COURSE NUMBER AND TITLE: N400, N400L - Professional Dimensions of Nursing

NUMBER OF UNITS AND PLACEMENT: 3 units (2 lecture, 1 lab), first semester, senior year

PREREQUISITES: Senior standing, N355, N355L, N357, Chemistry 300 and Pathobiology 425

FACULTY: Barbara Talento, RN, MSN, Ph.D. 773-2096 Office
Cal State U
773-3145 NSG Office

COURSE DESCRIPTION: Contemporary issues in nursing and health care are identified and analyzed in relation to current and emerging professional roles. Societal, political, legal and ethical issues and trends that affect nursing and health care are analyzed. Included are patterns of nursing education, licensure, certification, role of nursing organizations, entry into practice, and other professional issues. Nursing leadership tasks are explored by examination of group process, values clarification and ethical decision-making. Issues and theories related to ethics and bioethics are explored.

This course will concentrate on application of the principles of group process, dynamics, leadership and the interaction between these processes. Exploration of communication patterns and utilization of participant observation will contribute to the development of group leadership skills. Accountability and professional responsibility are emphasized.

COURSE OBJECTIVES:

Upon completion of this course, the student will be able to:

1. Analyze the social, political, legal and ethical issues and trends as they effect professional nursing, health care and health care delivery systems.
2. Identify monitoring mechanisms which promote accountability of the nursing profession to the consumer.
3. Understand the relationship of legal aspects and codes of ethics to professional accountability.
4. Demonstrate knowledge of the legal aspects of nursing practice.
5. Demonstrate knowledge of the theories of bioethics and its effect on professional nursing.
6. Demonstrate and apply knowledge of the theory and dynamics of group process.
7. Relate group dynamics concepts to the leadership and collaborative functions of the professional nursing role.
8. Analyze and facilitate group process as a function of the collaborative leadership role.
9. Seek opportunity to become an active participant in the adaptation process of self and peers.
10. Analyze stressors in society which affect the nurse and the nursing profession.
11. Recognize the professional nursing role within the constraints of changing social, political, legal and ethical issues and trends.
12. Accept responsibility for learning as a life-long process to promote personal and professional growth and to meet the changing needs of the profession and society.

COURSE CONTENT OUTLINE:

Unit I  The Health Professional and Group Process
A. Concept of group and group membership
B. Group roles and tasks
C. Concepts, types and techniques of leadership

Unit II  Current Status of Nursing
A. Licensure/Certification
   1. Model Nurse Practice Act/Calif. Practice Act
   2. Credentialing Study: Recommendations
B. Issues in Nursing Education
   1. Generic/Career Ladder Philosophies
   2. Economics of Nursing Education
   3. External Degree Programs: Pros/Cons
   4. R.N.'s and Non-Nursing Majors
   5. Nursing Education Studies

Unit III  Nursing Organizations
A. Purpose, Functions and Structure:
   A.N.A., N.L.N., I.C.N., etc.
B. Specialty Nursing Organizations

Unit IV  Bioethics
A. Ethics and values in Health Care
   1. Code of Ethics
B. Ethical Dilemmas and Nursing Practice:
   Social Stressors
C. The Health Care Consumer and Ethical Decision making

Unit V  Issues in Nursing
A. Independent Nursing Practice/Expanded Roles
B. Collective Bargaining/Unionization
D. Supply, Demand, Recruitment of Nurses
E. Unity/Disunity in Nursing
F. Satisfaction/Dissatisfaction among Nurses: Solutions(?)
Unit VI  Issues related to Clients
   A. Patient Bill of Rights
   B. Informed Consent
   C. Advocacy: Nursing Role

METHODOLOGY:
Lecture, Lecture/discussion, films, simulation games, seminar and student debates.

EVALUATION:

N400

Paper on Issues ...... 20%
Debates ............. 20%
Exams:  Mid-Term .... 30%
           Final ......... 30%

N400L

Group Report ...... 50%
Participation in Group 50%

*Write to:
   State of California
   Dept. of General Services
   Publications Section
   P.O. Box 1015
   - North Highlands, California  95660

for:

Laws relating to Nursing Education, Licensure - Practice
Rules and Regulations 1983    $3.50

If unavailable in the bookstore
GUIDELINES FOR PARTICIPATION:

Participation in class and seminar is essential. Points will be given for each class according to the following criteria:

A. Oral presentations of case examples, readings on articles.
B. Contributions to learning exercises: games or simulations.
C. Sharing from own experiences/thinking to clarify, support or differ with peer contributions.
D. Accepting leadership responsibilities whenever appropriate.

GRADERS AND ATTENDANCE:

Attendance is mandatory. If it falls below 90%, your grade will be lowered. Please see Student Handbook for Department Policy.

Late papers without prior arrangement will receive a failing grade, but must be turned in at minimal level competency.

Upon meeting minimum criteria for this course, a grade of "C" will be awarded.

Grades of A or B will be awarded based on quality of product. Criteria for quality includes by is not limited to:

1. Organization of Paper

   The ability to articulate ideas, thoughts, issues, arguments, and discussion with clarity, logic, conciseness and continuity. It includes the ability to utilize appropriate grammar, sentence construction (which includes spelling).

2. Formal papers include introduction, body, summary and conclusion. References used should be documented according to A.P.A. manual.

Please type papers, using double spacing for ease in reading and providing feedback.

**The Academic Dishonesty Policies for the University apply.**
6  Nursing Organizations
   A. A.N.A.
   B. N.L.N.
   C. Conflict - Real or Imagined
   D. Credentialing

7  MID-TERM

8  Bioethics
   A. Code of Ethics for Nurses
   B. Ethics in Health Care
   C. Values in Health Care

9  1. Ethical Dilemmas in Nursing Practice
    a. Kohlberg's Stages of Moral Development

10 1. Overview of Issues Facing Nurses Today
    A. Expanding Roles/Independent Practice
    B. Current Legislation
    C. Working Conditions
    D. Supply & Demand
    E. International Nursing

LEARNING ACTIVITIES/ASSIGNMENTS
Read: Kelly Chapter 25 and 26
Review: Kelly Chapter 20
   Licensure
   Accreditation
Read: "The Study of Credentialing in Nursing" in Syllabus pp.79-94

Issue Papers Due

SEMINAR
Participant Observation
The How and The Why
Read: S & M Chap. 6

Discussion: Student Leader
The Code and What It Means to Practice
Steele & Harmon
Exercise 11, p. 177
Exercise 12, p. 178

Video: Baby Jane Doe
Read: Aroskar, M. "Anatomy of An Ethical Dilemma"
   Nursing 80, May pp. 39-43
Recommend: Steele & Harmon Chap. 3
   pp 179-183
Read: Current Issues of A.J.N. * Group Paper
   N.O., Nsg. 85, etc. Read news, trends, legislation and editorial sections
   Due Week 12

Group Process Analysis
See Guidelines
Discuss: What is the future for Nursing? *

Video: Ethical Issues in Health Care
Moccia, P., "If Nurses Had Their Way" Ms. 5/83, pp. 104-106, 146
(In Learning Resource Center)
<table>
<thead>
<tr>
<th>WEEK</th>
<th>CONTENT</th>
<th>LEARNING ACTIVITIES/ASSIGNMENTS</th>
<th>SEMINAR</th>
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| 11/5 | 1. Issues  
A. Pt. Bill of Rights  
B. Informed Consent  
C. Nurse as Advocate | Read: Patient's Bill of Rights  
Kelly: Chap. 21-22 | Steele & Harmon  
Exercise 27, p. 104  
Appendix I |
| 11/12 | Issues Continue  
Assertion in Nursing  
Professionalism in Nursing | Debates Begin  
See Guidelines  
Read: Kelly Chapter 31 | Debate Process Paper Due Today  
Discuss: Health Care in U.S. Today and in the future |
| 11/19 | Issues  
A. Political Action  
B. Who Shall Represent Nursing? | Debates Continue  
Debates | Steele & Harmon  
Exercise 26, p. 103 |
| 11/26 | Final Exams Review | Final Exams Next Week  
Status of Nursing in your work place | Steele & Harmon  
Exercise 27, p. 104  
Appendix I |
| 12/2 | | Final EXAM  
No Meeting | Steele & Harmon  
Exercise 27, p. 104  
Appendix I |
| 12/9 | 16 | Good Luck! | |
REQUIRED TEXTBOOKS


California: *Laws Relating to Nursing Education Licensure-Practice*, issued by Board of Registered Nursing.


BIBLIOGRAPHY


COMPETENT REGISTERED NURSE CRITERIA

A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the patient and others, including the health team.

2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

3) Performs, and effectively supervises subordinates in the performance of skills essential to the kind of nursing action to be taken, respecting the rights and feelings of the client.

4) Evaluates the effectiveness of the nursing care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members.

5) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

Adopted at May 19, 20, 21, 1982 Board Meeting
1. The nurse provides services with respect for human dignity and the uniqueness of the client unrestricted by consideration of social or economic status, personal attributes, or the nature of health problems.

2. The nurse safeguards the client's right to privacy by judiciously protecting information of a confidential nature.

3. The nurse acts to safeguard the client and the public when health care and safety are affected by the incompetent, unethical, or illegal practice of any person.

4. The nurse assumes responsibility and accountability for individual nursing judgments and actions.

5. The nurse maintains competence in nursing.

6. The nurse exercises informed judgment and uses individual competence and qualifications as criteria in seeking consultation, accepting responsibilities and delegating nursing activities to others.

7. The nurse participates in activities that contribute to the ongoing development of the profession's body of knowledge.

8. The nurse participates in the profession's efforts to implement and improve standards of nursing.

9. The nurse participates in the profession's efforts to establish and maintain conditions of employment conducive to high quality nursing care.

10. The nurse participates in the profession's effort to protect the public from misinformation and misrepresentation and to maintain the integrity of nursing.

11. The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public.
PRINCIPLES AND GUIDELINES
CONCERNING THE FOREGOING OF
LIFE-SUSTAINING TREATMENT
FOR ADULT PATIENTS

THESE PRINCIPLES AND GUIDELINES HAVE BEEN APPROVED
BY THE GOVERNING BODIES OF THE LOS ANGELES COUNTY
MEDICAL ASSOCIATION (JANUARY 6, 1986) AND THE LOS
ANGELES COUNTY BAR ASSOCIATION (DECEMBER 11, 1985).
A. GENERAL PRINCIPLES FOR DECISION-MAKING

1. It is the right of an adult person capable of giving informed consent to make his or her own decision regarding medical care after having been fully informed about the benefits, risks, and consequences of treatment alternatives, even when such a decision might result in shortening the individual's life. The California Court of Appeal has stated: "... if the right of the patient to self-determination as to his own medical treatment is to have any meaning at all, it must be paramount to the interest of the patient's hospital and doctors. The right of a competent adult patient to refuse medical treatment is a constitutionally guaranteed right which must not be abridged."¹

2. Adult patients who are unable to give informed consent have the same rights as do persons who can give such consent. For such persons, a court-appointed conservator with authority to make medical decisions or an attorney-in-fact designated in a Durable Power of Attorney for Health Care has the legal authority to make such decisions. In the absence of a conservatorship or a Durable Power of Attorney for Health Care, immediate family members or close friends of such patients, are the surrogate decision-makers.² When the surrogate decision-makers agree, the responsible physician may act in accordance with their decision. When there is a disagreement, the physician should maintain life-sustaining treatment until either the disagreement is resolved or a conservator is appointed and makes a decision. In all cases, the patient's desires, if known, take priority. If the patient's desires are unknown, the person who has the authority to make the decision should act in the best interests of the patient.

3. Life-sustaining treatment need not be continued solely because it was initiated.


² In seeking to identify appropriate surrogates (representatives) of the patient with whom the health care provider should consult regarding treatment issues, one should consider immediate family members or non-family friends who: (a) are "in the best position to know (the patient's) feelings and desires (regarding treatment)," (b) "would be most affected by the (treatment) decision," (c) "are concerned for (the patient's) comfort and welfare," and (d) have expressed an interest in the patient by visits or inquiries to the patient's physician or hospital staff. Barber v. Superior Court, 147 Cal. App. 3d 1006, 1021, fn. 2 (1983).
5. Regardless of a patient's diagnosis or prognosis, it is always necessary to provide hygienic care, relieve discomfort, and respect the patient's dignity.

6. We endorse the following conclusions of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research on this subject:\(^3\)

   a. "The voluntary choice of a competent and informed patient should determine whether or not life-sustaining therapy will be undertaken, just as such choices provide the basis for other decisions about medical treatment. Health care institutions and professionals should try to enhance patients' abilities to make decisions on their own behalf and to promote understanding of the available treatment options. Health care professionals serve patients best by maintaining a presumption in favor of sustaining life, while recognizing that competent patients are entitled to choose to forego any treatments, including those that sustain life."

   b. "An appropriate surrogate, ordinarily a family member, should . . . make decisions for incompetent patients. The decisions of surrogates should, when possible, attempt to replicate the ones that the patient would make if capable of doing so. When lack of evidence about the patient's wishes precludes this, decisions by surrogates should seek to protect the patient's best interests ['do what, from an objective viewpoint, appears to promote a patient's good without reference to the patient's actual or supposed preferences']. Because such decisions are not instances of self-choice by the patient, the range of acceptable decisions by surrogates is sometimes not as broad as it would be for patients making decisions for themselves."

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B. SPECIFIC GUIDELINES ON FOREGOING (WITHHOLDING OR WITHDRAWING) LIFE-SUSTAINING TREATMENT

1. Based upon two decisions by the California Court of Appeal, physicians may forego (withhold or withdraw) life-sustaining treatment without prior court approval in at least two specified circumstances.

   a. An adult patient capable of giving informed consent who has a terminal illness or a serious illness that is probably incurable but has not been diagnosed as terminal, and who seeks to have life-sustaining treatment discontinued despite the fact that withdrawal of such treatment will surely hasten his or her death; and

   b. An adult patient "who has been reliably diagnosed as in a comatose state from which any meaningful recovery of cognitive brain function is exceedingly unlikely," and whose surrogate decision-maker(s) concur(s) with the patient's physician that continued treatment is not likely to significantly improve the patient's prognosis for recovery and is, therefore, considered "disproportionate" to any potential benefits from that treatment (147 Cal.App.3d 1006, 1017-1019).

In the two circumstances outlined above, the California Court of Appeal has found it permissible for physicians to give orders to forego life-sustaining treatment without prior court approval. The Court also said that physicians' orders to forego treatment in such situations do not create any civil or criminal liability. It should be noted that these two factual situations are not the only circumstances under which such treatment can be withheld or withdrawn. They are simply the only circumstances that have been reviewed thus far by the California appellate courts. However, most medical decision-making can be done in accordance with the principles stated in Section A and the statement regarding "proportionate" and "disproportionate" treatment in Appendix I without creating conflict that requires court intervention.

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5 For the purpose of these Guidelines, a "terminal illness" is an irreversible medical condition that will cause the patient's death in a time period from weeks to months, but no longer than one year.

6 See definition in footnote 2. The Barber case did not involve an attorney-in-fact or a conservator.

7 See discussion of "proportionate" and "disproportionate" treatment in Appendix I.
Many institutions have found a biomedical ethics committee functioning in an advisory capacity to be helpful in dealing with these decisions.

2. In the circumstance of the comatose or “vegetative state” patient specified in 1.b. above, we recommend that the following guidelines be followed before life-sustaining treatment being provided in health care facilities is withheld or withdrawn:

a. The medical record includes a statement that the responsible physician and at least one other physician (qualified by experience and training in the diagnosis, prognosis, and treatment of the condition in question) concur in their judgment that any meaningful recovery of the patient’s cognitive brain function is exceedingly unlikely. The medical record should include the basis for their judgment.

b. The medical record indicates that there has been no expressed intention on the part of the patient that life-support systems or life-sustaining treatment be initiated or maintained in such circumstances.

c. The medical record indicates that the person who has the authority to make the decision (as indicated in paragraph A.2 above) consents to the discontinuance of such treatment or support.

d. The decision is made in accordance with institutional procedures, if any, governing such decision-making.

In such circumstances, all life-sustaining interventions, including nutrition and hydration, are legally equivalent. It is legally acceptable for the caregiver to withhold or withdraw any or all of them. It is recognized, however, that nutrition and hydration have a powerful symbolic significance to both the members of the general public and to many caregivers. Decisions concerning the care of an individual patient should be made jointly by members of the health care team and the patient’s family and/or other appropriate persons. Under all circumstances, the hygiene and dignity of the patient must be preserved.
APPENDIX I

"PROPORTIONALITY"/"DISPROPORTIONALITY"
OF PROPOSED TREATMENT

The California Court of Appeal, in Barber v. Superior Court, offered the following analysis:

"The question presented by this modern technology is, once undertaken, at what point does it cease to perform its intended function and who should have the authority to decide that any further prolongation of the dying process is of no benefit to either the patient or his family? A physician has no duty to continue treatment, once it has been proved to be ineffective. Although there may be a duty to provide life-sustaining machinery in the immediate aftermath of a cardio-respiratory arrest, there is no duty to continue its use once it has become futile in the opinion of qualified medical personnel. A physician is authorized under the standards of medical practice to discontinue a form of therapy which in his medical judgment is useless .... If the treating physicians have determined that continued use of a respirator is useless, then they may decide to discontinue it without fear of civil or criminal liability. By useless is meant that the continued use of the therapy cannot and does not improve the prognosis for recovery ...... Of course, the difficult determinations that must be made under these principles is the point at which further treatment will be of no reasonable benefit to the patient, who should have the power to make that decision and who should have the authority to direct termination of treatment. No precise guidelines as to when or how these decisions should be made can be provided by this court since this determination is essentially a medical one to be made at a time and on the basis of facts which will be unique to each case .... However, we would be derelict in our duties if we did not provide some general guidelines for future conduct in the absence of ... legislation .... A more rational approach involves the determination of whether the proposed treatment is proportionate or disproportionate in terms of the benefits to be gained versus the burdens caused. Under this approach, proportionate treatment is that which, in the view of
benefits to the patient, which benefits outweigh the burdens attendant to the treatment. Thus, even if a proposed course of treatment might be extremely painful or intrusive, it would still be proportionate treatment if the prognosis was for complete cure or significant improvement in the patient’s condition. On the other hand, a treatment course which is only minimally painful or intrusive may nonetheless be considered disproportionate to the potential benefits if the prognosis is virtually hopeless for any significant improvement in condition...... Thus, the determination as to whether the burdens of treatment are worth enduring for any individual patient depends on facts unique to each case, namely, how long the treatment is likely to extend life under what conditions. "[5]0 long as a mere biological existence is not considered the only value, patients may want to take the nature of that additional life into account as well...... Of course, the patient’s interests and desires are the key ingredients of the decision making process. When dealing with patients for whom the possibility of full recovery is virtually non-existent, and who are incapable of expressing their desires, there is also something of a consensus on the standard to be applied. [T]he focal point of decision should be the prognosis as to the reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of that biological vegetative existence......" Prolongation of life...... does not mean a mere suspension of the act of dying, but contemplation, at the very least, a remission of symptoms enabling a return towards a normal, functioning, integrated existence...... Clearly, the medical diagnoses and prognoses must be determined by the treating and consulting physicians under the generally accepted standards of medical practice in the community and, whenever possible, the patient himself should then be the ultimate decision-maker." (147 Cal.App.3d 1017-1020)
BRAIN DEATH

Considerable confusion exists among some physicians regarding the determination of the death of a patient who is being supported on a ventilator or respirator (brain death) and the significance of turning off the ventilator after the patient is pronounced dead. There is no legal or ethical issue involved in discontinuing all treatment, including ventilatory support, once the patient has been pronounced dead.

The following information is provided to assist physicians in the determination of brain death:

Section 7180 of the California Health and Safety Code states in pertinent part: "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards." Separate Code sections also require that when a person is pronounced dead based upon a determination of irreversible cessation of all brain functions including the brain stem (i.e., brain death), a second physician must independently confirm the death, and that neither of these physicians shall participate in the procedures for removing or transplanting an organ or other body part from the dead person.

The most current nationally-accepted medical standards for the determination of death have been published in the article, "Guidelines for the Determination of Death: Report of the Medical Consultants on the Diagnosis of Death to the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research," JAMA 1981; 246:2184-2186.

The following procedural guidelines are suggested for use in connection with brain dead patients:

1. The physicians should document in the patient's record the basis for the diagnosis of brain death (clinical examination, confirmatory tests, etc.).
2. The physician should inform the patient’s family, significant others, and other appropriate surrogate decision-makers of the determination of brain death and the need to discontinue all treatment. They should have an opportunity, if they so desire, to request confirmation of the neurological determination by a physician of their choosing (i.e., a second opinion) before ventilatory support or other such interventions are discontinued. The determination of death remains a medical decision, however.

3. Physicians or nurses, after consultation with the patient’s physician, should in appropriate circumstances discuss with the patient’s family, prior to pronouncement of death, the opportunity for donation of organs and other body parts under the Uniform Anatomical Gift Act, in conformity with hospital protocols established to comply with Section 7184 of the California Health and Safety Code (effective January 1, 1986).

4. The patient should be pronounced dead before disconnecting the respirator or ventilator. Once the patient is pronounced dead and the time of death has been established, the disconnection of the respirator or ventilator has no greater medical or legal significance than the removal of any other modality (e.g., arterial line, IV, nasogastric tube, shunt, etc.) from the body of a dead patient.
APPENDIX III

DIRECTIVE TO PHYSICIANS
AND DURABLE POWER OF ATTORNEY
FOR HEALTH CARE

Decisions regarding life-sustaining treatment may arise in situations where the patient has previously signed a Directive to Physicians under the California Natural Death Act (sections 7185 through 7195 of the California Health and Safety Code) or a Durable Power of Attorney for Health Care (sections 2410 through 2443 of the California Civil Code). For further information regarding these documents, physicians should consult the California Hospital Association Consent Manual, available in most hospital administration offices. Chapter 5 (12th edition, 1985) discusses Directives to Physicians; Chapter 2 reviews the Durable Power of Attorney for Health Care.

Physicians are encouraged to discuss the availability of these documents with patients.
These guidelines are designed to apply to clinical situations involving adults (persons 18 years of age and older) only. Although, in general, parents and court-appointed guardians have legal authority to make treatment decisions for minor children, recent developments in Federal and California law relating to "medical neglect" and the publication of relevant regulations by the U.S. Department of Health and Human Services and the California Department of Social Services make such decision-making far more complex and sensitive. For current information, physicians should consult administrators, legal counsel, or ethics committees at their hospitals. Additional information is available in the California Hospital Association Consent Manual, Chapter 5 (12th edition, 1985) of which discusses developments in this area and the reporting requirements that may be applicable.