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Meeting with American Nurses Association 10-14-93

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American Nurses Association

600 Maryland Avenue SW, Suite 100 West, Washington, DC 20024-2571
202-554-4444 • Fax: 202-554-2262

Virginia Trotter Betts, JD, MSN, RN
President

Barbara K. Redman, PhD, RN, FAAN
Executive Director

September 3, 1993

Kristine Gebbie, MN, RN, FAAN
National AIDS Policy Coordinator
Office of National AIDS Policy
Executive Office of the President
750 17th Street, NW, Suite 1060
Washington, DC 20503

Dear Ms. Gebbie:

On behalf of Virginia Trotter Betts, JD, MSN, RN, President, American Nurses Association, the American Nurses Association HIV Task Force, of which I am chair, and the ANA staff, I extend our sincere thanks for taking time away from your exhausting schedule to meet with us on August 23, 1993.

We want you to know that we, like you, are committed to addressing the myriad of issues related to HIV and therefore look forward to working with you and assisting in anyway. Our first step towards that will be the submission to you, by late September, of our proposal, **HIV/AIDS Action Agenda** in response to *Nursing and the HIV Epidemic: An Action Agenda*.

I look forward to discussing the above with you when the time comes. In the interim we wish you success in your new position and are here if you need us.

Again, thank you for taking time to talk with us.

Sincerely,

Barbara Russell, RN, MPH, CIC
Chairperson, HIV Task Force

cc: Virginia Trotter Betts, JD, MSN, RN
Sarah Stanley, MS, RN, CNA, CS

BR:vmc:k:\vmc\sarah\hiv\august.fup\gebbie.res

FILE

KRISTINE M. GEBBIE, R.N., M.N., F.A.A.N.
NATIONAL AIDS POLICY COORDINATOR
DEPARTMENT OF HEALTH & HUMAN SERVICES
Room 729H Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

DAY Thursday **DATE** October 14, 1993

TIME 8:30 a.m. **LOCATION** Grand Hyatt Hotel

SUBJECT American Nurses Association Meeting

PARTICIPANTS:
See attached materials.

October 13, 1993

SCHEDULED APPEARANCE
FOR
KRISTINE GEBBIE
NATIONAL AIDS POLICY COORDINATOR

ONAPC STAFFER:	John Paul Gurrola
DATE/TIME OF EVENT:	October 14 at 8:15 a.m.
LOCATION:	Grand Hyatt Hotel, 1000 H Street, NW Washington, D.C.
ORGANIZATION:	American Nurses Association
CONTACT:	Deborah McNeal 554-4444 Ext. 448 or Cheryl Peterson Ext. 320
PURPOSE:	To discuss the nurse's role in the policy development of health policy.
OTHER PARTICIPANTS:	There will be approximately 300 nurses in attendance. David Wilhelm, Haley Barbour, and Secretary Shalala, are also speaking.
MEDIA COVERAGE:	Medical News Network has been notified of the event.
REMARKS REQUIRED:	You are scheduled to speak for 20 minutes. The ANA is interested in having you speak on "Women changing the face of politics". With your experience in both the state and federal level how do you see the changing role of women? Donna Shalala will be discussing HCR after you speak.
BACKGROUND:	The welcome is from 8:00 am to 8:30 am. You will be speaking at about 8:35 am. This should give you plenty of time to make your 9:00 am, appointment. I have attached the program and list of speakers for your review.

"Nsg as winner" does not mean
Nsg as remedy for all practitioners —

Women Changing the face of Politics —

% of women in a legislature —
shifts content / focus of debate —
child care / family leave / etc —

% women in a Cabinet
??

Women as candidates & campaigners

? non-linear thinking
interrelationships

clearly consistent with a Nsg view —
whole person / linkages —

Politics — big & little P —

It isn't all a plot —
but pay attention to linkages

Content base —

3:00 p.m. - 4:00 p.m. **108** **Plenary 7**
Independence Ballroom
Political Parties: Where Do We Go From Here?
Panel: RNC- Donna Neal Givens, DNC- Craig Smith, United We Stand America, Inc.- Russell Verney

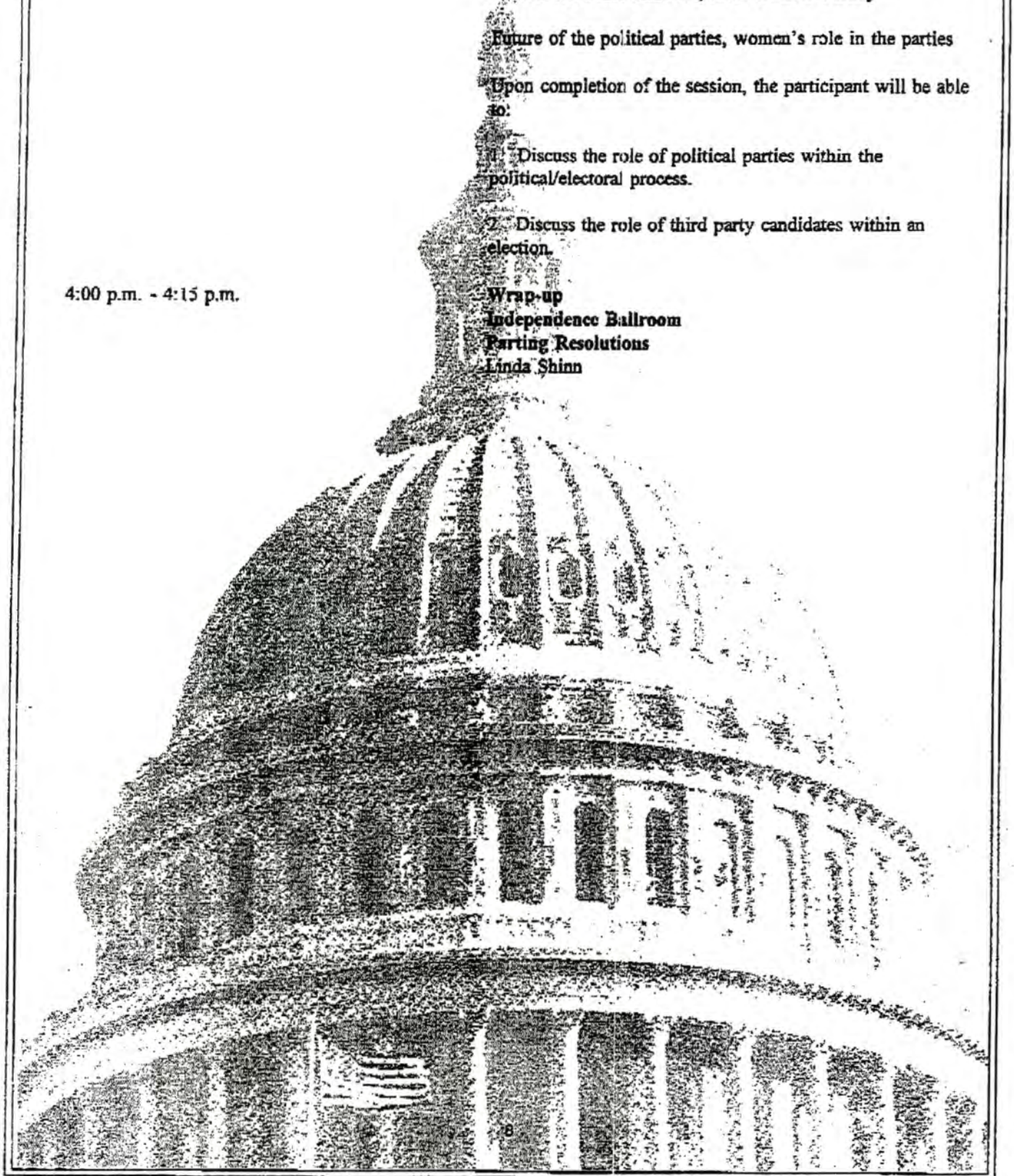
Future of the political parties, women's role in the parties

Upon completion of the session, the participant will be able to:

1. Discuss the role of political parties within the political/electoral process.

2. Discuss the role of third party candidates within an election.

4:00 p.m. - 4:15 p.m. **Wrap-up**
Independence Ballroom
Parting Resolutions
Linda Shinn



1993 AMERICAN NURSES ASSOCIATION
PUBLIC POLICY CONFERENCE
21ST CENTURY NURSING-- POLITICS & HEALTH

PROGRAM AGENDA

TIME/ROOM	SESSION CODE	
Thursday, October 14, 1993		
7:00 a.m. - 3:00 p.m.		**Registration** **Independence Foyer**
7:00 a.m. - 8:00 a.m.		**Continental Breakfast** **Independence Foyer**
8:00 a.m. - 9:15 a.m.	**101**	**Plenary 1** **Independence Ballroom**
8:00 a.m. - 8:30 a.m.		**Welcome and Introduction** Virginia Trotter Betts ANA president welcoming remarks and discussion on nursing's successes and future political involvement. Upon completion of the session, the participant will be able to: 1. Based on ANA's past political involvement, discuss future challenges that lie ahead for nursing.
8:30 a.m. - 9:15 a.m.		**Keynote: Women Changing the Face of Politics** Kristine Gebbie, Celinda Lake Women, politics, and their effect on Congress, the Administration and public policy development. Upon completion of the session, the participant will be able to: 1. Analyze in broad perspectives the impact of health care reform on the 1994 election cycle. 2. Discuss the direct impact of health care reform on local, state and federal level races. 3. Discuss the emerging role of women in the electoral process.

9:15 a.m. - 10:10 a.m. **102** **Plenary 2**
Independence Ballroom
Public Perception of Health Care Reform
William McInturff

A pollster's perspective on packaging reform for public consumption.

Upon completion of the session, the participant will be able to:

1. Discuss the impact of polling and public perception on the Administration.

2. Describe the public perception of the need for and the politics behind health care reform.

10:10 a.m. - 11:00 a.m. **103** **Plenary 3**
Independence Ballroom
Vision of Nursing in Health Care Reform
Donna Shalala

Clinton's vision for health care reform, nursing's role in the President's plan, and implementation of the reform process.

Upon completion of the session, the participant will be able to:

1. Discuss the key points in the White House Health Care Reform Plan.

2. Identify nursing's role in a reformed health care system.

3. Describe the political realities of implementing a reformed health care system.

11:00 a.m. - 11:15 a.m. **Break**

CONCURRENT SESSIONS

11:15 am - 12:30 pm **201** **Gaining Visibility in Political Campaigns**
McPherson Square
Judy Leavitt, Catherine Dodd

Upon completion of the session, the participant will be able to:

1. Discuss the political successes nurses have obtained in the last five years.

2. Describe campaign techniques that highlight both the candidate and nurses.

3. Assess their potential to become a successful candidate for public office.

202 **The Hidden Congress: Lobbying Regulatory Agencies**
LaFayette Park
Dan O'Neal, David Keepnews

Upon completion of the session, the participant will be able to:

1. Identify the relationship between passage of a law and implementation of related regulations.

2. Describe the process of proposed rule making utilized by many regulatory agencies.

3. Define a role for individuals and individual state nurses associations in the design of regulations which affect nursing practice.

203 **Using Media to Advance Nursing's Agenda**
Franklin Square
Lisa Wyatt, Wayne Pines

Upon completion of the session, the participant will be able to:

1. Discuss the use of the media in promoting Nursing's Agenda.

2. Create an effective message on health care reform.

3. List strategies for mobilizing the media on nursing issues.

204 **Positioned for Power: Obtaining a Government Appointment**
Farragut Square
Rebecca Tillet, Marcy Oppenheimer, Susan Enright, Marilyn Chow

Upon completion of the session, the participant will be able to:

1. Describe the opportunities that appointments at all levels of government provide for professional advancement and civic leadership.

2. Discuss the government appointment process.

3. Identify the knowledge and tools needed to seek government appointment successfully.

12:00 p.m. - 1:45 p.m. **Lunch**
Reality or Fiction: Covering Washington
Independence Ballrooms F, G, H, I
Eleanor Clift

A correspondent's inside view of the workings of Washington.

2:00 p.m. - 2:45 p.m. **HILL LOBBYING PREPARATION**
Hands-On Hill Lobbying
Governmental Affairs Staff

Current issues and practical tips for visiting a congressional office.

2:45 p.m. - 5:30 p.m. **Hill Time**
Meet with Members of Congress

6:00 p.m. - 7:30 p.m. **Reception**
Foyer, Rayburn House Office Building
Capitol Hill Reception

An exciting opportunity to meet Members of Congress and other friends of nursing.

Friday, October 15

7:00 a.m. - 8:15 a.m. **Continental Breakfast**
Independence Foyer

7:45 a.m. - 8:15 a.m. **Book Signing**
Marjorie Vanderbilt, Chris deVries

8:15 a.m. - 9:15 a.m. **104 Plenary 4**
Independence Ballroom
ANA's Legislative Agenda: 21st Century Priorities
Donna Richardson, Terri Gaffney

A glimpse of federal and state issues affecting nursing practice.

Upon completion of the session, the participant will be able to:

1. Discuss key provisions within Nursing's Agenda for Health Care Reform and how these provisions have been incorporated into the White House Health Care Reform Plan.

2. Describe the political environment that affects health care reform, the current legislation introduced related to health care reform, and nursing's strategies to impact the evolution of this legislation.

3. Identify essential strategies for state nurses associations to impact state health care reform legislation.

Concurrent Sessions
9:15 am - 10:15 am

205 Keeping Health Care Workers Healthy: Issues of the '90s
McPherson Square
Karen Worthington

Upon completion of the session, the participant will be able to:

1. Identify the standards/ regulations/ guidelines which promote the health and safety of nurses in the workplace.

2. Describe avenues of action for promoting Health & Safety Protections in individual worksites.

206 An Evolving Profession: Advanced Nursing Practice
LaFayette Park
Kay Schroer, Libby Lawson, B.J. Czarapata

Upon completion of the session, the participant will be able to:

1. Discuss barriers to establishing an independent practice.

2. Discuss how Health Care Reform may or may not impact these barriers to practice.

3. Identify how health care reform is shaping the nurse of the future, particularly in advanced practice.

207 Equity for Women's Health
Farragut Square
Christine deVries, Sue Simmons, Robyn Lipner

Upon completion of the session, the participant will be able to:

1. Demonstrate knowledge of women's health concerns in the areas of research, policy and treatment.

2. Identify legislation and other proposals concerning women's health including research, health care reform, access to care, and treatment of women as patients.

3. Identify cutting edge women's health issues.

4. Understand nursing's role as a participant in the women's health community and in health policy discussions on the advancement of women's health needs.

208 **New Directions for Minority Health**
Franklin Square
Charlene Douglas, Adolf Falcon, Yvette Joseph-Fox

Upon completion of the session, the participant will be able to:

1. Discuss at least two (2) major implications Health Care Reform will bring to the minority communities.

2. Discuss areas for policy development which would allow increased access for minority nurses to leadership and increased health access for minority populations.

3. Identify the value of Coalition Building.

10:15 a.m. - 10:30 a.m. **Break**

10:30 a.m. - 12:00 noon 105 **Plenary 5**
Independence Ballroom
Town Meeting: Organizational Perspectives on Health Care Reform and the Future of Nursing
Gwen Johnson, Polly Bednash, Susan Wysocki, Julie McGee, Diana Weaver

A moderated discussion by a distinguished panel of nursing leaders from ANA, AACN, AONE, NNPC, and NSNA addressing the implication of health care reform on roles within nursing.

Upon completion of the session, the participant will be able to:

1. Describe the impact of health care reform on various roles of nursing.

2. Discuss proactive strategies for meeting the future health care needs as they relate to these roles.

12:00 p.m. - 1:45 p.m.

Lunch
Independence Ballrooms F, G, H, I
Congressional Women Speak Out
Congresswoman Constance A. Morella
Congresswoman Eddie Bernice Johnson

This session will provide two views from Capitol Hill . . . one discussing women's health and violence issues. The second will be a new Congressional Member's view of the legislative process.

Upon completion of the session, the participant will be able to:

1. Identify the political forces driving issues such as health care and violence.

2. Discuss the contribution that associations such as the American Nurses Association have made to the formation of public policy as stated by Congressional Members.

3. Describe the impressions of a new Congressional Member of the differences in the State and federal legislative process.

1:45 p.m. - 2:45 p.m.

107 **Plenary 6**
Independence Ballroom
Planning for Rising Political Stars
Rebecca Tillet, Mary Lou Koerner

Taking steps to obtain future political appointments.

Upon completion of the session, the participant will be able to:

1. Describe ANA's Federal Appointments Project.

2. Identify the make up and process of the appointment to decision making bodies.

3. Identify strategies for moving an appointment forward.

2:45 pm - 3:00 p.m.

Break

R N

CECIL A. KING, RN, CNOR
Perioperative Consultant

419 George St.
(410) 225-7811 Baltimore, MD 21201

September 2, 1993

Kristine Gebbie, MN, RN, FAAN
National AIDS Policy Coordinator
750, 17th Street, N.W.
Suite #1060
Washington, D.C. 20003

Dear Ms. Gebbie

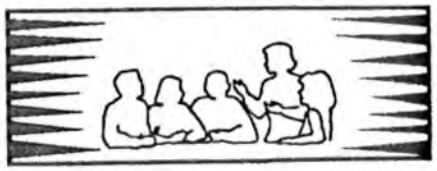
I personally want to thank you for taking time out of a busy schedule to meet with the ANA HIV Task Force. Your sincere interest and support is evident. The prefession of nursing is most proud to see a fellow colleague in your prestigious position. Congratulations!

As a board member of a community based clinic, I can appreciate the overwhelming task ahead of you. Please know you have my support and best wishes. If I can be of assistance, in any way, to you or your office, do not hesitate to call on me.

I have enclosed materials you may find of interest. The copy of AORN's Special Committee on Ethics is the most recent collaborative effort with the ANA. The AORN HIV Task Force signed on to the ANA HIV related position statements during 1992-93 Congress.

Sincerely,

Cecil A. King, RN, CNOR
419 George Street
Baltimore, Maryland 21201-1948
(410) 225-7811



Committee Report

ANA *Code for Nurses with Interpretive Statements—Explications for Perioperative Nursing*

AORN's Special Committee on Ethics elaborated on the American Nurses Association (ANA) Code for Nurses with Interpretive Statements,[1] *adding "explications for perioperative nursing" to the 11 ANA code statements and delineating the perioperative nursing explications of the Code. Implementation of the examples listed under each statement does not guarantee that the virtues required for professional practice are within the character of each nurse. In particular situations, the justification of behavior as ethical must satisfy not only the individual perioperative nurse, acting as a moral agent, but also the "Standards of perioperative clinical practice" and the "Standards of perioperative professional performance."[2] Together, the ANA code, reprinted here with permission from ANA, and the explications for perioperative nursing provide the framework within which perioperative nurses can make ethical decisions. This document demonstrates accountability and responsibility to the public, to other members of the health care team, and to the profession. The document also should assist perioperative nurses to relate the ANA code to their own area of practice and should provide examples of behaviors that reflect the ethical obligations of perioperative nurses. This is a proposed statement. AORN members are encouraged to respond to this document using the comment form that appears at the end of the article. Return the comment form to the Committee staff consultant at AORN Headquarters.*

Ethical Obligations, Moral Principles

The primary goals and values of a profession are made explicit in a code of ethics. The ANA *Code for Nurses with Interpretive Statements* expresses the moral commitment to uphold the values and special ethical obligations of all nurses in the protection, promotion, and restoration of health. In the dying patient, measures are taken to protect the patient, emphasize human contact, and prevent and relieve suffering.[3]

The perioperative nurse faces unique moral and ethical situations in the care of patients who undergo invasive procedures. In this context, the perioperative nurse accepts accountability for nursing actions to safeguard the rights of surgical patients. The perioperative nurse's decisions and actions on behalf of patients are determined in an ethical manner and are guided by the ANA code. These decisions and actions are based on universal moral principles (Table 1), the most fundamental of which is respect for persons.

Table 1
Universal Moral Principles

Autonomy: Self-determination
Beneficence: Doing good
Nonmaleficence: Avoiding harm, preventing harm
Veracity: Truth telling
Confidentiality: Respecting privileged information
Justice: Treating people fairly
Fidelity: Faithfulness to promises, duties

ANA Statement 1: The nurse provides services with respect for human dignity and the uniqueness of the client, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.

1.1 Respect for Human Dignity

The fundamental principle of nursing practice is respect for the inherent dignity and worth of every client. Nurses are morally obligated to respect human existence and the individuality of all persons who are the recipients of nursing actions. Nurses therefore must take all reasonable means to protect and preserve human life when there is hope of recovery or reasonable hope of benefit from life-prolonging treatment.

Truth telling and the process of reaching informed choice underlie the exercise of self-determination, which is basic to respect for persons. Clients should be as fully involved as possible in the planning and implementation of their own health care. Clients have the moral right to determine what will be done with their own person; to be given accurate information, and all the information necessary for making informed judgments; to be assisted with weighing the benefits and burdens of options in their treatment; to accept, refuse, or terminate treatment without coercion; and to be given necessary emotional support. Each nurse has an obligation to be knowledgeable about the moral and legal rights of all clients and to protect and support those rights. In situations in which the client lacks the capacity to make a decision, a surrogate decision maker should be designated.

Individuals are interdependent members of the community. Taking into account both individual rights and the interdependence of persons in decision making, the nurse recognizes those situations in which individual rights to autonomy in health care may temporarily be overridden to preserve the life of the human community; for example, when a disaster demands triage or when an individual presents a direct danger to others. The many variables involved make it imperative that each case be considered with full awareness of the need to preserve the rights and responsibilities of clients and the demands of justice. The suspension of individual rights must always be considered a deviation to be tolerated as briefly as possible.

1.2 Status and Attributes of Client

The need for health care is universal, transcending all national, ethnic, racial, religious, cultural, political, educational, economic, developmental, personality, role, and sexual differences. Nursing care is delivered without prejudicial behavior. Individual value systems and life-styles should be considered in the planning of health care with and for each client. Attributes of clients influence nursing practice to the extent that they represent factors the nurse must understand, consider, and respect in tailoring care to personal needs and in maintaining the individual's self-respect and dignity.

1.3 The Nature of Health Problems

The nurse's respect for the worth and dignity of the individual human being applies, irrespective of the nature of the health problem. It is reflected in care given the person who is disabled as well as one without disability, the person with long-term illness as well as one with acute illness, the recovering patient as well as one in the last phase of life. This respect extends to all who require the services of the nurse for the promotion of health, the prevention of illness, the restoration of health, the alleviation of suffering, and the provision of supportive care of the dying. The nurse does not act deliberately to terminate the life of any person.

The nurse's concern for human dignity and for the provision of high quality nursing care is not limited by personal attitudes or beliefs. If ethically opposed to interventions in a particular case because of the procedures to be used, the nurse is justified in refusing to participate. Such refusal should be made known in advance and in time for other appropriate arrangements to be made for the client's nursing care. If the nurse becomes involved in such a case and the client's life is in jeopardy, the nurse is obliged to provide for the client's safety, to avoid abandonment, and to withdraw only when assured that alternative sources of nursing care are available to the client.

The measures nurses take to care for the dying client and the client's family emphasize human contact. They enable the client to live with as much physical, emotional, and spiritual comfort as possible, and they maximize the values the client has treasured in life. Nursing care is directed toward the prevention and relief of the suffering commonly associated with the dying process. The nurse may provide interventions to relieve symptoms in the dying client even when the interventions entail

substantial risks of haste

1.4 The Setting for

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1.4 The Setting for Health Care

The nurse adheres to the principle of nondiscriminatory, nonprejudicial care in every situation and endeavors to promote its acceptance by others. The setting shall not determine the nurse's readiness to respect clients and to render or obtain needed services.[4]

Respect for human dignity–perioperative explications. The perioperative nurse provides care to each patient undergoing surgical intervention in a manner that preserves and protects patient autonomy, dignity, and human rights. The patient's autonomy in the decision-making process is acknowledged and supported by the perioperative nurse who provides accurate, appropriate, and reasonable information to assist the patient in making an informed choice. When individual rights must be temporarily overridden to preserve the life of the patient or of another, the suspension of those rights must be considered a deviation to be tolerated as briefly as possible.

Perioperative examples:

- Confirms informed consent for surgery; when possible, obtains surrogate's permission for emergent surgery.
- Explains procedures before initiating actions.
- Restrains patient only when patient poses a direct danger to self or others.
- Respects advance directives and end-of-life choices.
- Implements institutional advance directive policy in practice setting.
- Participates in perioperative teaching: answers patient's questions accurately and honestly.
- Allows choices within scope of care (eg, child's preference for mask or IV method of induction).
- Formulates ethical decisions with assistance of available resources (eg, ethics committee, counselors, ethicists).

Status and attributes of clients—perioperative explications. It is the responsibility of the perioperative nurse to provide care for each patient without prejudicial behavior. The care should be planned with consideration for the patient's value system and life-style. Attributes of the patient should be considered and respected to maintain the individual's self-respect and dignity.

Perioperative examples:

- Applies standards of nursing practice consistently to all patients with sensitivity to disability, economic, educational, cultural, religious, racial, age, and sexual differences.
- Provides language interpreters.
- Refrains from derogatory comments about patients, families and significant others, colleagues, and other associates.

The nature of health problems—perioperative explications. The perioperative nurse respects the worth and dignity of the patient regardless of the diagnosis, disease process, procedure, or projected outcome. When the perioperative nurse is ethically opposed to interventions or procedures in a particular case, the nurse is justified in refusing to participate if the refusal is made known in advance and in time for other appropriate arrangements to be made for the patient's nursing care. When the patient's life is in jeopardy, the perioperative nurse is obliged to provide for the patient's safety, to avoid abandonment, and to withdraw only when assured that alternative sources of nursing care are available to the patient.

Perioperative examples:

- Provides for spiritual comfort to the patient and significant others (eg, contacts religious counselor).
- Plans for appropriate substitute nursing care if personal beliefs conflict with required care.
- Respects the patient's decision for surgery.
- Provides care regardless of health status.

The setting for health care—perioperative explications. Perioperative care is given in various settings. The setting does not determine the nurse's readiness to respect patients or to provide services. The perioperative nurse adheres to the principles of

nondiscriminatory, nonprejudicial care.

Perioperative examples:

- Adheres to AORN, Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and other national, state, local, institutional, or agency policies and standards.
- Provides comparable levels of care regardless of physical setting (eg, inpatient, outpatient, public, private, emergency department).

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

2.1 The Client's Right to Privacy

The right to privacy is an inalienable human right. The client trusts the nurse to hold all information in confidence. This trust could be destroyed and the client's welfare jeopardized by injudicious disclosure of information provided in confidence. The duty of confidentiality, however, is not absolute when innocent parties are in direct jeopardy.

2.2 Protection of Information

The rights, well-being, and safety of the individual client should be the determining factors in arriving at any professional judgment concerning the disposition of confidential information received from the client relevant to his or her treatment. The standards of nursing practice and the nursing responsibility to provide high quality health services require that relevant data be shared with members of the health team. Only information pertinent to a client's treatment and welfare is disclosed, and it is disclosed only to those directly concerned with the client's care.

Information documenting the appropriateness, necessity, and quality of care required for the purposes of peer review, third-party payment, and other quality assurance mechanisms must be disclosed only under defined policies, mandates, or protocols. These written guidelines must assure that the rights, well-being, and safety of the client are maintained.

2.3 Access to Records

If in the course of providing care there is a need for the nurse to have access to the records of persons not under the nurse's care, the persons affected should be notified and, whenever possible, permission should be obtained first. Although records belong to the agency where the data are collected, the individual maintains the right of control over the information in the record. Similarly, professionals may exercise the right of control over information they have generated in the course of health care.

If the nurse wishes to use a client's treatment record for research or nonclinical purposes in which anonymity cannot be guaranteed, the client's consent must be obtained first. Ethically, this ensures the client's right to privacy; legally, it protects the client against unlawful invasion of privacy.[5]

The client's right to privacy—perioperative explications. Maintaining the patient's confidentiality is essential in preserving trust in the patient/nurse relationship. This is reflected in the nurse's interventions to maintain the dignity, modesty, and privacy of the surgical patient, as well as in measures taken to protect the confidentiality of patient information. Actions demeaning the dignity of the individual, or the inappropriate disclosure of information could destroy this relationship and jeopardize the patient's welfare. When innocent parties are in direct danger, the right of confidentiality may be waived.

Perioperative examples:

- Supports confidentiality of patient information.
- Discusses patient information only with appropriate health care providers.
- Refrains from discussing patients in public areas (eg, the cafeteria, hallways, elevators, lounges).
- Obtains consent prior to engaging in direct patient care activities.
- Protects patient modesty and privacy (eg, keeps OR doors closed, draws shades).
- Avoids needless exposure of patient's body.
- Treats deceased with respect.
- Provides protected area for viewing deceased.

Protection of information—perioperative explications. The patient must have trust and confidence in the nurse that information will be used to protect rights, well-being, and safety. Information pertinent to the patient's treatment and welfare is shared only with members of the health care team directly concerned with the patient's care. Information documenting the appropriateness, necessity, and quality of care may be disclosed only under defined policies, mandates, or protocols, and only when the rights and well-being of the patient can be assured.

Perioperative examples:

- Protects patient information.
- Maintains records in orderly manner.
- Completes operative records accurately and in an objective and nonjudgmental manner.
- Honors patient's request to withhold information from family and significant others whenever possible.
- Releases patient information only to individuals properly identified and in compliance with established policies, mandates, or protocols.
- Uses information for quality improvement purposes in a manner that protects patient confidentiality.

Access to records—perioperative explications. Although health care records belong to the agency where the data are collected, the patient maintains the right of control over the information in the record. Whenever possible, patient permission should be granted prior to using patient records for quality improvement data collection.

Perioperative examples:

- Obtains patient consent before use of patient record for research or for patient information needed to treat another patient.
- Provides for patient confidentiality during data collection (eg, nursing research).

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

3.1 Safeguarding the Health and Safety of the Client

The nurse's primary commitment is to the health, welfare, and safety of the client. As an advocate for the client, the nurse must be alert to and take appropriate action regarding any instances of incompetent, unethical, or illegal practice by any member of the health care team or the health care system, or any action on the part of others that places the rights or best interests of the client in jeopardy. To function effectively in this role, nurses must be aware of the employing institution's policies and procedures, nursing standards of practice, the ANA *Code for Nurses*, and laws governing nursing and health care practice with regard to incompetent, unethical, or illegal practice.

3.2 Acting on Questionable Practice

When the nurse is aware of inappropriate or questionable practice in the provision of health care, concern should be expressed to the person carrying out the questionable practice and attention called to the possible detrimental effect upon the client's welfare. When factors in the health care delivery system threaten the welfare of the client, similar action should be directed to the responsible administrative person. If indicated, the practice should then be reported to the appropriate authority within the institution, agency, or larger system.

There should be an established process for the reporting and handling of incompetent, unethical, or illegal practice within the employment setting so that such reporting can go through official channels without causing fear of reprisal. The nurse should be knowledgeable about the process and be prepared to use it if necessary. When questions are raised about the practices of individual practitioners or of health care systems, written documentation of the observed practices or behaviors must be available to the appropriate authorities. State nurses' associations should be prepared to provide assistance and support in the development and evaluation of such processes and in reporting procedures.

When incompetent, unethical, or illegal practice on the part of anyone concerned with the client's care is not corrected within the employment setting

and continues to jeopardize the client's welfare and safety, the problem should be reported to other appropriate authorities such as practice committees of the pertinent professional organizations or the legally constituted bodies concerned with licensing of specific categories of health workers or professional practitioners. Some situations may warrant the concern and involvement of all such groups. Accurate reporting and documentation undergird all actions.

3.3 Review Mechanisms

The nurse should participate in the planning, establishment, implementation, and evaluation of review mechanisms that serve to safeguard clients, such as duly constituted peer review processes or committees and ethics committees. Such ongoing review mechanisms are based on established criteria, have stated purposes, include a process for making recommendations, and facilitate improved delivery of nursing and other health services to clients wherever nursing services are provided.[6]

Safeguarding the health and safety of the client—perioperative explications. The perioperative nurse's primary obligation is to the health, welfare, and safety of the patient. The perioperative nurse acts as a patient advocate by protecting the patient from incompetent, unethical, or illegal practice. To fulfill this function, the nurse follows policies, practices, guidelines, and laws to safeguard the health and safety of the patient.

Perioperative examples:

- Respects "A Patient's Bill of Rights."
- Complies with institutional policies and procedures regarding competent performance of duties.
- Complies with federal and state regulations, such as the Occupational Safety and Health Administration (OSHA) regulations, the Americans with Disabilities Act, and state boards of nursing regulations.
- Complies with accrediting agencies, such as JCAHO and state regulatory agencies.
- Adheres to professional standards, such as AORN's "Standards of perioperative clinical practice" and "Standards of professional performance."
- Practices with a "surgical conscience."
- Confirms clinicians' practice privileges and credentials (eg, RN first assistants, physicians, physician's assistants).

Acting on questionable practices—perioperative explications. It is the ethical obligation of the perioperative nurse to identify and appropriately report questionable practices demonstrated by any member of the health care team. The nurse also must know the legal obligations to report questionable practices.

Perioperative examples:

- Expresses concern to person carrying out the questionable practice.
- Reports incompetent, unethical, or illegal practice to responsible administrative person.
- Consults with colleagues and supervisors to resolve concerns.
- Documents observations and occurrences in an objective manner according to institutional policy.
- Complies with institutional policies in resolving problems.
- Reports verbal, psychological, and physical harassment or abuse.
- Uses institutional procedural mechanisms to report substance abuse or impairment of colleagues.
- Intervenes appropriately to protect patient safety.

Review mechanisms—perioperative explications. The nurse participates in the establishment and evaluation of mechanisms to review practice. The perioperative nurse uses personal, institutional, professional, and regulatory resources to assist with the resolution of incompetent, unethical, and illegal practices in the work setting.

Perioperative examples:

- Uses institutional ethics committee, practice committee, and peer review.
- Supports and participates in institutional ethics committee, and institutional review boards.
- Participates in educational programs that enhance patient care (eg, morbidity/mortality

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conferences, ethics grand rounds, patient care conferences).
- Participates in quality improvement processes.
- Participates in development and revision of standards of practice
- Participates in joint review of patient outcomes.

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

4.1 Acceptance of Responsibility and Accountability

The recipients of professional nursing services are entitled to high quality nursing care. Individual professional licensure is the protective mechanism legislated by the public to ensure the basic and minimum competencies of the professional nurse. Beyond that, society has accorded to the nursing profession the right to regulate its own practice. The regulation and control of nursing practice by nurses demand that individual practitioners of professional nursing must bear primary responsibility for the nursing care clients receive and must be individually accountable for their own practice.

4.2 Responsibility for Nursing Judgment and Action

Responsibility refers to the carrying out of duties associated with a particular role assumed by the nurse. Nursing obligations are reflected in the ANA publications *Nursing: A Social Policy Statement* and *Standards of Nursing Practice*.[7] In recognizing the rights of clients, the standards describe a collaborative relationship between the nurse and the client through use of the nursing process. Nursing responsibilities include data collection and assessment of the health status of the client; formation of nursing diagnoses derived from client assessment; development of a nursing care plan that is directed toward designated goals, assists the client in maximizing his or her health capabilities, and provides for the client's participation in promoting, maintaining, and restoring his or her health; evaluation of the effectiveness of nursing care in achieving goals as determined by the client and the nurse; and subsequent reassessment and revision of the nursing care plan as warranted. In the process of assuming these responsibilities, the nurse is held accountable for them.

4.3 Accountability for Nursing Judgment and Action

Accountability refers to being answerable to someone for something one has done. It means providing an explanation or rationale to oneself, to clients, to peers, to the nursing profession, and to society. In order to be accountable, nurses act under a code of ethical conduct that is grounded in the moral principles of fidelity and respect for the dignity, worth, and self-determination of clients.

The nursing profession continues to develop ways to clarify nursing's accountability to society. The contract between the profession and society is made explicit through such mechanisms as (a) the ANA *Code for Nurses*, (b) the standards of nursing practice, (c) the development of nursing theory derived from nursing research in order to guide nursing actions, (d) educational requirements for practice, (e) certification, and (f) mechanisms for evaluating the effectiveness of the nurse's performance of nursing responsibilities.

Nurses are accountable for judgments made and actions taken in the course of nursing practice. Neither physicians' orders nor the employing agency's policies relieve the nurse of accountability for actions taken and judgments made.[8]

Acceptance of responsibility and accountability—perioperative explications. Individual professional licensure protects the public by assuring the basic competencies of the professional nurse. Moreover, society grants the nursing profession the right to regulate its own practice. Perioperative nurses bear primary responsibility for the perioperative nursing care that patients receive and must be accountable individually for their own practice.

Perioperative examples:
- Maintains basic nursing licensure.
- Accepts responsibility and accountability for perioperative nursing practice, staffing schedules, and on-call assignments.

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Responsibility for nursing judgment and action—perioperative explications. Responsibility refers to carrying out the duties associated with perioperative nursing. Perioperative nursing obligations are reflected in AORN's standards and recommended practices. The perioperative nurse uses the nursing process to promote a collaborative relationship between patient and nurse.

Perioperative examples:

- Collaborates with the patient regarding health care whenever possible.
- Collects patient health data.
- Analyzes assessment data to formulate nursing diagnoses.
- Identifies expected outcomes unique to the patient.
- Develops a plan of care to attain designated patient outcomes.
- Implements interventions identified in the plan of care.
- Evaluates the patient's progress toward attainment of outcomes.
- Revises the plan of care as needed.
- Practices in a cost-effective manner.

Accountability for nursing judgment and action—perioperative explications. Accountability refers to being answerable to one's self, patients, peers, the profession, and society for judgments made and actions taken as a perioperative nurse. Neither physicians' orders nor the employing agency's policies relieve the perioperative nurse of accountability for those actions and judgments. Professional accountability to society is reflected in the ANA *Code for Nurses*, standards of practice, educational requirements for practice, certification, and performance evaluation.

Perioperative examples:

- Provides safe patient care.
- Accounts for sponges, needles, instruments, and other potential foreign bodies.
- Promotes certification for perioperative nursing (CNOR) and RN first assisting (CRNFA).
- Evaluates own performance and solicits peer review.

ANA Statement 5: The nurse maintains competence in nursing.

5.1 Personal Responsibility for Competence

The profession of nursing is obligated to provide adequate and competent nursing care. Therefore it is the personal responsibility of each nurse to maintain competency in practice. For the client's optimum well-being and for the nurse's own professional development, the care of the client reflects and incorporates new techniques and knowledge in health care as these develop, especially as they relate to the nurse's particular field of practice. The nurse must be aware of the need for continued professional learning and must assume personal responsibility for currency of knowledge and skills.

5.2 Measurement of Competence in Nursing Practice

Evaluation of one's performance by peers is a hallmark of professionalism and a method by which the profession is held accountable to society. Nurses must be willing to have their practice reviewed and evaluated by their peers. Guidelines for evaluating the scope of practice and the appropriateness, effectiveness, and efficiency of nursing practice are found in nursing practice acts, ANA standards of practice, and other quality assurance mechanisms. Each nurse is responsible for participating in the development of objective criteria for evaluation. In addition, the nurse engages in ongoing self-evaluation of clinical competency, decision-making abilities, and professional judgments.

5.3 Intraprofessional Responsibility for Competence in Nursing Care

Nurses share responsibility for high quality nursing care. Nurses are required to have knowledge relevant to the current scope of nursing practice, changing issues and concerns, and ethical concepts and principles. Since individual competencies vary, nurses refer clients to and consult with other nurses with expertise and recognized competencies in various fields of practice.[9]

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Personal responsibility for competence—perioperative explications. The perioperative nurse assumes responsibility for maintaining clinical competence. Knowledge and skill related to technological advances and surgical interventions should be incorporated into the perioperative nurse's practice.

Perioperative examples:

- Uses AORN's competency statements in perioperative nursing.
- Participates in certification processes (eg, CNOR, CRNFA, Basic Life Support, Advanced Cardiac Life Support).
- Remains current on new procedures affecting practice.
- Identifies and develops a plan of corrective action related to deficits and limitations in knowledge and/or skills.
- Assumes responsibility for continuous education through personal study; attendance at institutional inservice programs, staff orientation workshops, seminars, AORN Congress, and AORN chapter and other professional meetings; and reading the *AORN Journal* and other perioperative and professional journals.

Measurement of competence in nursing practice—perioperative explications. The perioperative nurse is accountable to society and the profession for appropriate, effective, and efficient nursing practice. Mechanisms are established to demonstrate professional accountability.

Perioperative examples:

- Uses competency-based orientation and annual review process.
- Demonstrates competency in use of new technologies.
- Participates in self-evaluation and peer evaluation of clinical competence, decision-making skills, and professional judgment.
- Participates in risk management efforts and continuous quality improvement studies.

Intraprofessional responsibility for competence in nursing care—perioperative explications. To provide continuity of care to the surgical patient, the perioperative nurse recognizes individual competence in others and consults with colleagues with expertise in specific clinical areas of practice.

Perioperative examples:

- Collaborates and consults with nursing colleagues practicing in other specialty areas (eg, critical care, psychiatry, pain management, pediatrics, postanesthesia care, home health).
- Promotes comparable levels of care in all practice settings where invasive procedures are performed.
- Uses medical devices in a safe manner and complies with the Safe Medical Devices Act and other laws and regulations.
- Acts as a mentor and/or preceptor.

ANA Statement 6: The nurse exercises informed judgment and uses individual competency and qualifications as criteria in seeking consultation, accepting responsibilities, and delegating nursing activities.

6.1 Changing Functions

Nurses are faced with decisions in the context of the increased complexity of health care, changing patterns in the delivery of health services, and the development of evolving nursing practice in response to the health needs of clients. As the scope of nursing practice changes, the nurse must exercise judgment in accepting responsibilities, seeking consultation, and assigning responsibilities to others who carry out nursing care.

6.2 Accepting Responsibilities

The nurse must not engage in practices prohibited by law or delegate to others activities prohibited by practice acts of other health care personnel or by other laws. Nurses determine the scope of their practice in light of their education, knowledge, competency, and extent of experience. If the nurse concludes that he or she lacks competence or is inadequately prepared to carry out a specific function, the nurse has the

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responsibility to refuse that work and to seek alternative sources of care based on concern for the client's welfare. In that refusal, both the client and the nurse are protected. Inasmuch as the nurse is responsible for the continuous care of patients in health care settings, the nurse is frequently called upon to carry out components of care delegated by other health professionals as part of the client's treatment regimen. The nurse should not accept these interdependent functions if they are so extensive as to prevent the nurse from fulfilling the responsibility to provide appropriate nursing care to clients.

6.3 Consultation and Collaboration

The provision of health and illness care to clients is a complex process that requires a wide range of knowledge, skills, and collaborative efforts. Nurses must be aware of their own individual competencies. When the needs of the client are beyond the qualifications and competencies of the nurse, consultation and collaboration must be sought from qualified nurses, other health professionals, or other appropriate sources. Participation on intradisciplinary or interdisciplinary teams is often an effective approach to the provision of high quality total health services.

6.4 Delegation of Nursing Activities

Inasmuch as the nurse is accountable for the quality of nursing care rendered to clients, nurses are accountable for the delegation of nursing care activities to other health workers. Therefore, the nurse must assess individual competency in assigning selected components of nursing care to other nursing service personnel. The nurse should not delegate to any member of the nursing team a function for which that person is not prepared or qualified. Employer policies or directives do not relieve the nurse of accountability for making judgments about the delegation of nursing care activities.[10]

Changing functions—perioperative explications. The increased complexity of surgical interventions, an expanding array of technological devices and systems, and the evolving role of perioperative nursing require that the perioperative nurse exercise judgment, seek consultation, and assign responsibilities in a manner that reflects changing practice patterns.

Perioperative examples:

- Maintains knowledge about changing perioperative practice patterns (eg, case management, shared governance, practice partnerships).
- Delegates duties only to competent and appropriate personnel.
- Maintains awareness of changing health care policy at the local, state, and national levels.
- Keeps informed about status of or proposed changes to state nurse practice act.
- Promotes expanded perioperative practice roles (eg, RNFA, laser nurse, endoscopy video nurse).

Accepting responsibilities—perioperative explications. Perioperative nurses determine the scope of their practice relative to education, knowledge, competence, and experience. When the perioperative nurse concludes that he or she is incapable or unable to carry out specific functions, the nurse has the responsibility to refuse that work and seek alternative sources of care to meet the needs of the patient. In carrying out interdependent functions, the perioperative nurse should not lose sight of the primary obligation to the patient.

Perioperative examples:

- Assigns nonnursing functions to appropriate personnel.
- Is aware of limitations and accepts assignments only when qualified to function safely.
- Participates in defining and revising, and acts within the scope of the state nurse practice act (eg, RN, RNFA).

Consultation and collaboration—perioperative explications. The care of surgical patients is a complex process requiring collaborative efforts as well as individual knowledge and skill. Perioperative nurses consult and collaborate with health professionals and other appropriate sources to provide effective health services.

Perioperative examples:

- Seeks and/or provides consultation for special patient needs.
- Fosters intradisciplinary and interdisciplinary communication to enhance patient care (eg, among perioperative, critical care, pediatric, psychiatric nurses; physicians; other surgical team members).
- Networks with other nurses and health care professionals to enhance professional growth and patient care.
- Uses institutional committees as a resource (eg, infection control committee, ethics committee).
- Promotes interagency exchange of material resources when needed.
- Demonstrates collaborative practice among subspecialties within and outside the perioperative arena.

Delegation of nursing activities—perioperative explications. Perioperative nurses are accountable for the quality of care rendered to patients and for the delegation of nursing care activities to other health care workers. The perioperative nurse follows facility policies or directives in delegating functions, but these do not relieve the nurse of accountability for making judgments about the competency of personnel and the appropriateness of delegated activities.

Perioperative examples:

- Delegates nursing functions to nurses.
- Allows assistive personnel to assist with nursing functions only when competence to do so has been established.
- Bases assignments on individual competency, patient acuity, staffing pattern, and staff availability.

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

7.1 The Nurse and Development of Knowledge

Every profession must engage in scholarly inquiry to identify, verify, and continually enlarge the body of knowledge that forms the foundation for its practice. A unique body of verified knowledge provides both framework and direction for the profession in all of its activities and for the practitioner in the provision of nursing care. The accrual of scientific and humanistic knowledge promotes the advancement of practice and the well-being of the profession's clients. Ongoing scholarly activity such as research and the development of theory is indispensable to the full discharge of a profession's obligations to society. Each nurse has a role in this area of professional activity, whether as an investigator in furthering knowledge, as a participant in research, or as a user of theoretical and empirical knowledge.

7.2 Protection of Rights of Human Participants in Research

Individual rights valued by society and by the nursing profession that have particular application in research include the right of adequately informed consent, the right to freedom from risk of injury, and the right of privacy and preservation of dignity. Inherent in these rights is respect for each individual's rights to exercise self-determination, to choose to participate or not, to have full information, and to terminate participation in research without penalty.

It is the duty of the nurse functioning in any research role to maintain vigilance in protecting the life, health, and privacy of human subjects from both anticipated and unanticipated risks and in assuring informed consent. Subjects' integrity, privacy, and rights must be especially safeguarded if the subjects are unable to protect themselves because of incapacity or because they are in a dependent relationship to the investigator. The investigation should be discontinued if its continuance might be harmful to the subject.

7.3 General Guidelines for Participating in Research

Before participating in research conducted by others, the nurse has an obligation to (a) obtain information about the intent and the

nature of the research and (b) ascertain that the study proposal is approved by the appropriate bodies, such as institutional review boards.

Research should be conducted and directed by qualified persons. The nurse who participates in research in any capacity should be fully informed about both the nurse's and the client's rights and obligations.[1]

The nurse and development of knowledge—perioperative explications. As part of the obligation to the patient and to society, the perioperative nurse engages in activities that promote scholarly inquiry to identify, verify, and continually enlarge the body of scientific knowledge. Perioperative nursing roles include investigation to further knowledge, participation in research, and use of theoretical and empirical knowledge. Perioperative nurses can support research as content experts, data collectors, research subjects, or researchers.

Perioperative examples:

- Uses research findings to support clinical practice.
- Fosters an environment of intellectual curiosity.
- Identifies problems amenable to the research process (eg, questions outmoded, ritualistic practices).
- Disseminates research findings to colleagues.

Protection of rights of human participation in research—perioperative explications. The perioperative nurse protects the rights of subjects involved in research studies. These rights include the right of adequately informed consent, the right to freedom from risk of injury, the right of privacy, and the right to the preservation of dignity. The perioperative nurse respects the subject's right to participate, decline, or to terminate participation in research.

Perioperative examples:

- Confirms informed consent of patient prior to initiation of study.
- Safeguards patient's rights as research subject.
- Submits research proposals to appropriate review committee.
- Follows recommended guidelines and protocols when using investigational devices or when engaging in new procedures.
- Follows federal guidelines for treatment of human and animal subjects.

General guidelines for participating in research—perioperative explications. Perioperative nurses have an obligation to (a) ensure that research is conducted by qualified persons, (b) obtain information about the intent and nature of the research, and (c) confirm that the study is approved by appropriate review bodies. The rights and obligations of the patient and the perioperative nurse should be disclosed by the researcher. Furthermore, the researcher has an obligation to provide information about the nature of the study to the staff members providing care to the patient-subjects.

Perioperative examples:

- Follows appropriate research protocol during data collection.
- Determines that appropriate safeguards are followed.
- Follows guidelines to protect subjects' rights.

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

8.1 Responsibility to the Public for Standards

Nursing is responsible and accountable for admitting to the profession only those individuals who have demonstrated the knowledge, skills, and commitment considered essential to professional practice. Nurse educators have a major responsibility for ensuring that these competencies and a demonstrated commitment to professional practice have been achieved before the entry of an individual into the practice of professional nursing.

Established standards and guidelines for nursing practice provide guidance for the delivery of professional nursing care and are a means for evaluating care received by the public. The nurse has a personal responsibility and commitment to clients for implementation and maintenance of

optimal standards of nursing practice.

8.2 Responsibility to the Profession for Standards

Established standards reflect the practice of nursing grounded in ethical commitments and a body of knowledge. Professional standards or guidelines exist in nursing practice, nursing service, nursing education, and nursing research. The nurse has the responsibility to monitor these standards in daily practice and to participate actively in the profession's ongoing efforts to foster optimal standards of practice at the local, regional, state, and national levels of the health care system.

Nurse educators have the additional responsibility to maintain optimal standards of nursing practice and education in nursing education programs and in any other settings where planned learning activities for nursing students take place.[12]

Responsibility to the public for standards—perioperative explications. AORN establishes standards and recommended practices to guide the perioperative nurse in the delivery of nursing practice and to evaluate patient care. The perioperative nurse has a personal responsibility and commitment to patients for implementing and maintaining standards of perioperative nursing. Perioperative educators and managers are additionally responsible to provide an environment conducive to implementing and improving standards and recommended practices.

Perioperative examples:

- Bases clinical privileges on competency-based performance (eg, laser nurse, RNFA).
- Bases practice on AORN and ANA standards of clinical practice and professional performance.
- Follows regulatory guidelines (eg, JCAHO, OSHA, Centers for Disease Control and Prevention).

Responsibility to the profession for standards—perioperative explications. Perioperative nurses are responsible for monitoring standards of practice pertinent to their role and for fostering optimal standards of practice at the local, regional, state, and national levels of the health care system. Nursing educators have the additional responsibility of maintaining optimal standards of practice and education in perioperative nursing programs and in the institutional or academic setting.

Perioperative examples:

- Uses standards in nursing practice.
- Contributes to the work of AORN committees and projects to develop standards.
- Reviews and critiques practice standards (eg, responds to AORN proposed recommended practices).

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

9.1 Responsibility for Conditions of Employment

The nurse must be concerned with conditions of employment that (a) enable the nurse to practice in accordance with the standards of nursing practice and (b) provide a care environment that meets the standards of nursing service. The provision of high quality nursing care is the responsibility of both the individual nurse and the nursing profession. Professional autonomy and self-regulation in the control of conditions of practice are necessary for implementing nursing standards.

9.2 Maintaining Conditions for High Quality Nursing Care

Articulation and control of nursing practice can be accomplished through individual agreement and collective action. A nurse may enter into an agreement with individuals or organizations to provide health care. Nurses may participate in collective action such as collective bargaining through their state nurses' association to determine the terms and conditions of employment conducive to high quality nursing care. Such agreements should be consistent with the profession's standards of practice, the state law regulating nursing practice, and the *Code for Nurses*.[13]

Responsibility for conditions of employment—perioperative explications. The perioperative nurse understands conditions of employment that promote practice in accordance with AORN standards and recommended practices. The nurse provides a care environment that meets JCAHO standards. Quality nursing care is the responsibility of both the individual and the profession. Professional autonomy and self-regulation are necessary for implementing nursing standards.

Perioperative examples:

- Promotes an environment that eliminates harassment and abuse.
- Assists peers to be assertive and emotionally healthy.
- Facilitates a working atmosphere conducive to learning.
- Integrates personal philosophy of nursing into practice setting.
- Provides an environment that optimizes the occupational health and safety of all employees.
- Supports the philosophy of AORN.

Maintaining conditions for high-quality nursing care—perioperative explications. Articulation and control of perioperative nursing practice can be accomplished through individual efforts and collective action. Such activities should be consistent with AORN standards and recommended practices, JCAHO standards, state nurse practice acts, and the ANA *Code for Nurses*.

Perioperative examples:

- Participates in strategic planning and developing institutional goals and objectives.
- Promotes empowerment and team building.
- Facilitates a working atmosphere conducive to learning, teaching, and education.
- Supports perioperative preceptor programs.

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

10.1 Protection from Misinformation and Misrepresentation

Nurses are responsible for advising clients against the use of products that endanger the clients' safety and welfare. The nurse shall not use any form of public or professional communication to make claims that are false, fraudulent, misleading, deceptive, or unfair.

The nurse does not give or imply endorsement to advertising, promotion, or sale of commercial products or services in a manner that may be interpreted as reflecting the opinion or judgment of the profession as a whole. The nurse may use knowledge of specific services or products in advising an individual client, since this may contribute to the client's health and well-being. In the course of providing information or education to clients or other practitioners about commercial products or services, however, a variety of similar products or services should be offered or described so the client or practitioner can make an informed choice.

10.2 Maintaining the Integrity of Nursing

The use of the title *registered nurse* is granted by state governments for the protection of the public. Use of that title carries with it the responsibility to act in the public interest. The nurse may use the title *R.N.* and symbols of academic degrees or other earned or honorary professional symbols of recognition in all ways that are legal and appropriate. The title and other symbols of the profession should not be used, however, for benefits unrelated to nursing practice or the profession, or used by those who may seek to exploit them for other purposes.

Nurses should refrain from casting a vote in any deliberations involving health care services or facilities where the nurse has business or other interests that could be construed as a conflict of interest.[14]

Protection from misinformation and misrepresentation—perioperative explications. Perioperative nurses should advise physician and patient clients against using products that endanger their

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safety and welfare. The perioperative nurse does not give or imply endorsement to advertising, promotion, or sale of commercial products or services in a manner that may be interpreted as reflecting the opinion or judgment of the profession as a whole.

Perioperative examples:

- Responds promptly to recall notices and safety alerts.
- Participates in community education about surgical issues.
- Makes purchasing decisions equitably and justly to provide cost-effective, quality care.
- Provides adequate information to patients and colleagues about products so that they can make knowledgeable, informed choices.
- Uses and maintains supplies and equipment according to manufacturers' instructions.

Maintaining the integrity of nursing— perioperative explications. Use of the title *registered nurse/RN* as granted by state licensure carries with it the responsibility to act in the public interest. The title *RN* and all other symbols of academic degrees or other earned or honorary professional symbols of recognition may be used in all ways that are legal and appropriate.

Perioperative examples:

- Promotes a positive image of nursing in the media and the community.
- Promotes professional autonomy and self-regulation of practice.
- Uses nursing titles (eg, CNOR, CRNFA) appropriately.
- Identifies and resolves conflicts of interest effectively.
- Corrects inaccurate portrayals of and misinformation about the profession.

ANA Statement 11: The nurse collaborates with members of the health professions and other citizens in promoting community and national efforts to meet the health needs of the public.

11.1 Collaboration with Others to Meet Health Needs

The availability and accessibility of high quality health services to all people require collaborative planning at the local, state, national, and international levels that respects the interdependence of health professionals and clients in health care systems. Nursing care is an integral part of high quality health care, and nurses have an obligation to promote equitable access to nursing and health care for all people.

11.2 Responsibility to the Public

The nursing profession is committed to promoting the welfare and safety of all people. The goals and values of nursing are essential to effective delivery of health services. For the benefit of the individual client and the public at large, nursing's goals and commitments need adequate representation. Nurses should ensure this representation by active participation in decision making in institutional and political arenas to assure a just distribution of health care and nursing resources.

11.3 Relationships with Other Disciplines

The complexity of health care delivery systems requires a multidisciplinary approach to delivery of services that has the strong support and active participation of all the health professions. Nurses should actively promote the collaborative planning required to ensure the availability and accessibility of high quality health services to all persons whose health needs are unmet.[15]

Collaboration with others to meet health needs— perioperative explications. The nurse respects the interdependence of providers and patients in achieving access to health care. Collaborative planning is essential if nursing and health care are to be made available to all people.

Perioperative examples:

- Exercises voting privileges in local and national elections.
- Communicates with elected officials (eg, AORN officers and Board members, congressional representatives, health policy makers, regulatory and legislative representatives) about health care issues.
- Collaborates with members of other professional organizations at national, state, and local levels.

Special Committee on Ethics Comment Form

AORN's Special Committee on Ethics presents in this proposed statement what is believed to be an achievable and optimal level of ethical perioperative nursing practice. Because of differences in practice settings, this proposed statement is necessarily broad to meet the needs of the membership. This overall statement is meant to serve as a guideline for developing policies and procedures in individual practice settings.

The Special Committee on Ethics highly values all comments from AORN members regarding the individual interpretive statements and the overall document. Please comment on this form and return it to AORN Headquarters at the address below by **Sept 6, 1993**.
Please attach additional pages of comments and/or suggestions as needed. All comments will be considered.

1. What is your overall opinion of these interpretive statements? Excellent Good Fair Poor
   Explain: _____

2. Will these interpretive statements address the major issues in your practice setting?
   Yes _____ No _____
   Explain: _____

3. Do interpretive statements (in general) address the major issues in your practice?
   Yes _____ No _____ Explain: _____

4. Please comment on particular areas of concern in these interpretive statements and submit supporting documentation, if applicable. _____

5. Is the format workable and easy to understand? Yes _____ No _____ Explain: _____

6. What is your overall impression of the *ANA Code for Nurses with Interpretive Statements—Explications for Perioperative Nursing*?
   _____

7. How could the Special Committee on Ethics further assist you? _____

8. Please list suggestions for future ethics activities. _____

Thank you for your assistance.

Return to: Special Committee on Ethics
AORN, Inc
2170 S Parker Rd, Suite 300, Denver, CO 80231-5711
Attn: Cathy Devitt Smith, RN, MBA,CNOR

Name (optional): _____
Address: _____
City: _____
State: _____ Zip: _____

Responsibility to the public—perioperative explications. To promote the welfare and safety of all people, nurses need adequate representation to deliver health services effectively. Individual patients and society as a whole benefit from nursing participation in decisions made about health care.

Perioperative examples:

- Participates in institutional decision making.
- Participates in the electoral process.
- Volunteers in community health services.
- Supports political candidates that advance nursing's health care issues.
- Educates members of the community about perioperative nursing (eg, at health fairs, OR Nurse Week, educational programs).
- Collaborates with consumer, service, and support organizations (eg, Lion's Club, Reach to Recovery, American Association of Retired Persons).
- Collaborates with the public, industry, and health care workers regarding environmental and cost-containment issues.
- Fosters collaboration with and education of the public on national issues (eg, the environment, health care costs).

Relationships with other disciplines—perioperative explications. Perioperative nurses should actively promote an interdisciplinary and collaborative approach to the delivery of care, especially to those whose health needs are unmet.

Perioperative examples:

- Collaborates with other disciplines (eg, medicine, pastoral care, pharmacology).
- Participates in multidisciplinary conferences (eg, AORN/American College of Surgeons symposia).

SPECIAL COMMITTEE ON ETHICS
PATRICIA C. SEIFERT, RN, MSN, CNOR, CRNFA, CHAIRMAN, 1991-1993
AILEEN R. KILLEN, RN, MS, CNOR, CHAIRMAN, 1993-1994
CYNTHIA A. BRAY, RN, MS, CNOR
JACKIE L. HAMBLET, RN, MS, CNOR
CECIL A. KING, RN, CNOR
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JEAN M. REEDER, RN, PHD, CNOR, FAAN
ANNE URUBURU, RN, MBA, CNOR
BARBARA J. RANDOLPH, RN, MSN, CNOR, STAFF CONSULTANT 1991-1992
CATHY DEVITT SMITH, RN, MBA, CNOR, STAFF CONSULTANT 1992-1993

Notes

1. American Nurses Association, *Code for Nurses with Interpretive Statements* (Kansas City, Mo: American Nurses Association, 1985).
2. *AORN Standards and Recommended Practices* (Denver: Association of Operating Room Nurses, Inc, 1993).
3. American Nurses Association, *Code for Nurses with Interpretive Statements*.
4. *Ibid*, 4.
5. *Ibid*, 5.
6. *Ibid*, 7.
7. American Nurses Association, Nursing: *A Social Policy Statement* (Kansas City, Mo: American Nurses Association, 1990); Association of Operating Room Nurses, Inc, American Nurses Association, *Standards of Nursing Practice: Operating Room* (Kansas City, Mo: American Nurses Association, 1975).
8. American Nurses Association, *Code for Nurses with Interpretive Statements*, 9.
9. *Ibid*, 10.
10. *Ibid*, 11.
11. *Ibid*, 13.
12. *Ibid*, 14.
13. *Ibid*, 15.
14. *Ibid*, 16.
15. *Ibid*, 16.

Legacy of Tuskegee syphilis

By Donna St. George
Knight-Ridder News Service

William Mason of Baltimore is suspicious of doctors and medicines and government health programs, even now when he desperately needs them. As he considers why, his reason settles on a name that has lurked in his mind for 15 or 20 years.

Tuskegee. In one word, all the proof in the world. It is a word that resonates fearfully in black communities throughout America when critical health-care decisions are made. Often they are life and death decisions.

Tuskegee was the rural Alabama town where the government lied to 400 black men who were sick with syphilis. It told them their problem was "bad blood" and that they were being treated.

But the doctors never really gave them medicine. Not even after the men shriveled up and went blind and went insane. Not even as the men died.

For 40 years, the government just watched. This was research. And the doctors wanted to study these men all the way to the autopsy table.

"When you know about what happened in Tuskegee, you don't forget," says Mr. Mason, a slender, soft-spoken man of 48. "You may think you've dismissed it from your mind, but you find it's still locked up in your consciousness when you make a decision."

That wrenching moment has come for Mr. Mason, who has the AIDS virus, and he believes that his only chance to survive may be to join an experimental trial for a brand-new drug. It is a slim hope. But it is all he has.

Then he thinks of the men of Tuskegee.

Worrying about priorities

Like them, Mr. Mason is black. He worries that the doctors will be more concerned with their research than his health. That he will end up more sickly instead of healthier.

"I haven't decided what to do," Mr. Mason concedes one Saturday, conflict in his angular face.

He is caught between two of life's most powerful forces — the force of his will to survive and the force of his history, which was told and retold among family and friends until it became part of a common faith.

Among many blacks in America, that faith says: Don't believe what the doctors say. Don't let them experiment on you. If they did it once, they could do it again.

It is a voice of warning that has spoken with particular shrillness and consequence when it comes to the spread and treatment of AIDS.

Let Karen Reddick tell you about the legacy of Tuskegee. She is minority program coordinator for the AIDS task force in Pittsburgh and it is her job to bring AIDS education programs into the black community.

At every neighborhood program, at every community forum on AIDS, someone raises the issue of Tuskegee, she says.

"I feel like it's this barrier even before I open my mouth," Ms. Reddick says. "And it has a profound effect. They disbelieve what you're telling them, and they disbelieve the process of treatment.

"Where we have gone wrong in AIDS education is that we don't acknowledge that this is a problem. We don't acknowledge Tuskegee still exists for people."

Let Dr. Richard E. Chaisson tell you about the legacy of Tuskegee. He is director of the AIDS Service at Johns Hopkins Hospital in Baltimore, which treats 3,000 people with AIDS.

At Hopkins, Tuskegee comes up regularly — in the examination room, at community advisory board meetings and in discussions of clinical trials for new drugs.

"I would say that Tuskegee is a major issue in the African American community and it has an extraordinary legacy," he says.

There are plenty of examples:

Deterrent in Prince George's

In Prince George's County, Tuskegee keeps many blacks who are in need of medical care from coming into the public-health clinic, Director Maureen McCleary says.

In Atlanta, Tuskegee is one reason so many blacks have refused to take the drug AZT, says Terri Creagh, clinical director of the AIDS Research Consortium of Atlanta.

In Chicago, Tuskegee scares people even from answering AIDS survey questions.

"I'm just trying to get their opinions," laments Michael Norman Haynes, an AIDS activist in Chicago. "And as many as 30 percent of the people bring Tuskegee up and don't want to get involved."

In New York City, 25 to 33 percent of those asked to join in research trials decline "either because of Tuskegee or some variation thereof," says Dr. Lawrence S. Brown, staff physician at Harlem Hospital and assistant clinical professor of medicine at Columbia University.

"Tuskegee unfortunately lives on," Dr. Brown says.

In Philadelphia, Tuskegee has been one reason this summer that the city's free immunization for children has drawn far fewer youngsters than expected, says City Health Commissioner Robert K. Ross.

"There is still a lot of residual distrust that haunts public health from

Many blacks suspic

the Tuskegee study," Mr. Ross says.

Even Howard University in Washington, one of the nation's premier black institutions, has trouble getting blacks to join clinical trials, says study coordinator Viktoria Holley Trimmer.

"People are very, very mistrustful," says Thomas Gleaton, of the Inner City AIDS Network in Washington. "I think the fact that we are also people of color here and some of us are HIV-infected has helped us get through. . . . But there is an element you can't get past because of Tuskegee."

Very suspicious

In the humid heat of New Orleans, when the summer air is heavy and still inside the city's small frame houses, people sit on their porches on plastic chairs and wooden swings and kitchen stools. The talk crosses generations, a steady drifting of simple news and family stories, of laughter and lesson.

Here, Leonard Green remembers his grandmother telling him, "Baby, you can't trust the government." It may have been her way of referring to Tuskegee, he says. But his mother was more direct.

"My mother told me stories about Tuskegee, about what white people did to black people," says Mr. Green. "And my mother used to talk to other mothers. And they were all just very suspicious."

Years later, he founded an AIDS prevention program in New Orleans — and found himself confronted with Tuskegee once again.

"They would ask, 'How do we know you're not part of a plot from the government to get rid of black folks?' " he recounts.

"Certainly the predominantly black health department would not want to kill its own people," he remembers answering.

Not everyone was convinced.

"I think it's a real problem when you talk about black people getting involved in clinical trials, when you talk about black people taking AZT when you talk about black people using condoms," says Mr. Green, now editor of the African-American *Capital Spotlight* newspaper in Washington.

That is the same conclusion drawn by researchers Stephen B. Thomas and Sandra Crouse Quinn in a study at the University of Maryland at College Park.

Tuskegee's legacy of mistrust they said, has fostered doubts about condom distribution — seen as a measure to control black birthrates — and needle exchange programs seen as an effort to kill by promoting

project is fear of

ous of doctors

drug abuse. It also has helped fuel a widespread belief that AIDS is a plot by whites to wipe out blacks — a theory that has been deliberated in the African-American press, on radio shows and in academic papers.

The researchers cited a survey of 1,056 church members in five cities — Atlanta, Detroit, Charlotte, N.C., Kansas City, Mo., and Tuscaloosa, Ala. — in which a stunning 35 percent said they believed AIDS was genocide and 30 percent more were unsure.

Even more people — 44 percent — said they believed the government was not telling the truth about AIDS, while 35 percent more were unsure.

"The fear about Tuskegee, about genocide, cut across class, across educational level, across income levels," Ms. Quinn said in a recent interview.

"Should the day come when we do have an AIDS vaccine, many people will not take it for the simple reason of Tuskegee and the fear of being experimented on again."

Details are lost

The specific details of the Tuskegee Syphilis Study often are lost in some of the very communities where its impact is most fiercely felt.

People may not know that it began in 1932. That it was run by the U.S. Public Health Service. That it was to determine whether, as some believed, syphilis was as deadly for blacks as it was for whites — a finding that could then be used, the doctors said, to lobby for more treatment funds.

They may not know that even when penicillin was discovered, the government let the men suffer without it. That the government actually went out and stopped some from getting treatment at other clinics.

Or that, by the government's own estimates, between 28 and 100 of the men died from untreated syphilis.

Tuskegee was brought to national attention in 1972, when news stories unleashed a stormy debate about it.

Erroneous belief

As word of the study made it into neighborhoods and families, and then was passed on in bits and pieces, many people came to believe — and still do — that the government "infected" the Tuskegee men with syphilis.

Others didn't know details at all, just that "there was an experiment on black folks that created a situation where black people died," says Gregory Hutchings, director of Lifelink, an AIDS education group in Washington.

Still others inherited the wariness without ever learning the name "Tuskegee."

"We didn't go to hospitals," says Ferne Johnson, 43, an AIDS support group leader in Baltimore. "In our family, it was, 'You can only trust what you get at home.' The distrust came through more so than why. Syphilis was hush-hush in those days, anyway. I don't think my grandmother would have ever said the word."

Tuskegee gathered so much weight because it confirmed fears about the research being valued more than black lives.

It also became the best-known example for a larger truth: Black or poor patients were more likely to be abused by doctors — women given unneeded hysterectomies, patients held in hospitals while doctors explored conditions they found "interesting."

Story about Hopkins

In Baltimore, there is a story about the Johns Hopkins University.

Ferne Johnson says it goes like this: "The doctors at Hopkins take the homeless and the disadvantaged folks, people who have no family and late at night they go round them up and do studies on them."

This is not unfamiliar to the doctors at Hopkins, who often hear a slightly different tale, mostly from people who live in the immediate neighborhood. "At Hopkins," it goes, "they snatch children off the street and experiment on them at night in the basement."

Such fears are very real and very common in neighborhoods where prestigious research hospitals intersect with inner-city communities: Hopkins in Baltimore, University of Pennsylvania in Philadelphia, Columbia University in New York, to name a few.

"I think Tuskegee has great meaning when it's integrated with people's own personal experience at these institutions in their communities," says Dr. Mark D. Smith, who heard the tales while working at Hopkins. "All of this is heightened when it comes to AIDS."

With AIDS, there is added suspicion, uncertainty and fear. The disease is deadly. It's laden with more stigma. And it infects minorities in higher proportions, with blacks accounting for 29 percent of cases.

For people who are mistrustful in the first place, these factors are made worse by so few answers about AIDS. To them, it sounds like no one is talking straight.

"The constant change of information makes us leery," says Ms. Johnson. "People don't trust what they're

NURSES FOR A HEALTHIER AMERICA

THE
AMERICAN
NURSES
ASSOCIATION

The American Nurses Association is the national professional organization representing the nation's 2.2 million registered nurses. Its 53-member constituent associations include:

Alabama State Nurses Association
Alaska Nurses Association
Arizona Nurses Association
Arkansas Nurses Association
California Nurses Association
Colorado Nurses Association
Connecticut Nurses Association
Delaware Nurses Association
District of Columbia Nurses Association, Inc.
Florida Nurses Association
Georgia Nurses Association, Inc.
Guam Nurses Association
Hawaii Nurses Association
Idaho Nurses Association
Illinois Nurses Association
Indiana State Nurses Association
Iowa Nurses Association
Kansas State Nurses Association
Kentucky Nurses Association
Louisiana State Nurses Association
Maine State Nurses Association
Maryland Nurses Association, Inc.
Massachusetts Nurses Association
Michigan Nurses Association
Minnesota Nurses Association
Mississippi Nurses Association
Missouri Nurses Association
Montana Nurses Association
Nebraska Nurses Association
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New Mexico Nurses Association
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South Carolina Nurses Association
South Dakota Nurses Association, Inc.
Tennessee Nurses Association
Texas Nurses Association
Utah Nurses Association
Vermont State Nurses Association, Inc.
Virgin Islands State Nurses Association
Virginia Nurses Association
Washington State Nurses Association
West Virginia Nurses Association, Inc.
Wisconsin Nurses Association, Inc.
Wyoming Nurses Association

THE AMERICAN NURSES ASSOCIATION
600 Maryland Avenue SW
Suite 100 West
Washington, DC 20024
202 554 4444
FAX 202 554 2262

HIV/AIDS Discussion Group

Kristine Gebbie, MN, RN, FAAN	National AIDS Policy Coordinator
Virginia Trotter Betts, JD, MSN, RN	President, American Nurses Association
Linda Shinn, MBA, RN, CAE	Executive Director, (Interim) American Nurses Association

HIV Task Force

Barbara Russell, MPH, RN, CIC
Allen Harris, BSN, RN, C
Deborah Coleman, MS, RN, CS
Barbara Aranda-Naranjo, MSN, RN
Cecil King, CNOR, RN

ANA HIV Matrix Team

Sarah Stanley, MS, RN, CNA, CS
Deborah Arrindell
Barbara Sapin
Karen Worthington, MSN, RN
Kathryn Scott, RN
Colleen Scanlon, JD, RN

Jan Heinrich, PhD, RN, FAAN	American Academy of Nursing
Robin Cassetta	The American Nurse
Joan McNeal	International Nursing Center
Kent Nordvig	American Nurses Foundation

Dan O'Neal, MA, CNA, RN	Government Affairs
Valarie Carty	Practice, Economics, and Policy
Linda Minich	Executive Staff

~~Goldsmith~~

This is the mail for the meeting on the Mon 23rd. (luncheon 1p-3p)

Elena will be there (Pres)

American Nurses Association

600 Maryland Avenue SW, Suite 100 West, Washington, DC 20024-2571
202-554-4444 • Fax: 202-554-2262

Virginia Trotter Betts, JD, MSN, RN
President

Barbara K. Redman, PhD, RN, FAAN
Executive Director

August 9, 1993

Kristine Gebbie
National AIDS Policy Coordinator
Office of National AIDS Policy Coordination
Executive Office of the President
Washington, DC 20500

Dear Ms. Gebbie:

The American Nurses Association (ANA) was very pleased to learn of your appointment by President Clinton, as the National AIDS Policy Coordinator. The ANA and other nursing groups have been active throughout the decade of the AIDS epidemic, to voice concern for patient care issues and health care worker safety. We have enclosed a copy of the revised ANA HIV Compendium 1993 which summarizes ANA policies, positions and activities on behalf of nursing.

We would very much like to discuss our concerns with you. The HIV Task Force will meet at the ANA headquarters August 23-24, 1993. We would be most delighted if you could join us to discuss the government's frontline efforts for persons with AIDS.

Please inform us of your availability; through Sarah Stanley, MS, RN, CNA, CS, ANA staff, at (202) 554-4444, extension 289. Our schedule is most flexible to meet your needs. We look forward to hearing from you and working with you in the future.

Sincerely,

Barbara Russell

Barbara Russell, MPH, RN, CIC
Chairperson, HIV Task Force

Enclosure

BR:SRS:vmc:k:\vmc\sarah\hiv\gebbie.ltr

AMERICAN NURSES ASSOCIATION
600 Maryland Avenue, SW, Suite 100 West
Washington, DC 20024-2571
Voice: (202) 554-4444
Fax: (202) 554-0185 (202) 554-2262

CONFIDENTIAL

To: Retina **Fax:** 202-690-7054

From: Valarie Carty **Phone:**

Date: 8/11/93 **Total Pages with Cover:** 3

Please call me at 202-554-4444x282 when you have received.

Valarie

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Nurses: Charting the Course for a Healthy Nation

American Nurses Association
1994 Convention
San Antonio, Texas
June 10-15, 1994

REVISED 8/11/93

HIV Task Force
Washington, DC
August 23-24, 1993

Meeting Agenda

August 23, 1993

1:00 - 3:00 p.m.

Luncheon and Discussion with Kristine Gebbie, National AIDS Policy Coordinator

3:15 - 4:00 p.m.

1. Introduction . . . . . Barbara Russell, MPH, RN, CIC, BSHA
   New Member, Cecil King, RN CNOR
   Review of Agenda

2. Chairperson Report
   - 2a. HOD 1993, HIV Infection and Immigration
   - 2b. Agency for Health Care Policy and Research Guideline for Evaluation and Managment of Early HIV Infection
   - 2c. American Academy of Nursing Conference on HIV . . . . . Barbara Russell
   - 2d. Internation Council of Nurses HIV Activities
   - 2e. State Nurses Association
     Survey questions . . . . . Sarah Stanley, MS, RN, CNA, CS

4:00 - 5:00 p.m.

3. Finalize Publication . . . . . Barbara Russell
   - 3a. Revised copy of publication
   - 3b. HIV Compendium 1993

5:00 - 6:00 p.m.

Comments to Authors . . . . . Task Force Members
(Cliff Morrison conference call)
(Helen Schietinger at meeting)

August 24, 1993

8:00 - 9:00 a.m.

4. Legislative Report . . . . . Deborah Arrindell
   National AIDS Commission Final Report
   Testimonies and Proposed Legislation
   CDC

9:00 - 10:15 a.m.

5. Constituent/Member Communications
   AIDS Clearinghouse Demonstration . . . . . Karen Worthington, RN

BREAK 10:15 - 10:30 a.m.

10:30 a.m. - 12:00 p.m.

6. Peer Support Package Approval . . . . . Karen Worthington
   (Frank Lamendola, Congress of Nursing Practice and Barbara Fassbinder, Consultant, via conference call)

   6b. Implementation Plan
   1994 ANA Convention Presentation . . . . . Barbara Russell
   Regional Consultation

LUNCH 12:00 - 1:00 p.m.

1:00 - 4:00 p.m.

New Topics for Policy . . . . . Task Force Members
- Long-Term Care
- Elderly and AIDS
- Research
- HIV Insurance
- Teens & AIDS
- Health Care Reform & AIDS
  - quality
  - financing
  - consumer satisfaction
- Other_____

Task Force Assignments . . . . . Barbara Russell

Next Meeting Dates

Adjournment

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AMERICAN NURSES ASSOCIATION

Compendium of

HIV/AIDS

Position Statements, Policies, and Documents

American Nurses Association
600 Maryland Avenue, SW
Suite 100 West
Washington, DC 20024-2571
(202) 554-4444

REVISED 8/11/93

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