

Answer Key

1: Reading Skills for Nursing (pages 1–34)

Previewing a Reading (pages 2–4)

- Title
- Subtitle
- Abstract
- Objectives (referred to as: Learning Outcomes)
- Vocabulary list (referred to as: Key Terms)
- Headings and subheadings
- Excerpts from the text, highlighted in some way (e.g., in **bold** type)
- Bulleted items or lists
- Words in **bold** type
- Words in *italics*
- Photographs
- Graphs and charts
- Tables
- Boxes
- Research notes
- Summary (referred to as: Chapter Highlights)
- Review questions
- Links to other chapters
- Links to media resources (e.g., CD-ROM or companion website)
- Suggested readings
- Related research
- Internet resources
- Reference list
- Selected bibliography
- Other: _____

2. Three levels of headings: formatting is different: Level I—blue type, upper and lower case, flush left; Level II—black type, upper and lower case, flush left; Level III—black type, upper and lower case, flush left, italic
3. Seven main headings: Historical Perspectives, Contemporary Nursing Practice, Roles and Functions of the Nurse, Criteria of a Profession, Socialization to Nursing, Factors Influencing Contemporary Nursing Practice, Nursing Organizations

Comprehension and Discussion Questions (page 23)

1. Gordon has a very positive view of nursing and its potential effect on the health care system. The word *expanded* indicates that she wants nurses to have a greater role in health care. The word *healthy* in connection with an expanded role for nurses indicates that the health care system is currently unhealthy, a situation that an expanded role for nurses would help to change. *Would bring* is used rather than *bring* because this is not the current situation for nurses. (*Would bring* is an example of the present unreal conditional, used in hypothetical situations that are not currently real or true.)
2. Nurses attend to the emotional as well as physical needs of patients. They provide the care for patients 24 hours a day, seven days a week, without which patients could not be cured of their illness.
3. Five responsibilities of nurses: (1) carry out physician orders and treatment plans; (2) assess patients' needs; (3) provide care for patients; (4) educate patients about

how to cope with their illness; (5) advocate for patients by helping patients and families make informed decisions about their health care situation.

4. “Primary nursing” means that each patient has a primary nurse, like a primary doctor. The primary nurse draws up a nursing plan for his or her patients; other nurses follow those plans when the primary nurse is off duty. If a patient is readmitted to the hospital, he or she is sent to the floor where the primary nurse is working. In regular nursing, a nurse may or may not be assigned to the same patient from one day to the next, or from one hospital stay to the next. Primary nursing allows for a stronger relationship of trust to develop between nurses and patients, especially with patients who have chronic illnesses.
5. If patients trust their health care providers, they are more likely to seek health care and seek it earlier in the illness, when there is a greater chance of recovery. If nurses know their patients better, they are better able to assess their patients’ responses to the illness and to help them either get well or develop coping strategies.
6. In collaborative care, physician care of patients and nursing care of patients is integrated. Physicians and nurses go on rounds together every morning and talk about patients. In traditional care, interaction between physician and nurse does not necessarily happen on a regular basis, nor is their respective care for the same patient integrated. As a result, the care that is outlined in a physician-care plan may not have anything to do with the care outlined in the nursing-care plan, and vice versa. In collaborative care, nurses have the opportunity on a regular basis to brief physicians about any changes in the patient’s routine, so the physician can adjust the patient’s medical treatment accordingly.
7. A DNR order means “do not resuscitate.” It is intended not to prolong the suffering of a patient with a terminal illness. When a patient has a heart attack, it is clear what a DNR order means. However, there are many times while performing routine treatments and procedures that nurses feel they are torturing their patients and prolonging their suffering, e.g., putting a tube down a dying patient’s nose to draw fluid from the lungs or drawing blood from a very old patient with very frail veins.
8. “If we created a health care system that valued care as much as cure” (p. 21), the author claims the responsibilities of nurses would change, as follows: (1) “Nurse practitioners *would manage* patient care with quality—not simply cost containment” (2) “They *would identify* those at risk for particular illnesses and [they *would*] *recommend* either immediate treatment or long-term monitoring of a patient’s condition” (3) “Nurses *would* routinely *scan* patients’ records to make sure that recommended follow-up care was actually administered” (4) “Nurses *would keep in touch* with patients to schedule follow-up treatment and allay fears and anxieties patients may have about returning to the doctor, thus minimizing the chance that a minor complaint will escalate into a catastrophic illness” (5) “Nurses *would* officially *be able to ask* hard questions [about end-of-life decisions]” (6) “Nurses with advanced education *would be allowed to prescribe* medication and [*would*] be paid accordingly for the additional care they’d provide” (p. 21). Whether these changes are likely to occur is open to debate.
9. Nurses need to advocate for themselves. They need to be assertive in promoting the profession of nursing and the role of caring for people in the curing of their illness.
10. Gordon is advocating for a greater role for nurses in health care and for a restructuring of the health care system. Answers will vary regarding her effectiveness.

Activity: Understanding General versus Specialized Definitions (page 29)

1. General definition of *bipolar*: consisting of two opposite or clearly different ideas
2. Specialized definition of *bipolar*: someone who is bipolar has bipolar disorder or manic depression. Manic depression is a mental illness that makes people sometimes feel extremely happy and excited and sometimes extremely sad and hopeless.
3. On page 129, the word is meant in the generalized sense.
4. The notion of opposition, whether in ideas or moods.

Activity: More General versus Specialized Definitions (page 30)

1. *monitor* (n.)
General definition: a student appointed to assist a teacher
Specialized definition: screen (like a TV screen) that is part of an instrument that checks the functioning of an organ, e.g., cardiac monitor checks the functioning of the heart
2. *dressings* (n.)
General definition: the act of a person or thing that dresses
Specialized definition: covering or bandage applied to a wound to protect it
3. *discharge* (n.)
General definition: the act of removing the contents of a ship, load, etc.
Specialized definitions (2): secretion of liquid from an opening; sending a patient away from a hospital because the treatment has ended

4. *evacuation* (n.)
General definition: the act of making empty
Specialized definition: removing the contents of something, especially discharging feces from the bowel
5. *prescribe* (v.)
General definition: to lay down as a rule or course of action to be followed
Specialized definition: to give instructions for a patient to get a certain dosage of a drug or a certain form of therapeutic treatment
6. *administer* (v.)
General definition: to direct or manage
Specialized definition: to give a medicine to a patient
7. *present* (v.)
General definition: to furnish with a gift or the like
Specialized definition: to show, to be present
8. *terminal* (adj.)
General definition: situated at or forming the end of something
Specialized definition: referring to the last stage of a fatal illness
9. *sterile* (adj.)
General definition: free from microorganisms
Specialized definition: with no microbes or infectious organisms
10. *compliant* (adj.)
General definition: conforming or acquiescing
Specialized definition: agreeing of a patient to cooperate with a treatment

Parts of Speech (page 30)

Definitions of:

somatize (v): to convert mental experiences or states into bodily symptoms

somatization (n): the conversion of mental experiences or states into bodily symptoms

Parts of Speech 1 (page 31)		
Nouns	Verbs	Adjectives
1. monitor	monitor	monitory
2. operation	operate	operable
3. hospitalization	hospitalize	
4. dressing	dress	
5. treatment	treat	treatable
6. resuscitation	resuscitate	
7. prevention	prevent	preventable
8. maintenance	maintain	maintainable
9. complaint	complain	
10. discharge	discharge	
11. ventilator	ventilate	
12. medication	medicate	
Parts of Speech 2 (page 31)		
Verbs	Nouns	Adjectives
1. implant	implant	
2. assess	assessment	assessable
3. prolong	prolong	
4. probe	probe	
5. minimize	minimization	minimal
6. prescribe	prescription	prescriptive
Parts of Speech 3 (page 32)		
Adjectives	Nouns	Verbs
1. pediatric	pediatrics	
2. respiratory	respirator	respirate
3. sedated	sedative	sedate
4. diagnostic	diagnosis	diagnose
5. metastatic	metastasis	metastasize
6. circulatory	circulation	circulate
7. recurring	recurrence	recur
8. terminal	termination	terminate

2: Thinking Critically about Nursing (pages 35–80)

Activity: Evaluating Sources of Information (pages 38–39)

1. Reading 2.1: Bobbi Kimball and Edward O'Neil
Reading 2.2: Suzanne Gordon
Reading 2.3: Robert Steinbrook

2. Rdg. 2.1: Kimball is a registered nurse with an MBA (Master's in Business Administration). She has worked for 25 years as a health care management consultant specializing in change. O'Neill has a doctorate; he is director of the Center for the Health Professions and Professor of Family and Community Medicine and Dental Public Health at the University of California at San Francisco.

Rdg. 2.2: Gordon is an author and journalist.
Rdg. 2.3: Steinbrook is a physician.

Only Kimball is a nurse. As a professor of family and community medicine, O'Neill is probably familiar with the role of nurses in promoting public health. As a physician, Steinbrook should be familiar with the contributions of nurses to the well-being of their patients. In choosing to write an article about "nursing in the crossfire," Steinbrook is clearly interested in the situation of nurses. Gordon is an outsider, in the sense that she does not have credentials as a nurse or doctor or any other health care professional. However, as an outsider, she is more likely to understand from the patient's perspective the contribution nurses make to the welfare of their patients.

Kimball also has an MBA, so she should be able to look at proposed reforms to the health care system from a cost/benefit perspective, to determine whether they are both cost effective and quality ensured. As an M.D., Steinbrook may have a traditional view of nurses that is somewhat limited.

3. Rdg. 2.1: 2001
Rdg. 2.2: 2000
Rdg. 2.3: 2002
Some of the details may have changed since these articles were published, but the overall situation of nurses, the nursing shortage, and the health care crisis have not.
4. Rdg. 2.1: *Policy, Politics, & Nursing Practice*
This journal is a scholarly journal, created "to support the development of nursing leadership in health policy, health services research, and political initiatives worldwide," as stated in the masthead of the journal.
Rdg. 2.2: *The American Prospect*
This magazine includes articles on socioeconomic and political topics of concern in the United States. Articles are lengthy and in-depth.
Rdg. 2.3: *New England Journal of Medicine*
This is the leading journal of medical research in the United States. There is not one nurse on the editorial staff.

5. Rdg. 2.1: advanced practice nurses and nurse administrators
Rdg. 2.2: general but educated public interested in social issues
Rdg. 2.3: physicians, surgeons, and hospital administrators

Comprehension and Discussion Questions (page 45)

1. Three demographic factors: 1. U.S. population, including health care workers, is aging, 2. baby boomers are aging, creating a need for more health care workers, 3. there was a decline in population after the baby boomers, resulting in fewer workers in this age group to take care of the aging baby boomers.
2. As diversity within the general population increases, so will the diversity of patients in the health care system, as well as the diversity of people going into health care professions.
3. Physicians spend less time with patients; there are fewer people in middle management positions in hospitals; patients are more seriously ill in the hospitals, thereby increasing the stress on health care providers; there is more competition among health care providers; more demanding work environments; and fewer resources.
4. Increased dissatisfaction has made it more difficult to recruit and retain nurses and may very well have a negative impact on the ability to attract young people into nursing.
5. In the past, nursing used to be one of the only professions open to women. Now, with many more professional opportunities open to women, fewer women are looking to nursing for a career. Answers will vary regarding how women could become more interested in a career in nursing. Some possibilities are: change in public perception of nurses, greater public visibility, increased compensation, and more opportunities for leadership.
6. Many of the values of Generation X are opposite the traditional image of what it means to work in a hospital. For example, Generation X is anti-institutional and

egalitarian (or non-hierarchical), whereas the image of hospitals is of large, cold, unresponsive institutions that are hierarchical and highly structured. Answers will vary regarding ways to interest Generation X.

7. Work has become more service-oriented and more oriented around information and communications technology. There have been new entrepreneurial opportunities for individuals where once the only employment opportunities were in corporations. In general, the workplace has adapted to these changes and become more flexible. However, health care and nursing have generally been left behind in the changing nature of work.

Comprehension and Discussion Questions (pages 53–54)

1. According to the Institute for Health and Socio-Economic Policy (IHSP) in the state of California between 1994 and 1997, there was an 8.8% increase in the average number of patients that an RN cared for. At the same time there was a 7.2% decrease in the number of RNs employed. Between 1995 and 1998 there was also a 7.7% increase in the number of patients per staffed bed. According to the New York State Nurses Association, 22% of nurses said they were responsible for 10 or more patients. For hospital surgical nurses the average patient load was 9.4 patients and for critical care nurses, 3.14 patients. Because of the increase in patient workload, patients are not getting the care they need. According to the New York State Nurses Association, 46% of nurses said they couldn't provide the level of nursing care their patients needed. For example, one nurse reported not being able to administer pain medication on a timely basis to her elderly patients who have just had hip-replacement surgery. Without sufficient pain medication patients are less likely to heal from an operation.
2. A “Midas muffler shop” is a place where cars are taken to have their muffler replaced. A hospital that has become like a muffler shop no longer cares for its patients as people, but as a disease to be cured or an operation to be performed. The patient enters the hospital for just the amount of time it takes to “change the muffler,” which means patients do not recover from operations and other procedures in the hospital, but at home. Forty to 50% of patients admitted to a hospital unit may be discharged in 24 hours. The shortened length of stay in the hospital means that patients in the hospital are sicker and that nurses spend more time with admission and discharge activity, further reducing the amount of time spent with direct patient care. As a result, quality of patient care is jeopardized, and nurses are busier and more stressed out. They have no time to eat, go to the bathroom, take a break, or attend educational seminars. They suffer from stress-related illnesses, and many report back injuries.
3. “Failure to rescue” refers to health care workers missing something essential to the patient’s survival. Critical factors in patient rescue are: there needs to be enough educated staff in the hospital who recognize a problem when they see it; they must spend enough time with the patients to see the problem; and they must have enough status and authority to mobilize resources and handle the intervention. Nurses are the “educated eyes-on/hands-on, 24-hour-surveillance-and-intervention system in hospitals” (page 51).
4. Besides patient rescue, when hospitals employ enough nurses and give them enough time with patients, patients also have fewer urinary tract infections, falls, pneumonias, and bedsores.
5. In an effort to reduce costs, hospitals were restructured and the number of RNs was reduced and RNs were replaced with aides. These changes led to dissatisfaction among nurses, making it harder to fill vacancies and harder to attract new recruits to the profession.

6. “Whistle-blower” bills uncover hidden problems and make them public. In the first “safe-staffing law” passed in California, the state Department of Health is responsible for implementing safe nurse-to-patient ratios and limiting the amount of floating of nurses between units. (Floating refers to the practice of moving nurses from the unit where they usually work to one they may not be familiar with, another cost-saving measure.)
7. More fundamental changes in the health care system are needed. Gordon argues for national health insurance, rather than the current “job-based, employer-dominated private health insurance system in which billions of dollars are siphoned off every year for unnecessary advertising, marketing, and administrative costs (not to mention insurance and drug company profiteering)” (pp. 52–53). In addition, there needs to be a change in the organization of nursing care within hospitals and a change in public perception about the importance of nursing for patient outcomes. They also need to be better paid and treated.
8. Gordon’s purpose is to argue for improved working conditions for nurses, which are possible only if there are not only fundamental changes in the health care system, but also in the public perception of nurses. She sums up her main argument in the concluding paragraph of the article. Answers may vary, but yes, she was effective. She provided a lot of statistics and specific examples of the ways in which increased patient loads and decreased numbers of nurses have affected patient outcomes, evidence that is likely to convince the general public of the need for change.
9. Gordon’s first article, Reading 1.2, is more generally about the profession of nursing, what nurses do, and what their contribution is to the health care system. The article argues for a broader perspective on patient care; without the care that nurses provide for their patients, patients are less likely to be cured of their illness or recover from their surgery. Gordon’s focus in Reading 2.2 is the crisis in health care, specifically the results of hospital restructuring and the downsizing of nurses, and the effects these changes have had on patient outcomes and the working conditions of nurses. The article is more combative in tone and more urgent in its call for change.
10. In Reading 2.2, Gordon provides many specific examples of the crisis in health care and its effects on patient outcomes, thereby appealing to the emotions of readers. Gordon blames RN dissatisfaction for the current nursing crisis, whereas in Reading 2.1, the tone is more objective, and the focus is on demographic changes that have fueled the nursing shortage. Although the authors Kimball and O’Neill mention that women are less likely to choose nursing as a profession than in the past, they speak about increased opportunities for women in other professions, not dissatisfaction within the profession that is making recruitment and retention more difficult.

Reading and Interpreting Figures (pages 54–64)

Figure 1: Units along the *horizontal axis* in both figures represent years, from 1983–2000. The size of the increments is in one-year intervals. Units along the *vertical axis* in the *top* figure represent the number of patients or nurses. The size of the increments is in 100,000 units. Units along the *vertical axis* in the *bottom* figure represent the ratio of number of nurses to the adjusted average daily census, calculated by dividing the number of inpatient days by the number of days in the reporting period. The size of the increments is in .10 intervals.

1. 1990
2. decrease; 15,290
3. increase; 259,388
4. increase; .32. No; based on Reading 2.2, the ratio should be much higher.
5. The number of hospitalized patients has increased over the past 18 years, but the number of registered nurses has decreased, so the ratio of nurses to patients is higher than in the past.

Figure 2: Units along the *horizontal axis* represent years. The size of the increments is in four-year intervals, from 1980 to 2000. Units along the *vertical axis* represent average annual salary in dollars. The size of the increments is in units of \$10,000, from \$10,000 to \$50,000. “Actual average annual salary” refers to the salary that a nurse earns. “Inflation-adjusted average annual salary” is the amount of money the nurse receives from her salary after the amount of money lost to inflation has been subtracted.

1. \$29,384
2. \$5,971
3. No
4. The inflation-adjusted average annual salary for nurses has not increased since 1992.

Figure 3: Units along the *horizontal axis* represent years. The size of the increments is in one-year intervals, from 1992 to 2001. Units along the *vertical axis* represent number of students. The size of the increments is in units of 10,000, from 10,000 to 150,000.

1. 3; associate-degree, baccalaureate-degree, and diploma programs
2. decrease; 43,052
3. decrease; 11,905
4. decrease; 16,421
5. baccalaureate-degree programs for both entry-level students and registered nurses
6. The trend in nursing education is toward 4-year degree programs.

Figure 4: Two categories: (1) states with the highest number of nurses and (2) states with the lowest numbers of nurses.

1. 782
2. Nevada
3. Massachusetts
4. Southwest, Northeast, Midwest
5. The extent of the nursing shortage varies from state to state.

Figure 5: Units along the *horizontal axis* represent age in years. The size of the increments is in five-year intervals, beginning with age 25 and ending with age 64. Units along the *vertical axis*

represent number of nurses. The size of the increments is in 100,000 units, from 0 to 500,000.

1. years; 6
2. 25–29; 300,000
3. 30–34; 350,000
4. 35–39; 400,000
5. 40–44 and 45–49; 450,000
6. The average age of nurses is increasing.

Comprehension and Discussion Questions (pages 78–79)

1. Needleman and colleagues found in their study that a higher proportion of hours of nursing care provided by registered nurses and a greater number of registered-nurse-hours per day were associated with better outcomes for hospitalized patients, including shorter length of stay and lower rates of urinary tract infection and upper gastrointestinal bleeding. In addition, a higher proportion of registered-nurse-hours was associated with lower rates of pneumonia, shock, cardiac arrest, and death from these causes, as well as from upper gastrointestinal bleeding, sepsis, and deep venous thrombosis. Given the importance of nursing care for patient outcomes, it is especially important to find a solution to the nursing crisis. In the discussion of “failure to rescue” (page 51) in Reading 2.2, Gordon discusses similar findings from a collaborative study between the University of Pennsylvania’s School of Medicine and School of Nursing. Gordon provides quotes from nurses to support the research findings, whereas Steinbrook limits his discussion to reporting the results of Needleman et al.’s research study.
2. Using 1983–2000 data from the American Hospital Association, Figure 1 appears to show that there has been an increase in the number of nurses working in hospitals. Using similar data from 1992 to 1997 from the American Hospital Association, Gordon in Reading 2.2 challenges the claim that the number of nurses has increased over time.

She argues that these numbers do not reveal where RNs are working in the hospital. These numbers include RNs who have purely administrative functions, such as “case managers” and “utilization reviewers” (see page 47), who are dealing with insurance companies, not providing direct patient care. So, while the total number of RNs may have increased, the number of RNs providing patient care has not.

3. Figure 1 also appears to show that the ratio of registered nurses to patients increased, suggesting an increase in patient load. However, between 1994 and 2000, the ratio of nurses to patients remained relatively constant. Steinbrook mentions that these data do not take into consideration the severity of patients’ illnesses or their shorter length of stay. These data are somewhat consistent with Gordon’s discussion of the increase in patient load. In addition to the increase in patient load, Gordon emphasizes that numbers of nurses do not distinguish between bedside nurses and nurses who do not provide direct patient care. In general, Gordon is much more skeptical and critical of data that she thinks do not tell the whole story. Steinbrook is a physician writing for the leading medical journal in the United States. He represents the highest level and the most powerful group of professionals working in health care, whose numbers have not been reduced by hospital restructurings. Although Gordon is not a nurse herself, she has written a great deal about nursing as a profession and the plight of nurses (see her website at: www.suzannegordon.com/). She is clearly sympathetic to the working conditions of nurses and the dangers posed to the general public by the downsizing and replacing of nurses by less qualified health-care workers.
4. The word “perception” suggests there is a distinction between perception and reality. Nurses may perceive something that is not in fact true. Steinbrook goes on to provide data from two surveys, one conducted in Pennsylvania in 1998-1999 and the other a national survey conducted in 2001–2002, that suggest a decrease in the degree of nurse dissatisfaction with their current job, from 41% in 1998-1999 to 29% in 2001-2002. In contrast, Gordon provides many examples and quotes from nurses who are *harried* (page 49) and *stressed-out* (page 50) and who have left the profession; and she uses words like *plummeting* (page 50) and *bottomed out* (page 50) to describe nursing morale. Clearly, from her perspective, dissatisfaction among nurses is much more pervasive and serious than Steinbrook has suggested.
5. According to Figure 2, the average annual salary for nurses in 2000 was \$46,782, but adjusted for inflation, it was much less: \$23,369. Surprisingly, Steinbrook does not mention this lower amount in his brief discussion of financial issues. He mentions a slowing of the increase in real annual salaries from 1980 to 1992, but the complete lack of increase since 1992 in the amount adjusted for inflation is not mentioned at all. Gordon seems more concerned in Reading 2.2 about the overall working conditions of nurses rather than issues regarding compensation. In another article, “What Nurses Stand For” (1987), Gordon states that “nursing does provide attractive middle-income salaries,” but at the end of Reading 2.2, Gordon also argues that among other changes, better pay for nurses is needed to resolve the nursing crisis.
6. The growth of managed care resulted in fewer jobs for nurses. Some nurses lost their jobs; some new nurses could not find jobs. As a result, enrollment in nursing schools declined. These reasons do not acknowledge the demographic variables discussed in Reading 2.1, nor do they acknowledge the job dissatisfaction discussed in Reading 2.2. Gordon would agree that the origins of the nursing crisis are in the growth of managed care and cost-cutting measures that resulted in registered nurses being replaced with less qualified health care workers.

7. Cyclical shortages of nurses are periodic shortages of nurses due to economic factors. When the economy is weak, nurses who are married and those who are working mothers are more likely to seek employment or increase their hours. Conversely, when the economy is strong, these two groups are less likely to seek work or may work only part-time. Steinbrook claims that the current shortage of nurses may be similar to cyclical shortages that have occurred since World War II. If the current shortage is due primarily to economic factors, the short-term solution would be to offer better wages and better jobs, as well as better marketing of nursing schools and of nursing as a career, to encourage more students to enter nursing programs and current nurses to return to the workforce.
8. Steinbrook is not convinced that a long-term nursing shortage is inevitable. He refers to other predictions of shortages that “have turned out to be wrong” (page 72). He does acknowledge that *there is the potential* (page 72) for a long-term shortage, but the word “potential” indicates that Steinbrook is by no means convinced of its inevitability.
9. Establishing minimal nurse-staffing ratios and prohibiting mandatory overtime may result in an increase in the nursing shortage in the short term, as hospitals will most likely have to hire more nurses. In the long term, such changes might make nursing more attractive as a career choice, making it easier to recruit nurses.
10. Steinbrook’s use of the word *however* suggests some ambivalence on his part. On the one hand, patients would benefit from a more educated workforce; however, a more educated workforce would want greater independence and responsibility and would require higher pay. As a physician, Steinbrook, may be wary of a more independent workforce of nurses. He may also be concerned about having to choose between better educated nurses and state-of-the-art hospital equipment, such as com-

puterized order-entry systems, that facilitates the work of physicians and reduces costs in the long term. Steinbrook seems somewhat sympathetic to the plight of nurses, but he also thinks that some of their concerns are self-serving and “reflect their interest in their own financial and job security” (page 77), suggesting some skepticism on his part that the working conditions of nurses are as bad as nurses have been saying they are.

3: Writing about Culture in Nursing (pages 81–122)

Activity: Paraphrasing (page 90)

There are two primary ways in which a student can prepare for a nursing career. Students can complete either a two-year or four-year program, at a community college or at a college or university, respectively. Both types of programs provide training for licensure as a registered nurse and include not only coursework, but also clinicals, where students gain experience in actual nursing practice in various hospital settings.

Using Quotes (pages 91–92)

1. promote and support
2. no
3. Yes; *health care organizations and nurses* is the subject; *should promote and support* is the verb.
4. A context for the quote has been provided first, specifically, a rationale for the National Standards for Culturally and Linguistically Appropriate Services in Health Care.
5. Office of Minority Health
6. To give it importance and so that it stands out as official policy.

Deleting Words (page 93)

1. Nursing is “the provision, ~~at various levels of preparation,~~ of services that are essential to or helpful in the promotion, maintenance, and restoration of health and well-being or

in the prevention of illness, ~~as of infants, of the sick and injured, or of others for any reason unable to provide such services for themselves. Sometimes designated according to the age of the patients being cared for (e.g., pediatric or geriatric nursing), or the particular health problems (e.g., gynecologic, medical, obstetrical, orthopedic, psychiatric, surgical, urological nursing, or the like), or the setting in which the services are provided (e.g., office, school, or occupational health nurse)~~” (p. 1248).

2. To include only the most essential part of definition.

Choosing Verbs (pages 98–99)

1. In the article “Fright Illness in Hmong Children” by Lisa Capps (1999), the author *believes* that children in the Hmong community experience health problems due to fright illness.

Believes: Author is stating an opinion.

2. In “Changing womanhood: Perimenopause among Filipina-Americans,” Mary Ann Hautman (1996) describes what Filipina-Americans in perimenopause generally experience.

Describes: Author is neutral.

3. Calvillo and Flaskerud (1991) claim that many Hispanics believe “one’s fate is to suffer in this world.”

Claim: Author is making an assertion of truth.

4. The author, Judy Mill (2001), of the article “I’m Not a ‘Basabasa’ woman: An Explanatory Model of HIV Illness in Ghanaian Women” explores what Ghanaians believe about HIV illness and the problems that HIV patients encounter.

Explores: Author is neutral.

Maintaining an Objective Voice (pages 101–2)

Words that convey the author’s agreement or disagreement or that are evaluative in some way are italicized.

1. Even though the surveys used in the study (Bertrand, Seiber, & Escudero, 2001) were *reliable* and included *large* sample groups, it is *questionable* whether or not the participants represented the entire population. One of the *weaknesses* of the survey is that when the authors classified Guatemalans into two groups, they did not include a third group: the Burgesses.
2. Overall, Miller (1995) points out common Cambodian health care values and beliefs. Information regarding wind illness along with self-care techniques are described *accurately*. As a registered nurse, Miller provides *excellent* suggestions on how to be an effective caregiver for Cambodian patients. *However*, Miller *misinterprets* the use of the coining and cupping techniques. For instance, cupping is *only* used to treat headaches. *Also*, cooking oil and wax are *rarely* used as a lubricant during coining. *In addition*, Miller’s findings were *not based upon* cultural research of the Cambodian ethnic groups. The author *failed to provide* statistics from past research findings. Her conclusions *seem to be based only* upon her experiences as a registered nurse.

Comprehension and Discussion Questions (page 111)

- 1–7. Answers will vary.
2. National Standards on Culturally and Linguistically Appropriate Services (CLAS) is available online through the Office of Minority Health website, at: www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=15. There are 14 standards. Answers to other questions will vary.

Comprehension and Discussion Questions (pages 118–19)

1. People’s behavior is based on their beliefs, and beliefs are culturally influenced. In Hispanic cultures, people believe in the value

- of suffering and in fatalism, in part as an expression of their religious beliefs. They believe that life has many difficulties and these difficulties must be accepted without complaint. It is their fate in life to suffer and they must accept that fate.
2. The gate control theory of pain explains the role of culture in the perception of pain. "Pain is not just a physiological response to tissue damage . . . psychological variables such as behavioral and emotional responses expected and accepted by one's cultural group . . . are stored in the brain and in cultural experiences and are capable of influencing the transmission of painful stimuli" (p. 113). The transmission of pain to the brain can be affected by blocking cells, much like a gate that is open or closed. These cells exist all along the nervous system; other pain-inhibiting mechanisms exist in the thalamus and cerebral cortex, where processes related to thoughts, emotions, and past experiences are processed. When these cells or mechanisms are activated, the gate is closed, and pain impulses do not reach the brain. In other words, "an individual's thoughts, cultural beliefs and values, and memories can influence whether pain impulses reach the level of awareness" (p. 113).
 3. According to Zborowski's study, Anglo-Americans try to remain calm when they are in pain. They show little emotional reaction to pain and avoid complaining, crying, and screaming. The cultural beliefs of Anglo-Americans have traditionally been considered dominant in the United States. They are often the reference group in transcultural comparison studies because their behaviors represent the accepted pattern. Answers will vary regarding their current status in society.
 4. Social class and education are variables that can also influence the transmission of pain stimuli to the brain. If a study includes people of different social classes and of different levels of education, culture may not be the only or the most important variable in the response to pain. In other words, there is less cultural difference between people of the same social class and educational background.
 5. Hispanics believe that there are many difficulties in life that must be accepted without complaining, so when a person is ill, he or she must bear the illness with dignity and courage. In this sense, stoicism is valued; the signs and symptoms of pain are not necessarily acknowledged because that would suggest the person is weak and lacks stamina. In Anglo-American culture, stoicism is also valued, but in a different way. The Anglo-American does not wish to be pitied and therefore behaves as if the pain were minimal or nonexistent.
 6. Moaning and crying out in Mexican culture are accepted expressions of discomfort and pain. They are also ways of relieving pain. They do not necessarily mean that the individual is experiencing extreme pain or cannot tolerate pain and is requesting pain medication. Nurses operating from the dominant cultural model, however, often identify Mexican-American patients as complainers who cannot tolerate pain.
 7. Answers may vary, but stereotypes do not go away easily. Moaning and crying are behaviors that have different meaning in different cultures. For Mexican Americans it has one meaning, but for nurses it has another. Rather than taking the time to understand cultural differences, nurses are relying on stereotypes.
 8. Answers will vary.
 9. Nurses are overly concerned about the potential for patients to become addicted to prescription narcotics. Also, in their management of pain, nurses tend to focus on reducing rather than relieving pain. Nurses also infer that patients are experiencing more psychological distress than pain, and over time they become less sensitive to patients' complaints of pain. These factors are significant because culture is an additional factor in the discussion of pain management; it is not the sole factor either in the patient's response to pain or in the nurse's.

10. In their pain assessment, nurses need to find out what the meanings and intended functions are in different cultures of particular behaviors in response to pain. Nurses also need to assess what kind of intervention a patient prefers.

4: Developing Note-Taking Skills for Nursing (pages 123–59)

Comprehension and Discussion Questions (pages 134–35)

1. Families in Vietnam extended collective patriarchal deferential to elderly	Families in the U.S. nuclear individualistic matriarchal youth oriented
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2. Role reversals between husband and wife occur because it is easier for women to find unskilled jobs than men—as hotel maids, sewing machine operators, and food service workers. Women who didn’t work before are now working and earning money for the family and taking on some of the status and power that come with that. Role reversals between parents and children occur because the children learn the language and American customs quickly and may be able to find employment more quickly than older members of the family.
3. Role reversals can provoke intergenerational conflict, hostility and resentment and can lead to wife or child abuse, depression, and alcoholism.
4. Answers will vary.
5. Answers will vary.
6. In general, immigrants choose to come to the United States; refugees must leave their country of origin because of war, persecution, etc. The trauma that many refugees have experienced due to war creates its own set of mental health challenges, most notably Post-Traumatic Stress Syndrome.

7. “American-style therapy” is unlikely to work with Vietnamese clients because they are unlikely to confide, do not believe in the unconscious, and are reluctant to criticize their parents openly. Mental health problems are so highly stigmatized by the Vietnamese, they would find it very difficult to discuss these issues without feeling shame. Answers to other questions will vary.
8. Noncompliance with medication can be a problem when symptoms subside or when side effects occur, or because of the advice of a family member. Answers to other questions will vary.
9. Because of the stigma attached to mental health concerns, practitioners should ask questions about symptoms in a straightforward manner to prevent clients from trying to maintain a false front. Direct, specific questions like: “Where does it hurt?” or “How do you hurt?” are more likely to be answered in a straightforward manner than “How do you feel?”
10. Treatment staff should let Vietnamese refugees first deal with their physical problems; then by developing a relationship of trust with treatment staff, they may be able to help the client eventually address submerged psychological issues. Some combination of traditional herbal medicine and Western medication might prove most effective. Health workers should also include the family in treating the individual; their trust and cooperation are needed. Answers to this will vary.

Comprehension and Discussion Questions (pages 143–45)

1. The word *zoe* is not in the dictionary. A *zoe* is like a witch doctor or a traditional healer. Answers to other questions will vary.
2. The three main reasons why people become mentally ill in Liberian culture are: punishment for something they did wrong, the result of being “witched” by another person, and from the illness being “passed down” through the family. Answers to other questions will vary.

14 Answer Key

3. The three types of treatments are: confession of wrongdoing to a zoe, removal of the spirit or sign through traditional medicine, and prevention of “down-the-line” illness. Answers to other questions will vary.
4. Students will be more open to learning about mental illness from a Western perspective if they see similarities, rather than
- 5.

just differences, between the Liberian and Western perspectives. Making sense of something new from the perspective of known information is more effective learning. In addition, adding to someone’s cultural perspective is less threatening than replacing it with something alien and unfamiliar.

Liberian Belief/Practice	Western Theory/Treatment
Spirit’s response to wrongdoing	Guilt about one’s wrongdoing
Confessing to a zoe	Talking about one’s feelings with a therapist
Trust in the zoe	Trust in the nurse and belief in the therapeutic process
Visiting a zoe	The therapeutic process
Talking with a zoe, who then determines source of anxiety	Nursing goal of helping client to examine sources of his or her anxiety
Women who have recently given birth carry a penknife to keep spirits away	Postpartum depression and postpartum psychosis
Taking someone’s clothes away from them when they are in the bush	Safety precaution for individuals who are suicidal
“Down the line” mental illness	Genetic predisposition and family history of mental illness

6.

Symptom of Mental Illness, Recognized in Both Liberian and Western Cultures	Type of Mental Illness, Identified in Western Medicine
Withdrawal from social relationships	Schizophrenia; major depressive disorder
Singing loudly while pacing the floor	Mania
Wearing dirty and torn clothes	Depression; psychosis

Activity: Using Telegraphic Language (pages 151–52)

1. Mental health = positive state
Mentally healthy person = self responsible, self-aware, self-directed, copes effectively with daily living, functions well with people and accepted by others, satisfied with life, finds pleasure in living, fulfills capacity for love and work, balanced
2. Factors that influence mental health: Inherited characteristics (genes inherited from parents): temperament (general outlook on life, personality); cognitive abilities (thinking abilities, judgments)
3. Another factor: Nurturing during childhood (bonding with mother, parents): interac-

tions with family members; influence of extended family

4. Another factor: Basic life circumstances: positive and negative life events, witnessing traumatic events (war)
5. Abraham Maslow—American psychologist: “Maslow’s Hierarchy of Needs”—model for understanding mental health

Activity: Using Abbreviations (page 154)

Answers will vary; some possibilities are:

1. mntl hlth
2. inher. char.
3. cog. abil.
4. child nrtrng
5. psych

5: Understanding Qualitative and Quantitative Research in Nursing (pages 160–98)

Activity: Understanding the Organization of a Research Article (page 161)

Components of a Research Article	“Current Nursing Practice Related to Sexuality”
Background to the Study	p. 161, Pars. 1–3
Literature Review	p. 161, Pars. 4–; p. 162, Par. 4.
Purpose of the Study	p. 162, Par. 5
Research Questions	not included
Methodology	Method
Participants	Sample
Instrument	Instrument
Procedure	not included
Data Analysis	p. 163, Pars. 2–
Results of the Study	Results
Discussion	Discussion
Conclusion	p. 168, Par. 3, Sent. 1
Implications	not included
Limitations of the Study	p. 168, Pars. 3–4 beginning with Sent. 2. of Par. 3
Recommendations for Future Research	p. 168, Par. 5

Activity: Reading and Interpreting Tables (pages 162–66)

Table 1: There are two columns. The right column refers to Practice Area. The left column refers to the Level of Relevance of Sexuality.

This table is showing how relevant sexuality is to patient care in each of these areas of nursing practice.

1. mental health
2. gerontology
3. rehabilitation
4. 43
5. 67
6. 42

Table 2: There are four questions. The six response categories refer to different percentages of clients.

This table is showing what percentage of nurses addressed sexuality-related concerns in different percentages of clients.

1. 5.3%
2. 12.5%
3. 28.7%
4. 92.7%
5. Number of times nursing diagnosis for sexuality was used.
6. 28.1%

Table 3: There are ten sexuality-related activities. Four responses: Never, Rarely, Occasionally, Frequently

This table is showing what percentage of nurses performed each of these activities at each of these rates of frequency.

1. 38.3%
2. 35.1%
3. 20.1%
4. 18.2%
5. Listening to concerns about sexuality
6. Teaching about sexually transmitted diseases

Table 4: Calculation of practice score:

“Responses to the ten frequency questions were scored 0 = never and 3 = frequently, and these frequency scores were totaled to yield an overall practice related to sexuality score (PRACTICE)”

Highest possible PRACTICE score: 30

Range of PRACTICE scores: 0–28

1. *respectively*: Each separately in the order mentioned.
2. PRACTICE score for staff nurses working in a practice area where sexuality was moderately important: 9.56; most important: 16.26; least important: 8.2

The researchers hypothesized that the PRACTICE score would differ by practice area, and by practice position. They found that nurses were more likely to address sexuality in their practice if they worked in a hospital in a practice area where sexuality was especially relevant. Their finding regarding practice area was consistent with their hypothesis, but not their finding regarding practice position. In other words, staff nurses, who have more direct contact with clients were not more likely to discuss sexuality-related concerns than nurse managers or nurse faculty.

Twelve variables are listed in Table 4.

3. Statistically significant variables in order of significance, beginning with most significant: (1) knowledge, (2) practice area, (3) comfort, (4) practice place, (5) responsibility.

Nurses are more likely to address sexuality in their practice if they feel they are knowledgeable about the topic, are practicing in an area and place where sexuality is relevant, feel comfortable and a sense of responsibility to address sexuality concerns with clients.

Your explanation of the results of the table should be consistent with the explanation in the article.

Activity: Understanding Research Terminology (pages 177–78)

Research Design

1. d. content validity
2. b. hypothesize
3. j. response rate
4. k. reliability
5. h. validity
6. a. pilot
7. i. sample
8. g. population
9. c. instrument
10. e. variables
11. f. demographic data

Statistical Procedures

1. d. nominal data
2. b. ordinal data
3. g. Chronbach alpha level
4. f. test-retest reliability
5. a. dichotomous variables
6. e. regression analysis
7. c. significant predictors
8. h. *t* values

Comprehension and Discussion Questions (page 179)

1. Sexuality is part of providing holistic care of clients, for example, in assessing sexual health, providing guidance with regards to sexual development, validating normal sexual functioning, educating about sexuality and prevention of sexually transmitted diseases as well as diseases of the reproductive organs, counseling clients about changes in sexuality, providing intensive therapy for sexual problems, and referring clients to other health care providers.
2. The PLISSIT model is a conceptual framework used to describe levels of sexuality

counseling and intervention that are provided to clients.

3. P=Permission; the nurse conveys to the patient that sexuality is a suitable subject for discussion and provides assurance that concerns or practices are normal.

LI=Limited Information; the nurse gives factual information relevant to the client's concern or problem. General sexual concerns, questions, myths, and misconceptions are also addressed.

SS=Specific Suggestions; the nurse gives specific suggestions about sexual concerns and dysfunctions.

IT=Intensive therapy; a trained professional provides sexual counseling.

All nurses should be competent in providing Permission and Limited Information.

4. The Survey on Sexuality in Nursing Practice was developed based on the Permission and Limited Information levels of the PLISSIT model.
5. "Listening to clients' concerns" and "answering [clients'] questions about sexuality" (p. 171) are both client-initiated activities, rather than interventions initiated by nurses. These were the only activities related to sexuality that were performed "occasionally to frequently" by a majority of nurses, indicating that nurses wait for clients to initiate discussions about sexuality rather than initiating them.
6. Generally when people are knowledgeable about a subject, they are comfortable talking about it. With sexuality, perhaps knowledge is not enough for someone to feel comfortable talking about it. So, when someone feels comfortable talking about sexuality, it may have little to do with knowledge. Answers to other questions will vary.
7. The variables that predicted practice related to sexuality were: (1) practice area and (2) place, and (3) nurses' perceived knowledge, (4) comfort, and (5) responsibility.

The variables that did not predict sexuality-related practice were: age, marital status, practice position, basic education, continuing education, and personal values.

8. Selection bias is when the participants in the study may have a particular interest in the study, so they completed their questionnaire and sent it in. There may have been a selection bias because nurses who are interested in nursing practice related to sexuality probably sent in their questionnaires, compared to those who were not interested in the topic and did not send in their questionnaires. This bias would strengthen the study's findings. Only 31% of nurses responded; those who did not respond are less likely to be interested in the topic and turn in their questionnaire, as well as less likely to address sexuality-related concerns in their clients.
9. Hospital nurses were more likely to address sexuality with their clients perhaps because the most critically ill and acute patients are seen in the hospital. Areas of concern may be addressed in the hospital setting that would not otherwise be addressed.
10. The increase in STDs (sexually transmitted diseases), including HIV/AIDS, have made discussions about sexuality-related matters of great importance to be discussed with all clients.

Activity: Understanding the Results of Qualitative Data Analysis (pages 180–82)

I. Talking

- A. Initiation
 1. Patient should initiate discussion on sexuality
- B. Upbringing
 1. Familial and social upbringing
 2. Sexuality as taboo subject
- C. Staff nurse status
 1. Prevents nurses from establishing close relationships with patients

2. Talk with patients limited to routine topics

D. Logistics

1. Lack of time
2. Heavy workload

E. Lack of privacy

F. Priority of care

1. Sexuality not a priority, especially in acute surgical settings

II. Stereotyping

A. Stereotypes of nurses

1. Public image of nurses as sex objects
2. Role of the media in creating negative images
3. Uniform of nurses as sexually provocative
 - a. White
 - b. See-through

B. Sexual harassment

1. Female nurse as sex object
2. Role of male stereotypes
 - a. Taboo body parts exposed
 - b. Unusual level of intimacy with stranger
3. Use of touch
 - a. Men see touch as sexual
 - b. Touch is routine for nurses
4. Acceptance of mild harassment

C. Homosexual patients

1. Nurses have negative attitudes toward homosexuals
2. Nursing care of homosexual patients is inadequate

III. Coping

A. Embarrassment

1. With intimate, invasive procedures
2. When privacy has been breached
 - a. Nurses touch or come too close to patients
 - b. Taboo part of the body is exposed
3. Events given inappropriate sexual connotations
 - a. Caring for homosexual patients
 - b. Vicarious embarrassment—nurse is embarrassed because patient is

- B. Coping strategies
1. Avoidance of patients
 2. Distancing from patients
 - a. “Coercive power”—way nurses can assert power
 - b. Negative sanctions
 - i. Detract from standard of care
 - ii. Remain in place unless patient behaves in acceptable manner
 3. Routinizing behavior
 - a. Claims event that caused embarrassment is routine
 - b. Minimizing the situation
 4. Use of humor
 - a. At expense of patients
 - b. Shared with patients
 - i. Changes focus of attention away from source of embarrassment
 - ii. Embarrassed patient becomes equal participant in interaction
 - c. Rationalizes behavior of patients

Comprehension and Discussion Questions (page 195)

1. Words that suggest a sexology orientation are: biological sex; positivist, scientific nature of research; medical model or biomedical model of care; physiological concept; and matters of sexual health. Words that suggest a sexuality orientation are: culturally and historically specific; social deconstructionism; social influences on sexuality; more abstract concept encompassing biological, psychological and sociological dimensions; holistic care.
2. Sexuality is an integral part of an individual and therefore needs to be included as part of the holistic nursing care provided to every individual.
3. The ways in which nurses avoid *talking* about sexuality with patients are as follows:
 - 1) Nurses feel it is up to patients to initiate discussions about sexuality, so they wait for patients to bring up the topic; 2) their upbringing, both familial and societal, make it difficult to bring up the topic; 3) if nurses are staff nurses, they do not generally establish close enough relationships with patients to bring up the topic; 4) Logistical factors such as lack of time and heavy workload limit the opportunity for discussion about sexuality; 5) finding somewhere to discuss sexuality or lack of privacy is problematic; and 6) in the acute surgical setting, sexuality is not considered a priority of care.
4. Nurse/patient interactions force male patients into a non-dominant role. For example, male patients are asked to expose taboo parts of their bodies; they are also subjected to a level of intimacy not normally found between strangers. The common male stereotypes that are challenged in an acute health care setting are that men are in the dominant role in interactions, particularly with strangers, and are the ones to decide whether interactions become intimate or even sexual.
5. Nurses use physical touch routinely in their everyday work; it is unlikely therefore that touch has a sexual meaning for them. On the contrary, men see touch as sexual and are more likely to see male/female interaction in a sexual way. As a result, male patients may misunderstand the meaning of touch in nursing care and may perceive female nurses as willing to enter into sexual interactions.
6. Answers will vary.
7. Answers will vary.
8. In this study the care given to homosexual patients was perceived as inadequate. Nurses reported embarrassment when caring for homosexual patients. Perhaps the nurses avoided talking with gays and lesbians or were reluctant to provide direct physical care. Avoidance and distancing

are two ways in which nurses avoid dealing with potentially uncomfortable situations. Answers to other questions will vary.

9. Recommendations are: (1) nurses should examine their attitudes towards sexuality, both individually and collectively, and gain insight into their own behavior and that of their peers; (2) nurses should challenge the portrayal of nurses in the media as sex objects; (3) hospital policies regarding sexual harassment should be openly displayed and made available to nurses; (4) assertiveness training should be offered to nurses; (5) training should include not only knowledge about sexuality, but also (6) the communication skills necessary to talk openly about sexuality with clients; and (7) private areas need to be made available for conversations between nurses and patients about private matters, including sexuality concerns.
10. Answers will vary.

Activity: Understanding Research Terminology (pages 196–97)

Research Design and Analysis

1. o. conceptualize
2. g. selective sample
3. c. abstract
4. a. positivism
5. d. holistic
6. i. sample size
7. e. construct
8. j. in-depth interviews
9. f. grounded theory
10. m. transcribe
11. n. phenomenon
12. b. social constructivism
13. l. respondents
14. k. informants
15. p. qualitative
16. h. convenience sample

6: Ethical Dilemmas in Nursing (pages 199–208)

Activity: Understanding Ethical Principles (page 202)

1. d. cultural relativism
2. a. autonomy
3. e. cultural competence
4. b. patient rights
5. c. informed consent

Comprehension and Discussion Questions (page 203)

1. Female circumcision or female genital mutilation refers to the cutting and partial or complete removal of female genitalia. Four types of female circumcision are listed in this article: Type 1 and 2 are both clitoridec-tomies; they both involve the removal of the clitoris. Type 2 also involves the excision of part of the labia minora. Types 3 and 4 are both labeled infibulations; they involve the excision of part or all of the labia majora, as well. Type 4 involves the stitching together of the remaining tissue, leaving a small pos-terior opening.
2. There are many theories regarding why female circumcision is practiced. According to one theory, its purpose is to oppress women and girls and control their sexuality. According to another perspective, it is a rite of passage for a girl, an important part of her socialization into the social, familial, sexual, and reproductive roles of a woman. In other groups, female circumcision is necessary for a girl's eligibility for marriage, which for women in many of the cultures that practice female circumcision may be their only eco-nomic option. See Table 2 for additional rea-sons. Answers to other questions will vary.
3. The short-term complications that can occur during the procedure or during the

recovery period include: injury to urethra, vagina, perineum, and anus; hemorrhage; infection, sepsis, and abscess; shock; and urinary retention. The long-term complications of Types I and II include: persistent wound infection; neuromas; and keloid scarring. For Types III and IV, they include: hematocolpos; dysmenorrhea; and dyspareunia. See Table 3 for additional short-term and long-term sequelae.

4. Answers will vary, but one factor to consider is that breast augmentation and liposuction are not cultural imperatives for women in the United States. There may be pressure brought on by the media and advertising to have the perfect figure, but a woman is not ostracized from her community nor does she lose her eligibility for marriage if she does not have these procedures done.
5. Answers will vary, but cultural practices do change when the cultural context is no longer the same and is no longer supportive or tolerant of such practices. Also, the younger generation that grows up without the larger community support of such practices may no longer be willing to undergo the procedure.
6. One reason why circumcised women do not attribute their health problems to circumcision is because the procedure may have been done on them when they were very young, and they may not know what normal female genitalia look like or what physiologic processes are normal. Also, they may have been socialized to accept some degree of discomfort or morbidity as their “lot in life” (p. 89 in reading, not provided) and may attribute illness to supernatural causes.
7. Efforts to eradicate the practice of female genital mutilation have failed because they are often seen as attempts by outsiders to interfere with the internal affairs of another country or with an important cultural ritual in a community that seeks to preserve its cultural identity and autonomy. The practice is also a tradition that is valued in the community. It is a time when women come together and solidify their relationships with one another. It is also an important rite of passage for girls and usually happens within the context of a special ceremony and gathering of women, during which the girl gains access to rituals and customs within her community that are important to her. Indeed, it may be the only time in a girl’s life when she is the center of such attention. Answers to other questions will vary.
8. Autonomy means individuals have the right to make their own decisions. Patient rights include the right of patients to make autonomous decisions about their health care. But what if the procedure that the patient requests is detrimental to his or her health? Although it is illegal to perform female circumcision on women younger than 18 years of age, what if the patient is older than 18 and requests the procedure?
9. Since female circumcision is a cultural practice, there is considerable pressure on a woman by her cultural community to have the procedure performed. Indeed, there might not be any option for the woman if she wishes to be married or remain a part of the community. Informed consent assumes that the individual has all the information necessary to make an autonomous decision about his or her health care, but given the cultural context and the cultural imperative to have the procedure done, Schwartz argues that a woman who agrees to the procedure is not making an informed decision because she is not able to “step outside her culture to objectively view the deleterious effects [of the procedure]” (p. 90 in reading, not provided). Answers to the other questions will vary.
10. Cultural relativism requires that individuals suspend their biases against norms and practices in another culture that they might not agree with. Culturally competent care, which is based on the equality of cultures,

requires that health care providers respect the cultures of their clients. But what if the culture dictates a procedure that is detrimental to the patient's health?

Activity: Understanding Ethical Principles (page 206)

1. h. community
2. c. moral absolutism
3. e. truth disclosure
4. g. informed consent
5. f. moral relativism
6. a. autonomy
7. b. beneficence
8. d. veracity

Comprehension and Discussion Questions (pages 207–8)

Page numbers here are not in student book.

1. Patient autonomy, or the right of individuals to make their own decisions about medical treatment, has become so important in the United States because of “increased public education, the strong focus on individual human rights, and a growing distrust of the medical industry” (p. 475). In many cultures, families would prefer not to inform the patient of a terminal illness. They believe this would cause unnecessary harm to the patient. However, if patients are not informed about their illness, how can they make autonomous decisions about their medical treatment?
2. The resident felt it was unethical or perhaps even illegal to withhold the truth about the diagnosis from the patient.
3. The family did not want the biopsy done because it would only cause discomfort for the patient without prolonging his life. In addition, the resident had told them the biopsy would most likely not affect the treatment or outcome of the illness. The family did not want the patient told the truth about his diagnosis because it would “break his spirit” (p. 476). They had planned for the patient to return to China so he could die in his homeland. If he knew the truth about his diagnosis, he might die before he had a chance to return. According to Chinese cultural values, the family was being respectful towards the patient by not telling him the truth, so as not to discourage him, and the patient was being respectful towards his family by pretending not to know how seriously ill he was. They were upholding the value of community (over autonomy) and doing what they felt was best for the patient (beneficence).
4. The Ethics Committee proposed the following compromise: an American-born Chinese physician serving as guest consultant would ask the patient whether he wished for his medical information to be given to him or to his family and whether they could make decisions for him. Answers may vary regarding the success of the compromise, but the patient's wishes were determined and then complied with. The patient readily agreed that the information be given to his family and that they make the decisions about his health care, an outcome which upholds the principle of autonomy so important in the United States, but which is also consistent with the Chinese values of community and beneficence. The patient was able to return to China and die in his homeland, without being told of his illness by his family. The compromise also “relieved” (p. 476) the resident of any guilt she might have felt for not telling the patient about his illness and the family was able to fulfill their duty of honoring their father's wishes and protecting him from harm in his old age.
5. The wife requested that her husband not be told the truth about his diagnosis because “in Georgian culture, having a disease such as cancer is seen as a burden on the family” (p. 477). The patient “would be at high risk of committing suicide to protect his honor” (p. 477). In addition, it is accepted practice in Georgian culture for the family to be

- informed of a terminal diagnosis, but not the patient.
6. Georgian culture values beneficence over autonomy with the focus on the family unit. In addition, it is considered a source of disgrace and shame if the father is unable to fulfill his role as head of the family, in this case due to a terminal illness. The wife did not want to put her husband in a position of having to respond to the shame and disgrace he would feel by committing suicide, and the husband was willing to have his wife make the decisions for him to avoid the feelings of shame and disgrace. In this way, the father was able “to maintain a sense of dignity and control” (p. 478) in the final days of his life. Other factors that may have influenced the wife’s decision not to tell her husband have to do with the role of medicine in Georgia and misunderstandings about the nature of cancer. Families do not generally have the resources to access Western medicine, so they rely on traditional folk remedies first. They seek out medical care as a last resort. To consult a physician or to have the patient enter a hospital is already a sign of failure of the family’s resources. Also, many people in Georgia believe that cancer is always fatal with no hope of recovery and that cancer is contagious. These misconceptions might have strengthened the wife’s conviction that the husband should not be told of his diagnosis, as his response would most likely be suicide.
 7. The Ethics Committee recommended that the patient be asked in the presence of an independent interpreter “whom he wished to be informed of his diagnosis and who should be asked for permission for procedures and therapies” (p. 477). The difference between this compromise and the one reached in the case of the Chinese patient was the need to ask about permission for procedures. The hospital was reluctant to allow a blanket waiver that would cover all procedures and treatments; they claimed that a waiver would be needed for each separate procedure. Answers may vary regarding the success of the compromise, but the patient’s wishes were determined and then complied with. The patient clearly indicated that he wanted his wife to take responsibility for all the decisions. The wife’s wish that her husband not be informed was also met. The hospital’s wishes that a separate waiver be granted for each procedure was apparently not met, but their concern seemed to be a legal one, not an ethical one.
 8. The authors propose that autonomy be redefined “to allow the patient to determine the extent of their own autonomy” (p. 479). Answers to the other questions may vary, but this new formulation does “satisfy the physician’s need to respect patient autonomy” (p. 479), while respecting other cultural traditions around truth disclosure.
 9. Answers will vary.
 10. Answers will vary.