Dear Mary

by Mary Annas ·

Dear Mary is a monthly feature in which readers can ask about any nursing care issue that concerns them. Answers will be supplied by Mary Annas or a consulting nurse, physician, lawyer, or ethicist where appropriate. Readers are also invited to comment on the answers. Letters to Dear Mary may be handwritten. All inquiries should be addressed to Mary Annas, Nursing Law & Ethics, P.O. Box 9026, JFK Station, Boston, MA 02114.

Dear Mary,

I work in the emergency room of a hospital which is used by the local medical school for training purposes. Very often relatively untrained medical students draw blood gases during emergency cardiac crises. Their technique is poor and more often than not they contaminate the site by withdrawing the needle completely and reusing the same needle. I understand that they have to learn, but often a patient's circulation is poor during cardiac crisis anyway, and when the student probes with the needle, it causes the alert patient severe pain. What do you think about this?

Katherine
Cooperstown, New York

Dear Katherine,

The hazards of drawing blood gases are severe and extremely traumatic even to comatose patients. There is always the chance of a fistula developing and, especially with femoral sticks, bleeding can be severe and even fatal. This is the most serious hazard, closely followed by infection.

Especially in a teaching hospital where fully trained and experienced personnel are always available, no one who is not totally proficient with anatomically exact practice models should be drawing blood gases. After this technique is smooth and successful the student should advance to a comatose patient who *needs* a blood gas drawn, and then on to a more alert person.

Because of the trauma on even a comatose patient, if a person has tried to get a specimen and been unsuccessful, another site should be used, and another person who has had more experience should try to draw it.

As a nurse you are often the last person to come between the patient and harm, and should intervene on the patient's behalf by suggesting that someone else try to obtain the specimen, and then bringing the matter to the attention of the student and supervisor.

Dear Mary,

I work on a busy med/surg floor in a community teaching hospital. We recently admitted a 23 year old "boy" with Down's Syndrome and a diagnosis of congestive heart failure. Though he had several previous admissions, I had never taken care of him before. His admission nursing assessment listed his mental age as 4-5 years old. His condition was noted in his chart as "Congestive Heart Failure — Mongoloid," and another notation followed: "When admitted he was whistling and making suggestive remarks to the nurses."

I was a little surprised because I had thought the term "Down's Syndrome" was the accepted one due to the racist connotation of the term "Mongoloid." I also questioned the attitude and general tone of the assessment since nurses and others who routinely work with retarded patients would not have found his whistling and comments especially unusual. What is your opinion?

Jane
Philadelphia

Dear Jane,

In 1961, 19 prominent workers in the fields of mental deficiency, pediatrics, and human genetics petitioned, through a letter to *Lancet*, for a change in nomenclature in the medical literature from the potentially "inflammatory, racist and embarrassing" term "Mongoloid." The petitioners had difficulty agreeing on an accepted alternative, but finally settled for the relatively noncommital term "Down's Syndrome." This, like all other syndromes, now often appears without the "'s" — the rationale being that the syndrome belongs to the client appearing with it, and not to the doctor who discovers it. "Down syndrome" is now accepted by many as correct.[2]

But people change slowly, especially in medicine, and you still often see the outdated term "Mongoloid" used. Perhaps you could suggest the *Lancet* letter to the person who wrote the assessment. It is an excellent historical summary of the background of Down syndrome.

As far as the man who was admitted to your hospital is concerned, it seems that no one took his mental age into consideration. If this patient was chronologically 4 or 5 years old, people would have been amused by his behavior. And even though the admitting nurse knew intellectually that the patient was retarded, emotionally she found it difficult to accept such behavior coming from a 23 year old.

I believe the initial assessment is one of the most important tools to evaluate a client who is being admitted to the hospital, and that it should be as objective and concise as possible, containing only relevant information and accepted terminology.

References

1. Letter to the Editor, LANCET 1:775 (April 8, 1961).
2. DORLAND'S MEDICAL DICTIONARY and the NEW ENGLAND JOURNAL OF MEDICINE still use the "'s," but the HASTINGS CENTER REPORT drops the "'s" before the word "syndrome."

Dear Mary,

As a nurse I am troubled about the professional ethics of a situation close to home. My 26 year old sister has been in psychotherapy for two years with a man she respects and depends on emotionally. Their relationship has been professional, yet friendly, throughout these two years.

Recently, he asked her to find another therapist. She objected, indicating that she relied upon him and would find it difficult not to see him anymore. He explained that he wanted to continue seeing her, but not professionally — he expressed a sexual interest in her. Her reaction was mixed; she finds him attractive and certainly is fond of him. But she is puzzled about what to do now.

Do you think it was ethical for her therapist to behave this way?

Natalie
Carson City

Dear Natalie,

Certainly not. I consulted a psychiatrist colleague about this question. He does not wish to be named, but says that this sort of thing is not as uncommon as one might believe. Taking advantage of a client's vulnerability in therapy is *always unethical*. My consultant said that the therapist should not have confronted her with his feelings, especially at a time when she was most dependent on him. Dealing with his own feelings about his patient is part of the therapist's job. If the therapist believes these feelings will interfere with treatment it is more desirable and more ethical to terminate and refer, rather than to act on his own feelings and risk harm.

(Continued on page 8)

Informed Consent *Continued*

planations remain the responsibility of the physician. The nurse's duty is to notify the physician of the patient's lack of comprehension, or, alternatively, to make the problem known to the nursing administrator who has the authority to deal with the matter. And since the nurse's first duty is to watch out for the patient's welfare, the governing principle should not be concern with form, but rather concern that the patient fully understands the nature of the procedure.

References

1. *Mitchell v. Robinson,* 334 S.W.2d 11 (Mo. 1960); *Martin v. Bralliear,* 540 P.2d 111 (Colo. 1975).
2. *Dunham v. Wright,* 423 F.2d 940 (3d Cir. 1970); *Young v. Group Health Cooperative of Puget Sound,* 534 F. Supp. 776 (D. Ark. 1976).
3. *Forney v. Memorial Hospital,* 543 S.W.2d 705 (Tex. 1976).
4. *Cooper v. Curry,* 589 P.2d 201 (N.M. 1979).
5. *Roberson v. Menorah Medical Center,* 588 S.W.2d 134 (Mo. 1979).
6. However, in a 1966 case involving a "novel and unorthodox" treatment, a New York court did hold a hospital liable for failure "to ascertain that the physician had made such a disclosure before permitting the operation to take place." *Fiorentino v. Wengen,* 272 N.Y.S.2d 557 (App. Div. 1966). And in the famous case, *Cobbs v. Grant,* 8 Cal. 3d 229, 502 P.2d 1 (1972), the hospital paid a jury verdict rather than appeal.
7. Holder, A.R., *What Commitment Is Made by a Witness to a Consent Form?* IRB 1(7):7 (November 1979).
8. Vaccarino, J.M., *Consent, Informed Consent and the Consent Form,* NEW ENGLAND JOURNAL OF MEDICINE 298(8):455 (February 23, 1978).
9. 45 C.F.R. § 46.110.
10. CALIFORNIA HEALTH AND SAFETY CODE §§ 24170-24179.5, at 24173(d).
11. VA. CODE Ch. 13 §§ 37.1-234-37.1-238, at 37.1-235.
12. *Hiatt v. Groce,* 523 P.2d 320 (Kans. 1974); *Utter v. United Hospital Center,* 236 S.E.2d 213 (W. Va. 1977).

NURSING LAW & ETHICS

520 Commonwealth Ave.
Boston, MA 02215

Co-editors
George J. Annas, J.D., M.P.H.
Jane L. Greenlaw, R.N., M.S., J.D.

Executive Editor
A. Edward Doudera, J.D.

Assistant Editor
Elizabeth M. Ollen

Nursing Law & Ethics is published by the American Society of Law & Medicine, 520 Commonwealth Avenue, Boston, MA 02215.

To Subscribe

Nursing Law & Ethics is published monthly except during the summer when double issues are published bimonthly. The subscription fee for NLE is $30 for 10 issues ($17.50 for students in either nursing or law school). Prepayment is preferred.

Subscriptions are begun with the issue immediately following the receipt of an order and run for 12 months/10 issues. Subscriptions will not be backdated, however, a bound set of the first 10 issues, Volume 1 (1980) of NLE, is available for $30.00.

Send your order to: American Society of Law & Medicine, *Nursing Law & Ethics,* 520 Commonwealth Ave., Boston, MA 02215.

Dear Mary *Continued*

Your sister may wish to report her therapist to the appropriate licensing body. If she does, she will probably need moral support because the emotional attachment between a therapist and patient makes it very difficult to take this kind of action.

Subscription Order Form

☐ Please enter my subscription to *Nursing Law & Ethics*. Enclosed is my check for $30.00.

☐ Please enter my subscription to *Nursing Law & Ethics* at the student rate of $17.50.

(Please send photocopy of your present ID card.)

☐ I am interested in distributing *Nursing Law & Ethics* to our staff or students. Please send me information on your bulk institutional subscription rate. I am interested in approximately _____ copies.

Name _____

Title _____

Mailing Address _____

Return to: American Society of Law & Medicine, Nursing Law & Ethics, 520 Commonwealth Avenue, Boston, MA 02215