method of delivery, both for mothers and for physicians. Since cesarean delivery has not been shown to be safer than vaginal delivery in uncomplicated pregnancies, this option should not be routinely offered to mothers as a choice for them to make. However, when confronted with a mother requesting a cesarean section without medical indication, physicians have the responsibility to weigh their patient’s autonomy against their obligation to uphold the principles of beneficence and nonmaleficence. Nursing staff, as well, have the same obligation
to uphold these ethical guidelines. A primary responsibility of nursing is to act as a patient advocate. As Miesnik and Reale (2007) point out, nurses are ideally situated to assess a woman’s knowledge about cesarean delivery and educate her on the risks and benefits. Perinatal nurses, nurse practitioners, and nurse midwives can advocate for their patients and uphold their autonomy by exploring reasons for requesting cesarean deliveries (Miesnik & Reale, 2007). Beneficence and nonmaleficence can be upheld by avoiding unnecessary c-sections which are requested due to fear of birth and labor pain. Nurses can advocate for continuous nursing support during labor and educate women on the availability of medication to control pain during labor (Miesnik & Reale, 2007). Both physicians and nurses are equipped with ways to work towards decreasing the national rate of cesarean deliveries, as well as an ethical obligation to do so.
References


