

# THE JOURNAL

of the New York State Nurses Association

VOLUME 45, NUMBER 2

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- **Editorial: Working Toward a Community-Oriented Healthcare System**  
*by Meredith King-Jensen, MSN, MA, RN; Dana Deravin Carr, DrPH, MS, MPH, RN, BC, CCM; Caroline Mosca, PhD-c, MSN, RN; Coreen Simmons, DNP, MSN, MPH, RN; Audrey Graham-O'Gilvie, DNP; Anne Bové, MSN, RN-BC, CCRN, ANP; and Seth Dressekie, MSN, RN, PMHNP-BC*
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## ■ EDITORIAL

### Working Toward a Community-Oriented Healthcare System

We are all cognizant of the fact that the provision of healthcare is ever changing. Driving those changes is the ever-increasing cost of healthcare.

New York's recent effort to transform the state's expensive, inefficient, and ineffective healthcare system into one that achieves the triple aim of healthcare reform—increased quality of care, improved population health, and decreased per-capita costs of care—is the Delivery System Reform Improvement Project (DSRIP). DSRIP's purpose is to fundamentally restructure the healthcare delivery system by reinvesting in New York's Medicaid program, with the primary goal of accomplishing healthcare system transformation, clinical management, and population health. The overarching goal of DSRIP is to facilitate a paradigm shift in the delivery of healthcare from hospital-based care to community health, while addressing the disparities in the accessibility and delivery of healthcare in the Medicaid population. New York nurses have thus far played a meaningful role in the DSRIP process and shared in the goals of improved quality care for Medicaid patients, improving actual health outcomes, and lowering costs of care per patient by reducing unnecessary hospital usage.

The National League for Nursing has recently suggested that nurses at all educational levels be prepared to work in a community-oriented healthcare system. New York schools of nursing have thus far facilitated this initiative and have played a meaningful role in the DSRIP process by recognizing that community nursing is necessary to the overall health of populations, and by presenting nursing students with unique opportunities to care for entire communities. In addition to providing nursing students with a community-based experience, New York schools of nursing have also recognized the need for students to learn the process of recognizing cultural differences within ethnic communities and to integrate understanding of cultural diversity into nursing practice.

The performance of the community health nurse in New York depends on a combination of scientific and practical competencies acquired through educational experiences during nursing curricula. By providing nursing students with meaningful and diverse New York community-based experiences, students begin to recognize that a number of neighborhood and community-level issues can foster an environment of inefficient care delivery and inadequate care receipt. Many New York neighborhoods, often those of a lower socioeconomic level, simply lack the number of providers needed to accommodate the healthcare needs of a population. By contrast, by providing nursing students with meaningful and diverse global-community-based experiences, students begin to recognize that there are a number of neighborhood and community-level models of healthcare that can foster environments of efficient care delivery and optimize care receipt.

In this issue of *The Journal*, readers are offered insights into the healthcare-delivery systems of other countries, and, through comparative analyses, can begin to correlate positive health outcomes to the fundamental healthcare delivery model that has been adopted by those countries to the biomedical model currently existing in the United States. By engaging in these comparative analyses, each reader can inform her or his own opinion on which model can facilitate a more efficient and effective healthcare delivery system.

Additionally, as you read this Journal's article on ethics, you will be offered an opportunity to reevaluate your professional values and to reflect upon how much professional ethics influence your practice.

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# The Road to NCLEX-RN Success

Barbara B. Blozen, EdD, MA, RN-BC, CNL

## Abstract

Using Malcom Knowles's adult learning theory as a guiding framework, this qualitative study explores and assesses accelerated nursing students' perceptions regarding factors that contributed to their first-time success on the National Council Licensure Examination (NCLEX-RN). The results of this research support, broaden, and provide additional knowledge and insight to a currently very limited body of literature on accelerated nursing students, while also outlining a programmatic foundation for success on the NCLEX-RN based on the precedent of students' success and perceptions. This unique research is one of a few studies in which accelerated nursing students are queried for their insights and feedback.

**Keywords:** accelerated nursing programs, accelerated nursing students, second-degree programs, accelerated nursing curriculum, NCLEX results

## Introduction

This study set out to identify what factors are positively associated with NCLEX-RN success by examining the demographics of, and interviewing accelerated nursing students who passed the NCLEX-RN on their first attempt. For the purpose of this research, success is defined as passing the NCLEX-RN, New York State's licensing exam, on the first attempt. Knowledge gained about the characteristics of accelerated nursing students can assist nursing schools in tailoring admissions programs and progression policies, as well as in identifying at-risk students. One of the primary indicators of a nursing program's effectiveness is the pass rate of its graduates on the NCLEX-RN among first-time test takers. A substandard first-time pass rate on the NCLEX-RN can affect a school's funding, enrollment, reputation, and ultimately, its accreditation. Given the paucity of research on accelerated nursing students, this study offers invaluable insight into decision-making about the preparation of accelerated nursing students for professional nursing practice. If there is agreement

that the factors reported by accelerated nursing students in this study are, in fact, fundamental to success on the NCLEX-RN, nursing faculty will need to incorporate and integrate them into every stage of nursing education, beginning with the selection process for admission into accelerated programs, and including alterations of their pedagogical approaches and educational programing. In addition to the impact of these findings on accelerated nursing students, the findings of this study have implications for educational policy, universities, schools of nursing, and recruitment as it relates to target populations and curriculum strategies in accelerated nursing programs. Information gleaned from this study will help accelerated nursing program administrators reevaluate their admission criteria and modify the interview questions asked of those seeking admission to their programs. Nursing faculty will gain information to assist in developing better ways to support accelerated students and aid in their understanding of essential elements of accelerated programs, which in turn, can lead to better success for students.

## Background and Significance

In December 2012, the National Council of State Boards of Nursing (NCSBN) Board of Directors voted to raise the passing standard for the NCLEX-RN. In December 2015, the NCSBN voted to uphold the passing standard for the NCLEX-RN. The passing standard was revised from -0.16 logits to 0.00 logit (NCSBN, 2015). A substandard, first-time passing rate on the NCLEX-RN can affect a school's funding, enrollment, reputation, and ultimately, its accreditation. For universities and nurses, considering the importance of the first-time passing rate, it behooves nursing programs to determine exactly what factors, measures, and/or resources best ensure

students' success in this regard.

The healthcare industry has been the topic of discussion in the industry and public media on a variety of fronts, one of the most pressing being the nursing shortage. It is expected that employment rates for RNs will surpass those of all other professions (USDHHS, 2013). Currently, 16,935 students are enrolled in the nation's 293 accelerated entry-level baccalaureate programs, up from 14,124 in 2011 (AACN, 2015). This is in line with the fact that over the past two decades, the number of accelerated nursing programs has proliferated from 31 in 1990 to 293 in 2015 (AACN, 2015).

## Research Questions

*The research questions that guide and inform this study are as follows:*

Research Question 1	What are the experiences and challenges of accelerated nursing students on their paths to success in passing the state licensing exam (NCLEX-RN) on their first attempt?
Research Question 2	Several factors that relate to students' success on the NCLEX-RN seem to emerge from the literature as important; how do students perceive how three of these (academic background, demographics, and program elements) influence their success on the NCLEX-RN?
Research Question 3	What factors do accelerated nursing students identify as the most critical to their success in passing the NCLEX-RN on their first attempt?

## LITERATURE REVIEW

### Predictors of Success

Although quite a number of research studies have compared accelerated and traditional nursing students, very few have compared the success rates of traditional students to accelerated students on the NCLEX-RN. One such study examined predictors of success and found a difference for accelerated students who held a previous science degree at the time of their NCLEX-RN testing (Abbott et al., 2008). Amy Abbott and colleagues (2008) found that students who already held a science degree were more likely to be successful on their first NCLEX-RN attempt. A 2013 Barbara Penprase and Meghan Harris study found that the completion of two mandatory courses offered in the accelerated curriculum, "Developmental Psychology" and "Health Assessment," was an accurate predictor of students' successful performance on the NCLEX-RN.

Of three additional studies comparing NCLEX-RN first-time pass rates between traditional and accelerated students, two found no statistically significant difference in NCLEX-RN first-time pass rates between the two student groups, but noted that accelerated students did score higher and had higher pass rates (McDonald, 1992; Mills et al., 1992). W. K. McDonald (1995) found that out of a total of 56 traditional and accelerated students, the 27 in the accelerated group scored higher on nursing performance and had a higher passing rate on the NCLEX-RN than the 27 traditional nursing students.

A. C. Mills and his colleagues (1992) found that by the end of the first semester, the model used in their research on the NCLEX-RN predicted the failure for 94% of those who failed, but it was less accurate in correctly predicting the success of those who passed. Their study identified variables that placed the accelerated student becoming at-risk, including, first-semester GPA, gender, and having had a foreign education. Lastly, Mills and colleagues (1992) found a positive correlation between each full letter grade increase in GPA and students' success in passing the NCLEX-RN. Their research suggests that a positive relationship exists between GPA and NCLEX-RN success.

Regina Bentley (2008) used a correlational design to compare accelerated with traditional students (N = 224) and their success on the NCLEX-RN. She found no statistically significant difference in the pass rates of the two groups, but found science GPAs to be significant determinants for passing the NCLEX-RN for both groups. The sample sizes of the two groups used in this study were disproportionate: 52 accelerated student participants and 172 traditional students. This disparity between the number of accelerated and traditional students is common—accelerated programs typically enroll fewer students due to a number of significant variables, including the shortage of nursing faculty available to teach.

In summary, Mills (1992) found cumulative GPA to be a predictor of NCLEX-RN success, while Bentley (2008) cited the grade on pre-admission science courses, the number of C grades on nursing clinical courses, and

scores on the Health Education Systems Incorporated (HESI) exit exam to be predictors of success. Fatma Youssef and Nancy Goodrich (1996) reported accelerated students had significantly higher GPAs ( $M = 3.34$ ) than traditional students ( $M = 2.85$ ). In contrast, McDonald (1995) determined that GPA had no impact on exam outcomes. In yet other research, it was found that accelerated students performed significantly higher according to every measure than did students in traditional programs. Age was not found to be predictive of success in either group (Korvick et al., 2008; McDonald, 1995).

L. M. Korvick and colleagues' (2008) research demonstrated that the science GPA of students were associated with academic performance employing a retrospective, quasi-experimental research design at a medium-sized, private, urban university in the Midwest. Under controlled conditions, their study compared 29 accelerated second-degree BSN and 32 traditional BSN students matched for identical instruction and performance measures. They examined class test scores, nationally standardized examination scores, laboratory skills performance, and final course grades. The results of the study revealed with statistical significance that the mean scores of the accelerated students exceeded the mean scores of the traditional students. More noteworthy among the results of the study was that science GPAs for accelerated students were consistently higher than those of the traditional students throughout the program, demonstrating that a higher science GPA is positively associated with academic performance. However, accelerated students' science GPAs had little variability as they related to the total points for the semester as compared to those of traditional students, who showed a moderate correlation to their total points for the semester (Korvick et al., 2008). The previous baccalaureate GPAs of both groups were minimally a 3.0–4.0, and all other requirements for admission were identical except for the accelerated students' requirement of at least one B in prerequisite science courses.

Though a number of studies have reported a positive relationship between GPA and NCLEX-RN success among both accelerated and traditional students, the most notable limitation of these studies are their small sample sizes, which may account for the studies' varying research conclusions.

## Theoretical Framework

The theoretical framework that guided this study stemmed from Knowles's (1990) theory of andragogy. Knowles, who has widely explored and written on principles of adult learning, describes andragogy as the art and science of helping adults to learn. His theory of andragogy proposes that adult learners learn best when they learn experientially, understand why they need to learn a concept, learn in a problem-oriented manner, and when the concept can be applied immediately. Pamela Cangelosi's (2007a) research found that nursing faculty should listen to the voices of accelerated nursing students, thereby allowing individuals to learn nursing skills and concepts in a manner better suited to their respective styles and needs. The principles of adult learning theory must be incorporated into the teaching of accelerated nursing students. Cangelosi (2007b) points out that nursing faculty must incorporate and build upon accelerated students' backgrounds. Adult learning theory supports the self-direction of an adult learner (Knowles, 1990). Hence, the learning environment of adult accelerated nursing students needs to embrace Knowles's theory of andragogy.

## Method

Following approval of the university's Institutional Review Board (IRB) every participant in this study signed an informed consent form, access was granted, and interviews began. To maintain confidentiality, all students' names were replaced by pseudonyms, and all collected data was coded to ensure anonymity. Participation in this study posed no anticipated risks or discomfort for any individuals, and participants were not coerced. No subjects in the study received any form of payment for their participation.

Due to the nature of the proposed question, "What are the factors identified by accelerated nursing students that affect their success in passing the NCLEX-RN on the first attempt?" a grounded theory approach informed this qualitative study. A grounded theory approach was used to spawn a general explanation that gives rise to predictive statements about individuals' experiences (Creswell, 2005). Anselm Strauss and Juliet Corbin (1998) have detailed the phases of grounded theory, starting with the collection of data, and ending with writing about the data. Using a grounded theory approach, the researcher gleaned themes from interviews with accelerated nursing students. Grounded theory lends itself to explaining a process by gathering information to develop a theory. A systematic design based in grounded theory was used, as it lent itself to formation of categories about the phenomenon being studied (Creswell, 2005). The purpose of this method is to describe, in detail, a particular phenomenon so that readers can appreciate the experience of participants. The research questions and grounded theory design enabled the researcher to holistically explore the experiences described by accelerated nursing students.

This study's subjects were drawn over a nine-month period from among students who had both completed the NCLEX-RN and graduated from a private, Mid-Atlantic university. Using the snowball technique, (a non-probability method, which relies on referrals from initial subjects to generate additional subjects [Vogt, 1999]), 12 participants were recruited. Eleven of the twelve participants were working as registered nurses in acute care hospital settings at the time of their interviews.

This study used semi-structured interviews to uncover the perspective of accelerated nursing students (Bogdan and Biklen, 2003). "Qualitative interviewing begins with the assumption that the perspective of others is meaningful, knowable, and able to be made explicit" (Patton 341). Twelve individual, face-to-face interviews that explored the participants' perceptions of their NCLEX-RN success were conducted over an eight-week period at a confidential site. Each semi-structured interview lasted between 60 and 90 minutes, and was audio-recorded. All interviews were held following the participants' completion of the NCLEX-RN.

The questions generated for the interviews were synthesized from current literature and the primary research question. All interview questions were open-ended, neutral, and woven into a conversational format. The researcher asked each question, with the order of some adjusted based on the participant's responses and/or the direction of the conversation; the researcher also ended discussion on all questions when no new information was being relayed. The researcher summarized the answers to all questions, and, when necessary, asked for further clarification before proceeding to the next question. The trajectory of the interview was directed by the questions asked by the researcher and replicated the tone of natural inquiry. Once data saturation was reached, the data was coded and analyzed, and categories were developed based on all the data that was collected. In the second phase of axial coding, the researcher selected one open-coded category as the core,

and then linked the other categories to it via a coding paradigm. Selective coding was the third phase, whereby the researcher developed and wrote the theory derived from the interrelationship of the categories in the axial coding.

In qualitative research, the researcher must verify that all data is valid. There are a number of methods for doing so. To improve the probability of producing credible data, Yvonna Lincoln and Egon Guba (1985) assert adherence to three behaviors: prolonged engagement, persistent observation, and triangulation. According to Frances Maggs-Rapport (2000), data is deemed trustworthy if one engages in persistent observation, prolonged engagement, and triangulation. Prolonged engagement offers the researcher the opportunity to earn and build the trust of participants. As triangulation necessitates the use of multiple methods, triangulation also improves the likelihood that interpretation will be accurate. Other qualitative researchers label the validation of data with differing nomenclature such as “member checking” (Creswell’ 2005), and “trustworthiness” and “authenticity” (Lincoln and Guba, 1985). Janice Morse and colleagues (Morse et al., 2002) feel that the literature on validity has become muddled to the point of making it unrecognizable. To attain trustworthiness, they recommend the use of several strategies, including negative cases, peer debriefing, prolonged engagement,

persistent observation, audit trails, and member checks. Triangulation requires the researcher to corroborate evidence from different individuals, and to use a variety of types of data and data collection, such as notes and interviews (Creswell, 2005). According to John Creswell (2005), drawing data from multiple sources of information, various procedures, and a diversity of individuals ensures that the research will be accurate. Creswell (2005) also cites member checking as a means of enhancing the accuracy of the research. Member checking is the process by which the researcher involves participants in checking the accuracy of the researcher’s accounts of the collected data. In member checking, findings are shared with the participants, who review them for accuracy. When all data is checked and verified, the researcher increases confidence in achieving validity.

For this qualitative research, issues of credibility were addressed with the following methods: (1) to explicate the researcher-participant relationship, field notes on actions, interactions, and body language during the interviews were collected immediately following each interview; (2) all students were asked to read excerpts from the data to confirm that it was meaningful, applicable, and accurately representative of their experiences; (3) a qualitative nurse researcher reviewed all the data and confirmed that the essence of the categories was accurate and true to the data.

**Table 1. Demographics of Accelerated Nursing Students Interviewed**

N = 11	FEMALE 9 White/Caucasian 2 Asian
N = 1	MALE 1 African American
Age Range	20-45 Years
Healthcare Experience	50% had previous healthcare experience
Bachelor’s of Science Degree	58% held a Bachelor’s of Science Degree
Children	25% had between 3-5 children while attending an accelerated nursing program

## Results

The common and salient factors that emerged are presented in four major categories: (1) practicing NCLEX-RN questions; (2) partaking in nursing clinicals; (3) receiving support; (4) participating in an NCLEX-RN review course (see fig. 1).

Participants recalled the accelerated nursing program experience clearly and were eager to serve as interviewees. The demographics of the participants (N = 12) revealed that one participant was male, and that the participants ranged in age from 20-45 years old, with the majority (n = 8), being between 25-30 years of age. Five of the participants were married, with three having between two and five children, and one participant qualified as the head of household. Nine participants were white/Caucasian, two were Asian, and one was African-American. Half of all participants

had no healthcare experience prior to enrollment in the accelerated nursing program, and although all held a bachelor’s degree, only seven were in science. All participants self-reported having earned a GPA of 3.0 or higher in their previous bachelor’s programs, and 11 self-reported a science GPA of 3.0 or higher. Four participants entered the accelerated program eight or more years after earning their first bachelor’s degree, and five had been out of school for four or five years. Nine participants were United States citizens, two were permanent residents, and one was enrolled on a work visa.

The summary of demographics of participants in this study is somewhat different from the characteristics of participants cited in current published studies; specifically, the number of children/dependents, and the extent of previous healthcare experience were greater in this group. Although small, the sample size of 12 provided a profile of the type of student in the accelerated nursing program.

Eleven of the twelve participants interviewed clearly stated that answering practice NCLEX-RN questions was the most crucial component of their success on the exam. Students in the accelerated program are exposed to NCLEX-RN-style questions throughout their course of study; as the program progresses, the cognitive level of the questions increases in difficulty, moving from knowledge and comprehension to analysis and evaluation, similar to Bloom’s taxonomy. Some participants reported that sitting at the computer simulating a timed test session “was useful and made it like a ‘real test’”; others corroborated, saying, “doing a full NCLEX-RN practice test” helped them to be successful. Another stated, “I think the questions and just taking a full test was beneficial.”

After practicing NCLEX-RN questions and tests, the second most cited reason for success as perceived by participants were their clinical experiences: “clinical (experiences) made it real”; “as if the textbook came to life”; “what we learned in theory came to life” (in clinical); and “paramount to anything, the clinical experience is more valuable to me.”

Most participants reported that their hands-on experiences in the clinical setting were instrumental to their success, and, in similar terms, most echoed the words of one student who commented that clinical experiences were “key to understanding the patient, their disease process, and retaining the skills learned in the lab.” The importance of the application of theory in clinical settings cannot be understated, and other comments from participants illustrate how vital it is, not only for connecting theory, but also for contributing to students’

NCLEX-RN success. One stated, “You learn 85 percent through clinical,” while another related, “Being able to touch it and see it in clinical really helped.” Yet another said, “Theory came to life in my clinical experience, and the clinical experience definitely made it real and helped me wrap my head around the theory.”

All of the participants spoke passionately about the support they received from their family, professors, and peers, and how this contributed to their NCLEX-RN success. Family members performed the mundane tasks of everyday life, thus enabling students to devote their time and attention to studies. Participants also spoke about the financial support they received from their families, but many also privately mentioned the fiscal strain of attending the accelerated nursing program. In the interviews, more than half of participants related that professor and peer support also played a significant role in their NCLEX-RN success, saying they gained “academic strength” from their classmates and professors. Professors who teach adult learners are cognizant of their students’ academic and life workloads, and often provided the specialized support such students needed. One participant recalled, “I could not have done it without the support of my classmates. . . . I think just knowing that so many people were supportive and were pulling for me to do it, whether it be my family or my classmates.” The participants interviewed were part of a cohort group, which they felt contributed to their cohesiveness and success. Many participants also indicated that the NCLEX-RN review course they completed positively affected their success, saying that it “summed up all we did.”

Most participants reported that their hands-on experiences in the clinical setting were instrumental to their success

### THE ROAD TO NCLEX-RN SUCCESS

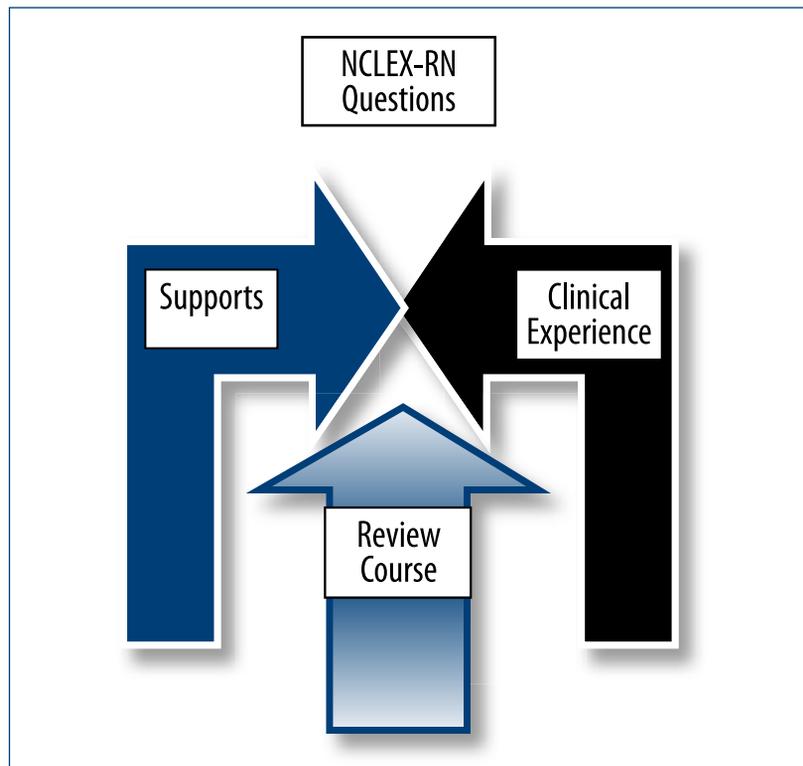


Figure 1. Reported factors contributing to NCLEX-RN success, using grounded theory methodology.

## Conclusion

Accelerated nursing students already hold a bachelor's degree; they present with the need to learn nursing skills, theories, and concepts as an adult learner, and must do so in a condensed amount of time. As the participants in the study stated, the practicing of NCLEX-RN questions was the factor that most contributed to their success on the NCLEX-RN. In addition, participants related their clinical experiences as a contributing factor to their NCLEX-RN success, as well as support from family, faculty, and peers.

## Recommendations for Future Research

Given the findings of this study, and as literature remains sparse in this area, additional research should be conducted on accelerated nursing

students. Although the study's small sample size limits generalizability, the rigor with which this study was conducted produces significance. Similar multisite studies should be conducted to ascertain accelerated nursing students' perspectives, ideas, and feedback. Studies that address the longevity of accelerated nurses and their commitment to the nursing profession should be explored. Future research should examine whether or not accelerated nursing graduates remain in nursing or if they transition to yet another career. All of these inquiries, and more, would help to further understanding of the long-term success of accelerated nursing programs and the endurance of graduates.

## Demographic Questions

The following questions seek to capture basic demographic information. The information collected will not be used to personally identify you.

1. What is your gender?      Male       Female
  
2. What was your age upon entering the accelerated program?  
 20-25 years     25-30 years     31-35 years     36-40 years     41-45 years     45 and above
  
3. Please select the category that best describes your ethnic background.    American Indian or Alaska Native   
 African-American       Asian       Hawaiian/Pacific Islander       Caucasian/White   
 Hispanic or Latino       Other (Specify) \_\_\_\_\_
  
4. What is your marital status?    Single       Married       Divorced       Separated
  
6. Including yourself, how many members are in your household?    0-1     2-3     4-5     6 or more
  
8. How many years of healthcare experience did you have prior to the start of the accelerated nursing program?  
 None       1-2 years     3-5 years     6-8 years     9-10 years     11 years or more
  
9. Which of the following best describes your bachelor's degree?      Science degree       Non-science degree
  
10. More specifically, which of the following academic programs best describes your bachelor's degree?    Biology       Business   
 Communication     Education     Engineering     Law     Liberal Arts     Mathematics     Medicine   
 Psychology       Science       Other (Please specify) \_\_\_\_\_
  
11. What is the highest degree you have earned?    First professional degree (e.g., MD, DDS)     Doctoral degree (e.g., PhD, EdD)   
 Master's degree       Bachelor's degree       Associate degree       Other (Specify) \_\_\_\_\_
  
12. Have you earned a master's degree?    Yes     (What field?) \_\_\_\_\_    No
  
13. Based on a four-point scale, what was your overall GPA prior to entering the accelerated nursing program?  
 2.0-2.4     2.5-2.9     3.0-3.4     3.5-3.8     3.8 and above
  
14. Based on a four-point scale, what was your SCIENCE GPA prior to entering the accelerated nursing program?  
 2.0-2.4     2.5-2.9     3.0-3.4     3.5-3.8     3.8 and above
  
15. What is the number of years since you earned your first bachelor's degree and your enrollment into the accelerated nursing program?  
 0-1 years     2-3 years     4-5 years     6-7 years     8 or more years
  
16. What is your citizenship status?    US citizen       Naturalized citizen   
 Permanent resident (green card holder)       Work visa

## Interview Guide

Tell me about your experience as an accelerated nursing student.

Tell me from your perspective what was the most important factor (or factors) that influenced your success on the NCLEX-RN?

Tell me about one incident that you experienced that you feel best prepared you for the NCLEX-RN.

In retrospect, what suggestions can you offer for enhancing the preparation of accelerated nursing students for the NCLEX-RN?

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## Analysis of an Ethical Conflict in Practice

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### Abstract

The controversy over whether it is professional and/or ethical for nurses to unionize and engage in strike activity has been longstanding and continues today. Those who oppose the idea of nurses joining a union and engaging in strike activity believe that the behavior is unprofessional, unethical, constitutes patient abandonment, and is antithetical to nursing's primary commitment to patient care and advocacy. Nevertheless, since 1946, the American Nurses Association (ANA) and, since 1999, the International Council of Nurses (ICN) have supported the nurses right to organize, to bargain collectively, and to take strike action, so long as the strike action is a measure of last resort and all essential patient services have been provided for. Since the 1940s, both the National Labor Management Relations Act (also called the Taft-Hartley Act) and the National Labor Relations Act (NLRA) provide for and protect a striking workers right to engage in behaviors and activities that are supportive of the union's cause.

When striking nurses are faced with the decision over whether or not to allow union truckers making deliveries of essential supplies and food to cross the picket line, a perplexing ethical dilemma and moral distress can develop. Nurses possessed of the requisite skills of moral reasoning and leadership as well as the strategies to carry out moral decisions can overcome and resolve such ethical tensions while, concomitantly, contributing to essential social goods such as advocating for self, advocating for the provision of health for all, and supporting the principles of beneficence, justice, and nonmaleficence.

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## Description of the Ethical Conflict

In an effort to establish and maintain a working environment conducive to exemplary patient care and outcomes, unionized nurses will often negotiate with their employers to secure: (1) safe staffing ratios; (2) no mandatory overtime; (3) a maximum number of continuous work hours; and (4) a prohibition to float nurses to a unit outside the individual nurses scope of knowledge, practice, or skill. In opposition, healthcare employers will frequently want to settle the contract with no provisions for: (1) staffing ratios; (2) the abolishment of mandatory overtime; (3) a cap on the continuous work hour obligation; or (4) limitations on the ability to float nurses whenever necessary and wherever needed. In those circumstances where there is no meeting of the minds, after debate and careful consideration nurses have often engaged in strike activity.

While maintaining a strike line, delivery trucks carrying medications, oxygen, and food might stop at the entranceway and declare that they will not cross the strike line unless the nurses give them permission to do so.

Federal law requires nurses to give a ten-day notice of their intent to strike. This notice is specifically designed to give facilities time to stop admitting patients, transfer existing patients to other facilities, and reduce medical procedures that require nurse-intensive labor. Nevertheless, hospital management often responds to the notice with resistance, and rather than implement a well formulated contingency plan, facilities will often react by continuing to admit new patients and proceeding with normal operations. This inevitably strains the system, instigates, and aggravates the ethical dilemma.

## The Source of the Conflict

In addition to the duty to care and advocate for their patients, nurses must assume many other collective responsibilities. These include advocating for: themselves; improved nursing standards; a safe work environment that is conducive to the delivery of quality patient care; a work environment that facilitates and supports the standards of nursing practice, the Nurse Practice Act, and community and national healthcare needs (Ketter, 1997).

Recognizing the need to maintain high standards of patient care in hospitals and facilitate and support the standards of practice for the nursing profession, and further recognizing that corporate concerns for improving the bottom line and controlling healthcare costs through managed-care programs has resulted in pervasive infringements and restrictions on nursing practice, the American Nurses Association (ANA), the national nurses' associations (NNAs), and the International Council of Nurses (ICN) strongly advocate a workplace that allows for excellence in nursing practice. In so doing, the ICN has charged the NNAs and the ANA has charged the state nurses associations (SNAs) with the responsibility of: (1) establishing, promoting, and maintaining programs which enable nurses to achieve a level of economic and social recognition commensurate with their contribution to society; (2) developing and maintaining mechanisms

which support the negotiating rights of nurses, provide protection from exploitation, and balance equity and employment issues; and (3) developing training programs which adequately prepare nurse employees for resolving employment concerns (International Council of Nurses [ICN] *Guidelines on Essential Services During Labour Conflict*, 2010; Ketter, 1997; Tiedje, 2000).

## Identification of the Ethical Dilemma: Moral Distress in Nursing

Some argue that despite references replete with accountings to the historic role of nursing in social reform, the *Code of Ethics for Nurses with Interpretive Statements* gives short shrift to a nursing model that endorses action to bring about broad systems change intended to improve national

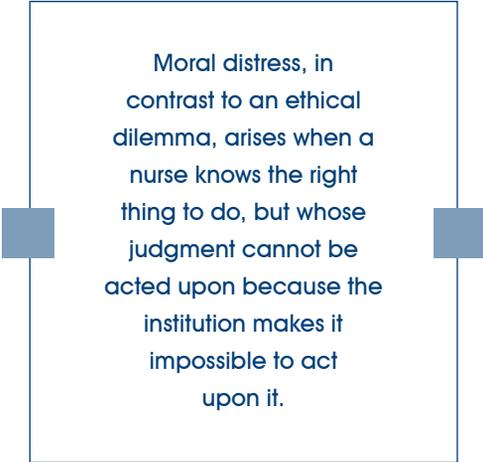
health disparities (Bekemeier & Butterfield, 2005). Others argue that although the concepts of social justice espoused in our three national nursing documents (*Code of Ethics for Nurses with Interpretive Statements*, *Nursing's Social Policy Statement*, and *Nursing: Scope and Standards of Practice*) require nurses to be accountable to both patients and the larger bureaucratic healthcare system, nevertheless, a great many nurses often maintain a self-effacing demeanor both in the sense of expectations about outcomes that will result from nursing interventions ("what difference will my actions make?") and expectations ("can I do this?"). This is especially noted in healthcare environments that are driven by efficiency, cost-containment pressures, and improving

the bottom line (Tiedje, 2000). Nurses have been noted to demonstrate a pattern of silencing themselves and will often sacrifice interpersonal confrontation and assertiveness to keep peace while not articulating what they need or feel directly (Demarco, Roberts, Norris & McCurry, 2007). Such self-silencing is often the direct result of the influence of organizational practices and business conditions on the ethical beliefs and clinical practices of nurses. The institutional difficulty an individual nurse has in speaking up and out often leads to feelings of powerlessness, or moral distress.

What results are feelings of frustration, anger, guilt, and a sense of moral responsibility accompanied by the knowledge that one cannot singularly change what is happening. Finally, and perhaps ironically, this situation often ultimately leads to the conclusion that only concerted collective action can adequately address deficiencies in the quality of patient care and the quality of working life (Andre, 1998; Tiedje, 2000).

Nevertheless, historically, there has been a shift in the conceptualization of the role of the nurse from loyal subordinate to autonomous advocate. The *Code of Ethics for Nurses with Interpretive Statements* (American Nurses Association [ANA], 2001) directs nurses to act to change those aspects of social structures that detract from health and well-being. The nurse's role as patient advocate and self-advocate in the instant case is premised on the following specific *Code of Ethics* provisions:

**Provision 2:** The nurse's primary commitment is to the patient, whether an individual, family, group, or community;



Moral distress, in contrast to an ethical dilemma, arises when a nurse knows the right thing to do, but whose judgment cannot be acted upon because the institution makes it impossible to act upon it.

**Provision 3:** The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient;

**Provision 5:** The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth;

**Provision 6:** The nurse participates in establishing, maintaining, and improving healthcare environments and conditions of employment conducive to the provision of quality healthcare and consistent with the values of the profession through individual and collective action;

**Provision 8:** The nurse collaborates with other health professionals and the public in promoting community, national, and international efforts to meet health needs;

**Provision 9:** The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy.

The possibility that the nurse's obligation to self, to the profession, and to the future patient might conflict with his/her obligation to the present patient is a perplexing and difficult ethical dilemma. Nursing's national documents declare that the primary ethical commitment of the nurse is to the patient. At the same time, the profession also requires of the nurse that he/she advocate beyond serving the present patient and engage in activities that bring about social change. What then is the nurse to do when working to benefit self and the profession compromises the care given to present patients?

## Strikes and the Nursing Profession: Considering the Stakeholders' Interests

There are many dimensions to the consideration of whether or not it is ethically and morally acceptable for nurses to engage in strike activity. Tensions clearly exist between the rights and expectations of stakeholders. Some of these tensions include: (1) the right of the nurse to engage in strike activity versus the right of the facility to manage and direct its workforce; (2) the right of the present patient to be attended by a nurse who, presently, is of the opinion that he/she is delivering less than standardized care versus the right of the future patient to be attended by a nurse who is of the opinion that he/she is delivering optimal care; (3) the right of the nurse to fight for working conditions supportive of self, the profession, and the recruitment/ retention of future nurses versus the right of the facility to allocate scarce nursing resources; (4) the right of the professional nurse to practice autonomously versus the expectation that nurses practice subordinately; and (5) the right of the professional associations to expect that their members function, act, and engage in activities that are supportive of and in accord with the profession's values and ethics, including the withdrawal of labor, versus the right of society to expect that the delivery of healthcare will be readily available, of substantive quality, and cost effective (Chadwick & Thompson, 2000; Fry & Veatch, 2000).

Although it is beyond the scope of this paper to address each of these issues in detail, we will look briefly at all of these considerations and examine why nurses are ethically obliged to and can proactively engage in activities supportive of their rights, including the right to strike and to ask union drivers to refrain from crossing the picket line to make deliveries of essential supplies and food.

## Conflict Resolution: Freedom and Power behind Ethical Analysis and Decision Making

Since the purpose of the ANA *Code of Ethics* (ANA, 2001) is to outline the aims, principles, and responsibilities of the profession, we will start our analysis with its provisions. While the first three provisions of the *Code* speak strongly to the premise that the nurse should primarily be focused on care and owes a commitment and duty to advocate strongly for the *patient*, the *Code's* preface defines the term patient as referring to *recipients* (the plural) of nursing care and particularly notes that the derivation of the word is reflective of a "universal aspect of human existence" (p. 6). Thus, the *Code* challenges nurses to understand that the real issues and interests surrounding patient care are premised beyond the traditional province of the care of the individual patient and therefore requires of the nurse the further understanding that he/she be accountable to, be the advocate for, and be the owner of the *health system* problems. The patient, therefore, becomes the much larger class of patients more reflective of the global patient, and the nurse, then, becomes responsible for the evolution of a healthcare system that will address the rights, health, safety, dignity, and care of the global class of patients (Williams, 2004).

Provisions four through six of the *Code* (ANA, 2001) address the nurse's duties to self and to the practice and professional community. Thus, these three provisions challenge nurses to understand that where patterns of institutional behavior or institutional professional practice compromise the integrity of all nurses, whether singularly or collectively, the nurse is obligated to engage in appropriate action. Nurses must ensure that the workplace environment is supportive of the creation, maintenance, and growth of virtues and excellences in nursing practice. Notably, the *Code* identifies that collective bargaining, with all of its concomitant rights, is an ethical and appropriate action not only to assure the right to just compensation and humane working conditions for all nurses, but also to help facilitate the nurse in fulfilling his/her ethical obligation to balance the interests of both nurses and patients alike (Bandman & Bandman, 2002; ANA, 2001, provisions 5.4, 6.1, 6.2, 6.3).

The last three provisions of the *Code* (ANA, 2001) speak to the nurse's obligations to the profession beyond caring for the patient and self and thus challenges nurses to understand that the profession has a social contract with and commitment to humanity. Nurses, therefore, on behalf of all people must engage in collective action on a community, national, and international level. Through the support of and participation in professional associations and community organizations, the *Code* obliges the nurse to identify conditions and circumstances that contribute to barriers to the provision of quality healthcare and then affirmatively and actively participate in institutional, organizational, and legislative efforts to address barriers, to promote health, and to meet national health objectives (ANA, 2001, provisions 7.1, 8.1, 8.2, 9.1; Bandman & Bandman, 2002; Ketter, 1997; Tiedje, 2000).

Learning to identify moral conflict and finding the strength to carry out strategically designed resolves are part of a nurses' moral work. Nurses have a moral responsibility to advocate against the acceptance of a substandard workplace and practice conditions that negatively affect the quality of healthcare, place the public at risk, demean the profession or the professional contribution of the nursing practitioner, abandon the public's

trust, or contribute to the notion that a reduction in the nurse workforce is directly related to cost effective outcomes (Tiedje, 2000). Thus, when employer resistance of the kind described in our scenario exists, nurses, with the help of their state nurses association leaders, are morally and ethically justified in engaging in strike activity if, after careful consideration, this is the only way to secure a safe and productive work environment or address professional or national healthcare interests.

Nevertheless, many nurses still struggle with the thought that strike action will result in harm to present patients and are not prepared to impose such suffering on their patients. Nurses are obliged to consider the degree of suffering imposed on those under their care during strike action. What then are nurses to do if they believe that strike action and the request to union drivers that they refrain from crossing the picket line and refuse to deliver essential supplies and food will result in harm to their patients? Could such actions be morally or ethically justified?

### Taking a Utilitarian View of Things

Utilitarianism, as a consequence-based ethical theory, is premised upon the belief that the only real factors a practitioner should consider when making an ethical decision are the consequences (or outcomes) of the actions; and whether there will be a positive outcome for a majority of people involved. With classical utilitarianism, it doesn't matter why a person does something (intent), nor does it matter what a person does (actions); only the end result and numbers of people affected matters. Thus, taking a utilitarian view of things, the nurse is indeed obliged to allow a few patients to suffer, or possibly even die, if the strike activity results in the overall improvement of the quality of care for the greatest number of patients and the overall improvement of the workplace environment for the greatest number of nurse employees (Bandman & Bandman, 2002; Chadwick & Thompson, 2000). Therefore, from a utilitarian viewpoint, the kind of strike action described in our scenario would be ethically justified if it actually prevented many more negative outcomes or deaths from taking place in the future.

Some practitioners nevertheless believe that the utilitarian view is unsophisticated and unacceptable. What professional nurse would find such action acceptable, knowing that, as a direct result of his/her actions, patients will suffer or die? But is there a moral difference in principle between causing harm through strike action and allowing it to happen by not taking such action? Will the degree of suffering imposed on patients as a result of strike activity be greater than if nurses take no action at all? Do patients suffer any less, or are there significant reductions in the numbers of patient deaths when nurses decide not to strike? Nurses should take comfort in the knowledge that: (1) there are no records of a positive correlation between loss of life and nurses' strike activity in this country (Ketter, 1997); and (2) strikes have been relatively uncommon events in the healthcare bargaining history in this country (Lancaster, 1999).

### Strikes in Support of the Concepts of Justice, beneficence, and Nonmaleficence

Outgrowths of utilitarian ethics and morality are the principles of justice, beneficence, and nonmaleficence (Bandman & Bandman, 2002;

Beauchamp & Childress, 2001). Justice refers broadly to the requirement that nurses advocate for fair distribution of all rights in society, including the right to access healthcare, the right to receive quality healthcare, and the right to receive cost-effective healthcare. Beneficence refers broadly to the requirement that healthcare workers, as healthcare (change) agents, must take affirmative, positive steps to help others. Nonmaleficence refers broadly to the requirement that nurses refrain from harming others; however, implicit in this principle are the distinctions between killing versus letting die, intending versus foreseeing harmful outcomes, withholding versus withdrawing treatments, and ordinary versus extraordinary treatments (Beauchamp & Childress, 2001).

Justice, as an element of social justice, would measure what others have and what others should be able to access within the context of institutional conditions that are needed. Thus, a social justice ethical framework would actively analyze and concern itself with who is harmed by and who would benefit from inequities, environmental exploitation, discrimination, and oppression. Outcomes should be focused not on one-on-one nursing care, but on whole populations, broad systems change, and political action. Therefore, similar to the utilitarian view, this core value necessitates a responsibility on the part of the nurse to engage in social action and to collaborate with others. Nurses must address the needs of the community of people, including the people and populations most impacted by negative social conditions, and to address failures in health systems that undermine the health of populations in a way that would positively affect the greatest numbers of people (Bekemeier & Butterfield, 2005).

Beneficence, as an element of a social obligation of loyalty, would require of healthcare or union workers who have no particular grievance of their own to decide to strike in support of others. Sympathetic strikes can take on global proportions, as would be the case here if fellow union supporters (union truckers) refused to cross a nurses' picket line to deliver essential supplies and food. Indeed, affiliated groups would have obligations of loyalty and beneficence to join the strike since they are in a unique position to help remedy the healthcare and workplace injustices by similarly withholding their labor (Shaw, 2004).

Nonmaleficence, as a social element, requires nurses to intentionally refrain from actions that cause harm. Rules on nonmaleficence, therefore, would take the form of "do not do X" (Beauchamp & Childress, 2001). Consistent with this principle, therefore, it would be morally and ethically wrong for nurses to make the decision to remain silent ("do not speak out") or to refrain from taking action ("do not do anything") inasmuch as these decisions are likely to result in inflicting harm to both patients and nurses alike by implicitly accepting a substandard workplace and practice conditions that negatively affect the quality of healthcare. Indeed, such failure to act could very well be viewed as negligence, a term that is generally regarded as blameworthy and is consistent with the act of maleficence (Pozgar, 2004).

### Opportunities for Leadership: A Call for moral and ethical Action

While interested dialogue is widely recognized as the principal and most effective means of resolving healthcare professional and workplace issues, where employer resistance in negotiations causes serious deficiencies in the quality of care, working life, and economic rewards of nurses as to affect the long-range prospects for maintaining high standards

of nursing care, nurses must choose to take collective action to bring about needed changes. Such action should comply with written guidelines, and such guidelines should summarize the moral and ethical commitments, objectives, and responsibilities of nurses and employers and detail the bottom line for striking as well as those actions that the professional associations will not support, such as engaging in illegal activity or in activity consistent with the total abandonment of all patient care services (Ketter, 1997). In extreme situations such as the one described in our scenario, such collective actions should include (New York State Nurses Association, 1977):

- Review of all circumstances to ensure that prior nursing actions are in compliance with a clear definition and documentation of those terms and conditions required to maintain professional values and standards of practice;
- Review of employer actions to affirm that they have failed in their responsibility to provide the environment essential for the maintenance of those standards;
- Review of all actions to ensure that good faith attempts at communication, bargaining, and settlement to secure such terms and conditions have been undertaken;
- Public exposure (community leafleting/hand-billing, letters to community leaders, letters to the editor, rallying, informational picketing, etc.) of those particular conditions which jeopardize standards of practice, including notification to and solicitation of public, regulatory, accrediting and other professional groups/bodies to support attempts to modify inappropriate terms and conditions;
- A call to action to, and the securing of a majority vote from, the nurses to proceed with organizationally disruptive concerted activity;

- The requisite filing of the ten-day notice to the employer and the Federal Mediation and Conciliation Service (FMCS) in those situations where execution of less disruptive measures does not result in the protection of professional standards;

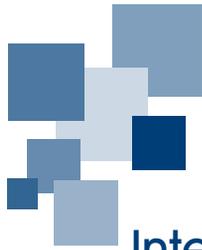
## Conclusion

Nurses have two principal ways of dealing with ethical, moral and workplace conflicts: they can react to the conflict, or they can work to resolve the conflict. Nurses who react to the conflict by withdrawing from action or by silencing themselves do not resolve the conflict. Rather, these nurses are likely to experience pent-up feelings of powerlessness which will only surface at a later date, and possibly contribute to non-constructive and potentially disruptive behaviors. This response should be abandoned as “the response of the past” as it will not serve our profession into the future.

On the other hand, nurses who work to resolve moral, ethical, and workplace conflicts collaboratively have a unique opportunity to become change agents. If nursing is to survive in the years to come, nurses need to sharpen their skills and transform their strategies. Trying different approaches to conflict resolution need not focus on finding the one best, perfect solution. Rather, nurses should try several different approaches, build on what works, and discard what doesn't. Nurses possessed of the requisite skills of conflict resolution, as well as the strength and motivation to carry out strategic decisions, can overcome conflicts. Concomitantly, nurses can continue in their work of contributing to essential social goods such as advocating for self, advocating for the provision of health for all, and supporting the principles of beneficence, justice, and nonmaleficence (Forman & Powell, 2003, Lancaster, 1999).

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# International Service-Learning Projects: A Role for Nursing Students

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## Abstract

International service-learning activities are becoming more popular in academic programs. Nursing programs are uniquely positioned to embed service-learning projects in their curriculum because their curricula address global health, health disparities, and health policy. This article describes the role of service-learning in developing student skills by moving them from theory to practice. Further, this article describes three faculty members' experiences visiting Guatemala to determine the suitability of this location for a service-learning activity for undergraduate and graduate nursing students. This article furthers our understanding that service-learning is a pedagogical framework.

**Keywords:** service-learning, Guatemala, nursing students, nursing programs, international service projects

## Introduction

International service-learning activities are becoming more popular in academic programs because faculty see the value in bringing students to areas outside the United States. Service-learning is defined as teaching

and learning strategies that utilize community service and principles of civic responsibility while working with other students, clinical professionals, and community members (Rockquemore and Schaffer, 2000).

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## BACKGROUND

### Nursing and Service-Learning

The four domains of nursing are person, environment, health, and nursing (Jarrin, 2012). This nursing philosophy necessitates an understanding of culture, politics, and policy. Service-learning facilitates teaching strategies that bring the classroom to specific community settings in which education is combined with experiential activities (Bassi, 2011). Service-learning, an important pedagogy, engages students in learning experiences in which they develop a social awareness of a patient's environment (Schmidt and Brown, 2016).

### Curriculum and Service-Learning

In the past, service-learning was not integrated into the curriculum or identified as a pedagogical method. Today, service-learning endeavors to develop curricula that link experiences to specific courses. Additionally, service-learning curricula reflect professional nursing goals of leadership and social justice by providing students with opportunities to practice developing skills (Groh et al., 2011). Further, curriculum promotes students learning about the country being visited within the pedagogical framework of a specific nursing value.

Service-learning curricula bridge classroom and experiential learning because students gain knowledge about the social and political issues of the host country (Grusky, 2000). The curriculum will require that students examine inside influences (social movements, economic resources, and political development), and outside influences (e.g., World Health Organization [WHO], International Monetary Fund, trade treaties, and foreign policy) that affect social policies and health policies. Knowledge gained from service-learning can also be used to reflect upon similar conditions in the United States and how these policies came about and their effect on population health.

### Behavior Development and Service-Learning

Nursing students are educated about leadership behaviors. However, learning these behaviors theoretically are less effective than practicing these burgeoning behaviors. Putting theory into practice requires that students participate in activities that allow them to achieve these skills before graduation. Karen Foli and colleagues (2014) examined the development of leadership behaviors in undergraduate nursing students taking a management and leadership course using service-learning activities. Service-learning did provide students with opportunities to demonstrate leadership behaviors and was an effective tool for observing peer leadership characteristics and community involvement.

### Cultural Awareness and Service-Learning

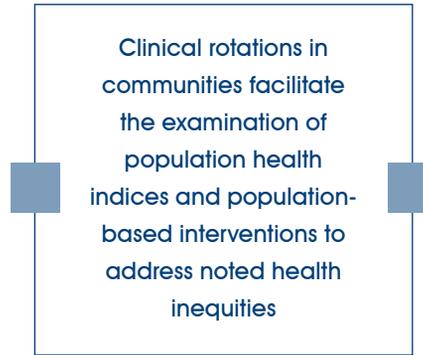
Community-based clinical experiences provide nursing students with a platform to examine social, cultural, and economic differences in patients and communities. Clinical rotations in communities facilitate the examination of population health indices and population-based interventions to address noted

health inequities. Additionally, these rotations allow students opportunities to learn about the cultural values and beliefs of their patients (Amerson, 2010) and how the community is situated to address health issues.

### Experiential Knowledge and Service-Learning

Examining another culture within a service-learning framework provides an excellent platform to discuss health disparities, social services, and socioeconomic issues in greater depth. Because many US students have limited interactions and experiences outside the United States, they often have stereotypical views of other nationalities. International service-learning projects become an important venue for students to learn about a specific community, thus reducing inaccurate beliefs students may hold.

This article describes an exploratory journey undertaken by nursing faculty (two nurse practitioners and a registered nurse [RN] and doctor of pharmacy [PharmD]) in Guatemala. Faculty used this trip to consider implementing international service-learning projects in their nursing program.



## SERVICE-LEARNING IN GUATEMALA

Guatemala was chosen because of faculty connections with the Sisters of Charity nuns, who work in Guatemala. Additionally, the proximity to the United States, cultural diversity, and the increasing healthcare needs of the country made Guatemala a perfect choice to explore the suitability of service-learning activities for undergraduate and graduate nurses.

### Guatemalan Healthcare System

Guatemala is an excellent example of a health system largely reliant on charity care. Government investment only accounts for 14.7%, and healthcare spending is only 6.7% of total gross domestic product (GDP). The healthcare system consists of a private sector (5% of Guatemalans covered), government sector (54% of Guatemalans covered), and social security sector (17% of Guatemalans covered). Indigenous people have the least access to healthcare services (Green et al., 2009). The World Health Organization ranked Guatemala's health system 78 out of 191 countries. WHO ranks countries based on their ability to maximize population health, which consists of the system's responsiveness, equitable distribution of health services, and fairness of financial contributions (Tandon et al., 2001).

### Guatemalan History

United States involvement in Guatemala began in 1954 when the US Central Intelligence Agency backed a coup commanded by Colonel Carlos Castillo Armas against the democratically elected president, Jacobo Arbenz. Guatemalans experienced a 36-year civil war from 1960-1996 and the government in place was considered repressive and militaristic. During the civil war, more than 200,000 indigenous people (largely Mayan) and political leaders were murdered. In 1996, the government signed a peace treaty and formally ended the conflict. When the war ended, a human rights tribunal found that United States involvement in Guatemala contributed to human rights violations, which included training officers in counterinsurgency

techniques and assisting the national intelligence apparatus. The war, however, and the subsequent human rights violations created healthcare needs in addition to increasing poverty (Schlesinger et al., 2005).

Currently, about 15 million people live in Guatemala, the most populous country in Central America. However, large areas are still undeveloped. Guatemala City is the capital of Guatemala. Guatemalan ethnic groups are Mestizo (mixed ancestry) and European. Mestizos account for 59% of the population. The other ethnicities are the indigenous populations: K'iche, Kaqchikel, Mam, and Q'eqchi and small Mayan groups. The official language is Spanish; however, there are also 21 Mayan languages. About 93% of the population speaks Spanish as a first or second language (World Population Statistics, 2014).

## Barbara Ford Center for Peace—Santa Cruz del Quiché

Our first stop after landing in Guatemala City was the Barbara Ford Peace Center, which was founded by The Sisters of Charity New York branch in 2009 ([www.scny.org/ministries/guatemala-mission/barbara-ford-peace-center/](http://www.scny.org/ministries/guatemala-mission/barbara-ford-peace-center/)). Sister Virginia Searing operates the center, which is named after the Sister of Charity nun who was murdered in Guatemala City in 2001 (Egbert, 2001). Human rights activists believe that Sister Barbara Ford's murder was politically motivated because of her involvement with the 1998 church report *Guatemala, Never Again*, which found the Guatemalan military culpable for civilian deaths during the civil war (Jeffrey, 2001; Farah, 1999). The center sits on 100 acres, and during our stay, we often hiked through the lush woods. On one day, we came across a Mayan altar, which is still in use by the community for ceremonies.

The Barbara Ford Peace Center promotes integrated human and spiritual development by offering programs that address social, spiritual, educational, cultural, political, and judicial issues. The programs are designed so that local individuals, families, and communities can become change agents in social and political matters. To assist in sustaining the center as well as funding programs, the center has a fully functioning hotel available for conferences to local, national, and international groups.

The majority of staff employed at the center has lost family members to genocide during Guatemalan political upheavals. The center's midwife, dressed in traditional Mayan *huipile*, recounted how she witnessed the murder of her father and brothers. Due to the long civil war and culture of torture and oppression of the indigenous communities in Guatemala, this was a common experience for many women (Halvorsen, 2014), and many with whom we met echoed the midwife's story. The midwife has been active in the community for years and is currently working with project staff, local schools, organizations, and young people in the K'iche area to reduce unintended births. The health project also includes a complementary medicine component (e.g., acupuncture).

On the day we arrived, representatives of the German government were at the center. The German government funds a business initiative project for young people to set up beehives so they can produce honey and sell it locally. German representatives were touring the beehive installations and looking at the products being sold.

At the Barbara Ford Peace Center site, there are several service-learning activities for undergraduate and graduate nursing students. Nursing students in a bachelor's of science (BS) program would complete part of their



Figure 1. Nursing faculty, center director, and staff.

community health clinical requirements by assisting in community-driven projects. Graduate students in Nursing Administration would implement material learned in their strategic planning course, and Nursing Education students would develop educational strategies for health promotion activities.

## Santa Elena National Hospital—Santa Cruz del Quiché

To further understand the health needs of different Guatemalan communities, faculty met with the medical director and nursing director of Santa Elena National Hospital in Santa Cruz del Quiché. This teaching hospital was located a few miles down the mountain from the Peace Center. The 100-bed hospital serves about one million people, and educates nursing students and medical residents. Health problems commonly seen at the hospital are maternal deaths, diabetes, and alcohol-related illnesses. The medical director and nursing director (gracious and welcoming) took time out of their busy schedules to show us around the hospital. We toured during patient visiting hours. Within the two-hour visiting timeframe, patients are allowed as many visitors as they like. We saw one patient surrounded by family members praying for her recovery. We noticed state-of-the-art ICU equipment that had been recently donated by a wealthy US patron who schedules medical missions to the area.

At the Santa Elena National Hospital site, the medical and nursing directors indicated nursing students would be welcome to work at the hospital. BS students would be able to complete a part of their clinical hours as medical students do currently. Nursing Education students would be able to work with staff in areas of health education and health promotion, while Nursing Administration students would work with staff on human resources, finance, and leadership issues.

## Centro de Promoción de Salud Rural—El Novillero

To get a sense of opportunities elsewhere, we traveled to El Novillero (around 98 miles south of K'iche). The Novillero clinic was established by the Sisters of Charity in the 1940s. Sister Ceil Harrington runs the house of hospitality, which is next to the medical clinic on the same property. A relative newcomer to Guatemala, Sister Harrington recruits students from the College of Mount Saint Vincent in the Bronx to spend time at the clinic, as well as to visit other areas in Guatemala to gain an understanding of its history and culture. Nursing students who visit assist in day-to-day clinic operations.

The physician managing the clinic grew up in the community. Prior to our trip, we were informed that the clinic needed medical supplies. We



*Figure 2. Nursing faculty, physician, health educator, and medical assistant.*

brought antibiotics, vitamins, suturing material, and a nebulizer machine for treating asthma. We attended a clinic session and saw several patients with the physician. One patient, a young woman, came to the clinic with her mother. She had been prescribed medication at a private clinic in Guatemala City after complaining of stomach problems. Because she was pregnant, the mother was worried about the medication. An exam and pregnancy test confirmed that the young woman was indeed pregnant with her first child. The physician advised the patient not to take the medication. Because this clinic is already partnered with a nursing program in New York, this site would be an excellent placement for nursing students. BS students would complete part of their clinical hour requirements and be able to practice skills learned in fundamentals and physical assessment. Nursing Education and Nursing Administration students could assist in clinic operations and develop health education programs.

## Casa de Fe—Antigua

In Antigua, Guatemala (about 30 miles east of El Novillero), we visited Casa de Fe (House of Faith). Casa de Fe provides free accommodation and meals to patients and family members seen by medical and surgical volunteers ([www.faithinpractice.org/programs](http://www.faithinpractice.org/programs)). The Village Medical Clinic Program travels to rural areas where clinicians evaluate patients, and treat wounds, infections, dental pain, parasites, and other health conditions. Patients requiring surgery receive care at Obras Sociales del Santo Hermano Pedro Hospital. Casa de Fe houses more than 10,000 people (patients and family members) each year.

At this site, nursing students would participate in planned medical missions, as well as provide nursing care at Casa de Fe. Nursing faculty, particularly nurse practitioners, would also benefit from working alongside their own students in addition to Guatemalan colleagues.



*Figure 3. Nursing faculty and director.*

## Discussion

Service-learning affords nursing students the opportunity to enrich their education and engage with faculty in smaller groups. Additionally, structured activities such as community assessment of resources, examination of the political climate, and the social environment are necessary to bring about self-reflection and an in-depth understanding of civic engagement (Bentley and Ellison, 2011). Service-learning studies show that student learning outcomes can be met through participation in learning environments that use pedagogical frameworks (Dahan, 2016). Service-learning also allows faculty to become active learners alongside their students as they work in unfamiliar settings. Additionally, service-learning is a robust educational tool in which faculty can move students from the theoretical world to practice by linking projects to academic content and student learning outcomes (Rusu et al., 2015).

International service-learning experiences can influence students and faculty in meaningful ways. Service-learning offers a framework to transform students into responsible global citizens who are compassionate and adhere to the American Nurses Association commitment to human rights (ANA, 2016). Additionally, international service-learning facilitates advancing a deeper understanding of cultural similarities and differences (Fry et al., 2017).

## Conclusion

The purpose of the trip was to answer the question: Would nursing students benefit from an international service-learning project and which students? Mercy College is located in Dobbs Ferry, New York. The nursing program has a generic four-year BS in Nursing, a RN-BS completion program, and two graduate programs (Nursing Education and Nursing Administration).

We concluded that undergraduate students enrolled in community health would be excellent candidates for an international service-learning project. The service project could be used for part of their clinical practicum requirements. Graduate students enrolled in health policy and diversity courses, and practicum in Nursing Education and Nursing Administration are well suited for an international experience. Students taking health policy must attend an advocacy activity that addresses healthcare issues. The diversity course advances an understanding and appreciation of diverse patient populations, thus an international service project gives students a different medical, social, and cultural perspective. Nursing Education and Nursing Administration students enrolled in their practicum courses could use the international project to contribute to their 120-hour requirement. We do recommend that faculty organize pilot service-learning trips because they will be able to select the best locations and situations for optimal learning. Pilot trips allow contacts to be made, safety concerns addressed and assuaged, and potential challenges noted.

Guatemala provides an excellent venue for students to discuss the medical, nursing, and psychosocial challenges faced by survivors of a civil war, ongoing political strife, and limited access to healthcare services. Students learning about Guatemala's history, geography and political landscapes will help them understand how health policies are shaped, the availability of health resources, and how Guatemalans obtain health services. Nursing students and faculty alike benefit from learning about and participating in healthcare systems in other parts of the world. This trip had all of the ingredients of an excellent service-learning experience and provided the groundwork for future in-depth service-learning projects.

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## WHAT'S NEW IN HEALTHCARE LITERATURE

### Myeloproliferative Neoplasms

■ Mesa, Ruben A., et al. "NCCN Guidelines Insights: Myeloproliferative Neoplasms, Version 2.2018." *Journal of the National Comprehensive Cancer Network*, vol. 15, no. 10, 2017, pp. 1193-1207, doi:10.6004/jnccn.2017.0157.

Advanced age (>60 years) and history of thrombosis are the most consistent risk factors associated with risk of thrombosis.

Leukocytosis at diagnosis is associated with a higher risk of thrombosis and major hemorrhage in patients with polycythemia vera (PV) and essential thrombocythemia (ET).

Age  $\geq 60$  years, leukocyte count  $\geq 11 \times 10^9/L$ , and prior thrombosis are significantly associated with inferior survival.

The safety and efficacy of low-dose aspirin for the prevention of thrombotic complications in PV was established in a multicenter trial of patients with no contraindication to aspirin therapy and no history of a thrombotic event.

Hydroxyurea, interferon alfa, and peginterferon alfa have been shown to be effective for the prevention of thrombotic complications in patients with PV.

Hydroxyurea, interferon alfa, and peginterferon alfa, and possibly anagrelide, have been shown to be effective for the prevention of venous thrombotic complications in patients with high-risk ET.

Treatment options should be individualized based on age and history of thrombosis for patients with PV.

Aspirin (81-100 mg/day) and phlebotomy (to maintain a hematocrit level of <45%) are recommended for all patients with low-risk PV. Cytoreductive therapy is not recommended as initial treatment.

In addition to aspirin and phlebotomy, cytoreductive therapy is also used to reduce the risk of thrombotic complications for patients with high-risk PV. Cytoreductive therapy (hydroxyurea) with aspirin (81-100 mg/day) for vascular symptoms and phlebotomy (to maintain a hematocrit level of <45%) is recommended as initial treatment. Interferon alfa-2b, peginterferon alfa-2a, or peginterferon alfa-2b could be considered for younger patients,

pregnant patients requiring cytoreductive therapy, or patients requiring cytoreductive therapy who defer hydroxyurea.

Monitoring for new thrombosis, acquired von Willebrand disease (VWD), and/or disease-related major bleeding (in patients with ET) and management of cardiovascular risk factors are recommended for all patients. After initiation of low-dose aspirin (and phlebotomy for patients with PV), it is recommended to monitor symptom status using the MPN Symptom Assessment Form Total Symptom Score (MPN-SAF TSS), to evaluate for signs and symptoms of disease progression every 3 to 6 months, and to assess for potential indications for cytoreductive therapy. Bone marrow aspirate and biopsy should be performed as clinically indicated (if supported by increased symptoms and signs of progression).

The thrombotic and bleeding risk should be strongly considered before elective surgery because patients with PV and ET are at higher risk for bleeding despite optimal management.

Pregnancy is considered a high-risk clinical situation in patients with PV and ET. The presence of JAK2 V617F mutation is an adverse prognostic factor for pregnancy outcome, and pregnancy complications are associated with a higher risk of subsequent thrombotic events in patients with ET. Use of aspirin has been reported to be effective in reducing pregnancy complications, especially in patients with JAK2-mutated ET.

Evaluation by a high-risk obstetrician should be considered before conception, and consultation with a high-risk obstetrician and an obstetric anesthesiologist is recommended regarding the optimal timing for discontinuation of anticoagulant therapy in preparation for an epidural before delivery.

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# Systemic Lupus Erythematosus

■ Gordon, Caroline, et al. "The British Society for Rheumatology Guideline for the Management of Systemic Lupus Erythematosus in Adults." *Rheumatology*, 2017, doi.org/10.1093/rheumatology/kex286.

Any sign of renal involvement—in particular, urinary findings such as reproducible proteinuria  $\geq 0.5$  g/24 hr, especially with glomerular hematuria and/or cellular casts—should be an indication for renal biopsy. Renal biopsy is indispensable, since, in most cases, clinical, serologic and laboratory tests cannot accurately predict renal biopsy findings.

Treatment should aim for complete renal response with UPCR (urine protein:creatinine ratio)  $< 50$  mg/mol and normal or near-normal (within 10% of normal GFR if previously abnormal) renal function. Partial renal response, defined as  $\geq 50\%$  reduction in proteinuria to subnephrotic levels and normal or near-normal renal function, should be achieved preferably by 6 months but no later than 12 months following initiation of treatment.

For patients with class IIIA or IIIA/C and class IVA or IVA/C lupus nephritis (LN), mycophenolic acid (MPA) (mycophenolate mofetil [MMF] target dose: 3 g/day for 6 months, or MPA sodium at equivalent dose) or low-dose IV cyclophosphamide (CYC) (total dose 3 g over 3 months), in combination with glucocorticoids, are recommended as initial treatment, as they have the best efficacy/toxicity ratio.

To increase efficacy and reduce cumulative glucocorticoid doses, treatment regimens should be combined initially with 3 consecutive pulses of IV methylprednisolone 500-750 mg, followed by oral prednisone 0.5 mg/kg/day for 4 weeks, reducing to  $\leq 10$  mg/day by 4-6 months.

In pure class V nephritis with nephrotic-range proteinuria, MPA (MMF target dose 3 g/day for 6 months) in combination with oral prednisone (0.5 mg/kg/day) may be used as initial treatment based on better efficacy/toxicity ratio. CYC or calcineurin inhibitors (cyclosporine, tacrolimus) or rituximab are recommended as alternative options or for nonresponders.

For patients who fail treatment with MPA or CYC, either because of lack of effect (as defined above) or due to adverse events, it is recommended that the treatment be switched from MPA to CYC, or CYC to MPA, or that rituximab be given.

Antiphospholipid antibodies (aPLs) should be tested in all lupus patients at baseline, especially in those with an adverse pregnancy history or arterial/venous thrombotic events. Confirmatory tests for antiphospholipid antibody syndrome (APS) are positive lupus anticoagulants (LA), anticardiolipin (aCL) (IgG, IgM), and/or anti-beta-2 glycoprotein-I (IgG, IgM) on 2 occasions at least 12 weeks apart.

Those with active disease should be reviewed at least every 1 to 3 months, with blood pressure, urinalysis, renal function, anti-dsDNA (double-stranded DNA) antibodies, complement levels, CRP, full blood count, and liver function tests forming part of the assessment, and further tests as necessary. Patients with stable low disease activity or in remission can be reviewed less frequently.

Treatments to be considered for the management of mild non-organ-threatening disease include the disease-modifying drugs hydroxychloroquine (HCQ) and methotrexate (MTX), and short courses of NSAIDs for symptomatic control. These drugs allow for the avoidance of or dose reduction of corticosteroids. Prednisolone treatment at a low dose of  $\leq 7.5$  mg/day may be required for maintenance therapy. Topical preparations may be used for cutaneous manifestations, and intra-articular injections for arthritis.

The management of moderate SLE involves higher doses of prednisolone (up to 0.5 mg/kg/day), or the use of IM or IV doses of methylprednisolone. Immunosuppressive agents are often required to control active disease and are steroid-sparing agents. They can also reduce the risk of long-term damage accrual.

MTX, azathioprine (AZA), MMF, cyclosporine, and other calcineurin inhibitors should be considered in cases of arthritis, cutaneous disease, serositis, vasculitis, or cytopenias if HCQ is insufficient.

For refractory cases, belimumab or rituximab may be considered.

Patients who present with severe SLE, including renal and NP manifestations, need thorough investigation to exclude other etiologies, including infection. Treatment is dependent on the underlying etiology (inflammatory and/or thrombotic), and patients should be treated accordingly with immunosuppression and/or anticoagulation, respectively.

Immunosuppressive regimens for severe active SLE involve IV MP or high-dose oral prednisolone (up to 1 mg/kg/day) to induce remission, either on their own or more often as part of a treatment protocol with another immunosuppressive drug.

MMF or CYC is used for most cases of LN and for refractory, severe nonrenal disease.

Biologic therapies belimumab or rituximab may be considered, on a case-by-case basis, where patients have failed to respond to other immunosuppressive drugs, due to inefficacy or intolerance.

IVIG and plasmapheresis may be considered in patients with refractory cytopenias, thrombotic thrombocytopenic purpura (TTP), rapidly deteriorating acute confusional state, and the catastrophic variant of APS.

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# Patient Blood Management for Cardiac Surgery

■ Pagano, D., et al. "2017 EACTS/EACTA Guidelines on Patient Blood Management for Adult Cardiac Surgery: The Task Force on Patient Blood Management for Adult Cardiac Surgery of the European Association for Cardio-Thoracic Surgery (EACTS) and the European Association of Cardiothoracic Anaesthesiology (EACTA)." *European Journal of Cardio-Thoracic Surgery*, vol. 53, no. 1, 2 October 2017, doi.org/10.1093/ejcts/ezx325.

Preoperative fibrinogen levels may be considered to identify patients at high risk of bleeding.

In patients undergoing coronary artery bypass grafting (CABG), acetylsalicylic acid (ASA) should be continued throughout the preoperative period.

In patients taking dual antiplatelet therapy (DAPT) who need to have nonemergent cardiac surgery, postponing surgery for at least 3 days after discontinuation of ticagrelor, 5 days after clopidogrel, and 7 days after prasugrel should be considered.

Recommend that GPIIb/IIIa inhibitors be discontinued at least 4 hours before surgery.

Recommend that prophylactic low-molecular-weight heparin (LMWH) be discontinued 12 hours before surgery and fondaparinux 24 hours before surgery.

Oral or IV iron alone before cardiac surgery may be considered in mildly anemic patients (women, Hb 100-120 g/L; men, Hb 100-130 g/L) or in severely anemic patients (both genders, Hb <100 g/L) to improve erythropoiesis.

Erythropoietin (EPO) with or without iron supplementation should be considered in patients with non-iron deficiency anemia undergoing elective surgery to reduce postoperative transfusions.

Off-pump CABG surgery may be considered in selected patients to reduce perioperative infusions.

The routine use of topical sealants in cardiac surgery is not recommended and may only be considered in cases of persistent bleeding where the bleeding is localized.

The routine use of cell salvage should be considered to prevent transfusions, but the retransfusion of large volumes of cell salvaged blood (>1000 ml) may impair coagulation. Overall, postoperative cell salvage and reinfusion of washed erythrocytes may be considered to reduce transfusions in patients with bleeding.

Heparin level-guided heparin management should be considered over activated clotting time (ACT)-guided heparin management to reduce bleeding, especially in patients who are resistant to heparin.

Limitation of hemodilution is recommended as part of a blood conservation strategy to reduce bleeding and transfusions.

Based on the current evidence, preoperative autologous blood donation in patients without severe aortic stenosis, Canadian Cardiovascular Society (CCS) grade 3-4 angina, or ACS <4 weeks and with high Hb levels (>110 g/L) who are having elective surgery may be considered to reduce the number of postoperative transfusions.

In patients in whom bleeding is related to coagulation factor deficiency, prothrombin complex concentrate (PCC) or fresh-frozen plasma (FFP) administration should be used to reduce bleeding and transfusions. PCC may be preferred over FFP when rapid normalization of coagulation factors is needed.

Recommend the use of packed red blood cells (PRBCs) of all ages, because the storage time of the PRBCs does not affect outcomes. In an attempt to reduce infectious complications, the use of leukocyte-depleted PRBCs is recommended; in contrast, the pooled solvent-detergent FFP may be preferred over standard FFP to reduce the risk for transfusion-related acute lung injury (TRALI).

## References

- Anello, John, et al. "New Clinical Practice Guidelines, November 2017." *Medscape*, 8 November 2017.
- Pagano, D., et al. "2017 EACTS/EACTA Guidelines on Patient Blood Management for Adult Cardiac Surgery: The Task Force on Patient Blood Management for Adult Cardiac Surgery of the European Association for Cardio-Thoracic Surgery (EACTS) and the European Association of Cardiothoracic Anaesthesiology (EACTA)." *European Journal of Cardio-Thoracic Surgery*, vol. 53, no. 1, 2 October 2017, doi.org/10.1093/ejcts/ezx325.

# Antiretroviral Therapy / Chronic HIV Infection

■ EACS: European AIDS Clinical Society. *EACS: European AIDS Clinical Society Guidelines*, Version 9.0, October 2017, [www.eacsociety.org/guidelines/eacs-guidelines/eacs-guidelines.html](http://www.eacsociety.org/guidelines/eacs-guidelines/eacs-guidelines.html).

Antiretroviral therapy (ART) is recommended in all adults with chronic HIV infection, irrespective of CD4 counts.

Human papillomavirus (HPV) vaccination is now recommended for all HIV-positive persons up to 26 years of age and up to 40 years of age for men who have sex with men (MSM).

All HIV-positive women of reproductive age should have a pregnancy test.

Screen for sexually transmitted infections (STIs) not only for those at risk, but also during pregnancy.

Pre-exposure prophylaxis (PrEP) should be used in adults at high risk of acquiring HIV infection when condoms are not used consistently.

Before PrEP is initiated, HBV serology status should be documented.

Intermittent tuberculosis (TB) regimens (2 or 3 times per week) are contraindicated in HIV-positive persons.

PrEP is recommended in HIV-negative MSM and transgender individuals when condoms are not used consistently with casual partners or with HIV-positive partners who are not on treatment. A recent STI, use of post-exposure prophylaxis, or chemsex may be markers of increased risk for HIV acquisition.

PrEP may be considered in HIV-negative heterosexual women and men who are inconsistent in their use of condoms and have multiple sexual partners, some of whom are likely to have HIV infection and not being on treatment.

Documented negative fourth generation HIV test is recommended prior to starting PrEP. During PrEP, this test should be repeated every 3 months, and PrEP should be stopped immediately in case of early clinical signs of HIV seroconversion or a positive HIV diagnostic test and the person referred for evaluation to an HIV unit.

## Reference

EACS: European AIDS Clinical Society. *EACS: European AIDS Clinical Society Guidelines*, Version 9.0, October 2017, [www.eacsociety.org/guidelines/eacs-guidelines/eacs-guidelines.html](http://www.eacsociety.org/guidelines/eacs-guidelines/eacs-guidelines.html).

# Metastatic Breast Cancer Treatment

■ Van Poznak, Catherine, et al. "Role of Bone-Modifying Agents in Metastatic Breast Cancer: An American Society of Clinical Oncology–Cancer Care Ontario Focused Guideline Update Summary." *Journal of Oncology Practice*, 16 October 2017, DOI: 10.1200/JOP.2017.027672.

Patients with breast cancer who have evidence of bone metastases should be treated with bone-modifying agents (BMAs). Options include denosumab, 120 mg subcutaneously every 4 weeks; pamidronate, 90 mg intravenously every 3 to 4 weeks; or zoledronic acid, 4 mg intravenously every 12 weeks or every 3 to 4 weeks.

The analgesic effects of BMAs are modest, and they should not be used alone for bone pain.

Recommend that the current standard of care for supportive care and pain management—analgesia, adjunct therapies, radiotherapy, surgery,

systemic anticancer therapy, and referral to supportive care and pain management—be applied.

Evidence is insufficient to support the use of one BMA over another.

## References

Anello, John, et al. "New Clinical Practice Guidelines, November 2017." *Medscape*, 8 November 2017.

Douglas David. "Guidelines on Bone-Modifying Agents in Metastatic Breast Cancer Updated." *Reuters Health Information*, 26 October 2017, [reference.medscape.com/viewarticle/888107\\_13](http://reference.medscape.com/viewarticle/888107_13).

Van Poznak, Catherine, et al. "Role of Bone-Modifying Agents in Metastatic Breast Cancer: An American Society of Clinical Oncology–Cancer Care Ontario Focused Guideline Update Summary." *Journal of Oncology Practice*, 16 October 2017, DOI: 10.1200/JOP.2017.027672.

# Congenital Zika in Infants

■ Adebajo Tolulope, et al. “Update: Interim Guidance for the Diagnosis, Evaluation, and Management of Infants with Possible Congenital Zika Virus Infection—United States, October 2017. *MMWR Morb Mortal Wkly Rep*, vol. 66, no. 41, 20 October 2017, pp. 1089-99, dx.doi.org/10.15585/mmwr.mm6641a1.

Zika virus nucleic acid testing (NAT) should be offered as part of routine obstetric care to asymptomatic pregnant women with ongoing possible Zika virus exposure (residing in or frequently traveling to an area with risk for Zika virus transmission); serologic testing is no longer routinely recommended because of the limitations of IgM tests, specifically the potential persistence of IgM antibodies from an infection before conception and the potential for false-positive results. Zika virus testing is not routinely recommended for asymptomatic pregnant women who have possible recent, but not ongoing, Zika virus exposure.

Zika virus testing is recommended for infants with clinical findings consistent with congenital Zika syndrome and possible maternal Zika virus exposure during pregnancy, regardless of maternal testing results. Testing CSF for Zika virus RNA and Zika virus IgM antibodies should be considered, especially if serum and urine testing are negative and another etiology has not been identified.

In addition to a standard evaluation, infants with clinical findings consistent with congenital Zika syndrome should have a head ultrasound and a comprehensive ophthalmologic exam performed by age 1 month by an ophthalmologist experienced in assessment of and intervention in infants. Infants should be referred for automated auditory brainstem

response (ABR) by age 1 month if the newborn hearing screen was passed using only otoacoustic emissions methodology.

Zika virus testing is recommended for infants without clinical findings consistent with congenital Zika syndrome born to mothers with laboratory evidence of possible Zika virus infection during pregnancy.

In addition to a standard evaluation, infants who do not have clinical findings consistent with congenital Zika syndrome born to mothers with laboratory evidence of possible Zika virus infection during pregnancy should have a head ultrasound and a comprehensive ophthalmologic exam performed by age 1 month to detect subclinical brain and eye findings.

A diagnostic ABR at 4 to 6 months or behavioral audiology at age 9 months is no longer recommended if the initial hearing screen is passed by automated ABR, because of absence of data suggesting delayed-onset hearing loss in congenital Zika virus infection.

## References

- Adebajo Tolulope, et al. “Update: Interim Guidance for the Diagnosis, Evaluation, and Management of Infants with Possible Congenital Zika Virus Infection — United States, October 2017. *MMWR Morb Mortal Wkly Rep*, vol. 66, no. 41, 20 October 2017, pp. 1089–99, dx.doi.org/10.15585/mmwr.mm6641a1.
- Anello, John, et. al. “New Clinical Practice Guidelines, November 2017.” *Medscape*, 8 November 2017.
- Kelly, Janis C. “New CDC Guidance on Caring for Infants With Congenital Zika.” *Medscape News*, 20 October 2017, [www.medscape.com/viewarticle/887366](http://www.medscape.com/viewarticle/887366).

# Breast Cancer in Young Women

■ Paluch-Shimon, Shani., et al. "ESO-ESMO 3rd International Consensus Guidelines for Breast Cancer in Young Women (BCY3)." *The Breast*, vol. 35, October 2017, pp. 203-17, dx.doi.org/10.1016/j.breast.2017.07.01.

In patients with triple-negative breast cancer (TNBC) or BRCA-associated tumors, the incorporation of platinum agents increases pathologic complete response (pCR) rates and may be considered when neoadjuvant chemotherapy is indicated. Data on the impact of incremental increases in pCR on long-term outcome are not conclusive.

The use of platinum derivatives has potential additional impact on fertility and increased toxicity that may compromise standard duration and dosing of systemic treatment, and this needs to be clearly communicated to patients.

For patients with TNBC not achieving a pCR after standard neoadjuvant regimens, the routine addition of adjuvant chemotherapy (such as capecitabine or metronomic CM [cyclophosphamide and methotrexate]) is not recommended; however, it may be considered in highly selected patients, as in other age groups.

It is recommended that young women with ER-positive advanced breast cancer (ABC) have adequate ovarian suppression or ablation and then be treated in the same way as postmenopausal women with endocrine agents and targeted therapies, such as an aromatase inhibitor or fulvestrant plus a cyclin-dependent kinase (CDK) 4/6 inhibitor or exemestane with everolimus.

Olaparib monotherapy may be considered in women with ABC harboring a germline BRCA mutation in early lines of therapy.

There is no clear role for routine screening by any imaging for early breast cancer detection in healthy, average-risk young women. However, in the presence of a cancer predisposition syndrome (germline mutation in a known cancer predisposition gene), significant family history, or prior personal history of ionizing radiation to the chest, consideration may be given to screening breast MRI.

In young women with the diagnosis of either invasive disease or preinvasive lesions who are not high-risk mutation carriers, there is no evidence for improved overall survival (OS) by performing risk-reducing bilateral mastectomy.

All patients with HR-positive disease should receive adjuvant endocrine therapy (ET). Tamoxifen alone for 5 years is indicated for low-risk patients. Tamoxifen for 10 years should be considered in high-risk patients, if tolerated. The addition of a GnRH (gonadotropin-releasing hormone) agonist (or ovarian ablation) to tamoxifen is indicated in patients at higher risk who remain premenopausal after chemotherapy.

Young women with stage I or II breast cancer who cannot take tamoxifen (due to contraindications or severe side effects) may receive a GnRH agonist alone, oophorectomy, or an aromatase inhibitor + GnRH agonist.

## References

- Anello, John, et. al. "New Clinical Practice Guidelines, November 2017." *Medscape*, 8 November 2017.
- Paluch-Shimon, Shani., et al. "ESO-ESMO 3rd International Consensus Guidelines for Breast Cancer in Young Women (BCY3)." *The Breast*, vol. 35, October 2017, pp. 203-17, dx.doi.org/10.1016/j.breast.2017.07.01.

## ■ CE Activity: Analysis of an Ethical Conflict in Practice

Thank you for your participation in Analysis of an Ethical Conflict in Practice, a new 0.5 contact hour continuing education (CE) activity offered by NYSNA. NYSNA members and non-members are invited to take part in this activity, and you do not need to be a resident of New York State.

### INSTRUCTIONS:

In order to receive contact hours for this educational activity, participants are to read the article presented in this issue of The Journal, complete and return the post-test, evaluation form, and earn 80% or better on the post-test.

This activity is free to NYSNA members and \$10 for non-members. Participants can pay by check (made out to NYSNA & please include CE code D973EB on your check) or credit card. The completed answer sheet and evaluation form may be mailed or faxed back to NYSNA; see the evaluation form for more information.

*The New York State Nurses Association is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.*

*NYSNA wishes to disclose that no commercial support was received for this educational activity.*

*All planners/authors involved with the development of this independent study have declared that they have no vested interest.*

*NYSNA Program Planners and Authors declare that they have no conflict of interest in this program.*

### GOAL:

For many years, American nurses have been conflicted on the ethics of striking. Those who oppose the idea of engaging in strike activity believe that the behavior is unprofessional, unethical, constitutes patient abandonment and is antithetical to nursing's primary commitment to patient care and advocacy. The purpose of this program is to analyze whether it is ethical for nurses to engage in strike activity.

### OBJECTIVES:

By completion of the article, the reader should be able to:

1. Appraise the ethics of striking while concomitantly defending the right to strike and to contribute to essential social goods, such as advocating for self, advocating for the provision of health for all, and supporting the principles of beneficence, justice, and non-maleficence.

Please answer either **True** or **False** to the questions below. Remember to complete the answer sheet by putting the letter of your corresponding answer next to the question number. Each question has only one correct answer.

*The 0.5 contact hours for this program will be offered until January 15, 2021.*

- 1) According to the article, the source of ethical conflicts regarding the need to strike often is premised on whether a particular patient's and/or nurse's right is codified in a collective bargaining agreement.
  - a. True
  - b. False
- 2) Before a nurse can engage in strike activity, the union must provide a twenty-four (24) hour notice to the facility. (FALSE)
  - a. True
  - b. False
- 3) The American Nurses Association, The New York State Nurses Association, and the International Council of Nurses recognize a nurse's right to engage in strike activity. (TRUE)
  - a. True
  - b. False
- 4) Nurses often feel moral distress when thinking about the need to advocate for the present patient as distinguished by engaging in social activities that would bring about social change for the future patient. (TRUE)
  - a. True
  - b. False
- 5) The Nurses Code of Ethics supports a nurse's decision to engage in strike activity. (TRUE)
  - a. True
  - b. False
- 6) Before nurses engage in strike activity, they should only think about patients and nurses as interested stakeholders in the final analysis. (FALSE)
  - a. True
  - b. False
- 7) The nurse's obligation to the patient when considering strike activity is limited to the present patient. (FALSE)
  - a. True
  - b. False

## ■ CE Activity: Analysis of an Ethical Conflict in Practice, continued

- 8)** Nurses have a moral and ethical responsibility to advocate against the acceptance of substandard workplace and practice conditions that negatively affect the quality of healthcare. (TRUE)
- a.** True
  - b.** False
- 9)** One ethical theory that supports a nurse's right to engage in strike activity is the Utilitarian Theory. (TRUE)
- a.** True
  - b.** False
- 10)** Before a nurse engages in strike activity, critical analysis of the situation should include a moral and ethical process to determine whether the strike activity is the last resort needed to address the employer's failure in their responsibility to provide an environment that is essential for quality nursing care in accordance with accepted nursing standards. (TRUE)
- a.** True
  - b.** False

# Answer Sheet

## Analysis of an Ethical Conflict in Practice

**Note:** The contact hours for this program will be offered until **January 15, 2021**.

**Please print legibly** and verify that all information is correct.

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Daytime Phone Number (include area code): \_\_\_\_\_

E-mail: \_\_\_\_\_

Profession: \_\_\_\_\_ Currently Licensed in NY state? Y / N (circle one)

NYSNA Member # (if applicable): \_\_\_\_\_ License #: \_\_\_\_\_ License State: \_\_\_\_\_

**ACTIVITY FEE: Free for NYSNA members/\$10 non-members**

### PAYMENT METHOD

Check—payable to New York State Nurses Association (please include “Journal CE” and your CE code D973EB on your check).

Credit card:  Mastercard  Visa  Discover  American Express

Card Number: \_\_\_\_\_ Expiration Date: / / CVV# \_\_\_\_\_

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: / /

Please print your answers in the spaces provided below. **There is only one answer for each question.**

1. \_\_\_\_\_

6. \_\_\_\_\_

2. \_\_\_\_\_

7. \_\_\_\_\_

3. \_\_\_\_\_

8. \_\_\_\_\_

4. \_\_\_\_\_

9. \_\_\_\_\_

5. \_\_\_\_\_

10. \_\_\_\_\_

**Please complete the answer sheet above and course evaluation form on reverse.**

**Submit both the answer sheet and course evaluation form along with the activity fee for processing.**

### Mail to:

NYSNA, Attn. Nursing Education and Practice Dept.  
131 West 33rd Street, 4th Floor, NY, NY 10001

### Or fax to:

212-785-0429

## Learning Activity Evaluation

### Analysis of an Ethical Conflict in Practice

**Please use the following scale to rate statements 1-7 below:**

	<b>Poor</b>	<b>Fair</b>	<b>Good</b>	<b>Very Good</b>	<b>Excellent</b>
1. The content fulfills the overall purpose of the CE Activity.	<input type="checkbox"/>				
2. The content fulfills each of the CE Activity objectives.	<input type="checkbox"/>				
3. The CE Activity subject matter is current and accurate.	<input type="checkbox"/>				
4. The material presented is clear and understandable.	<input type="checkbox"/>				
5. The teaching/learning method is effective.	<input type="checkbox"/>				
6. The test is clear and the answers are appropriately covered in the CE Activity.	<input type="checkbox"/>				
7. How would you rate this CE Activity overall?	<input type="checkbox"/>				

8. Time to complete the entire CE Activity and the test?    \_\_\_ Hours (enter 0-99)    \_\_\_ Minutes (enter 0-59)

9. Was this course fair, balanced, and free of commercial bias?    Yes / No (Circle One)

10. Comments:

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11. Do you have any suggestions about how we can improve this CE Activity?

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