Dear Mary

by Mary Annas

Dear Mary is a monthly feature in which readers can ask about any nursing care issue that concerns them. Answers will be supplied by Mary Annas or a consulting nurse, physician, lawyer, or ethicist where appropriate. Readers are also invited to comment on the answers.

Dear Mary,

I am a respiratory therapy student at a large teaching hospital. During my clinical rotation through the ICU, my instructor asked if I would like to practice endotracheal intubation. I said yes, not realizing what was about to happen. We went behind closed curtains where a large group of medical and nursing students were standing around the body of a recently expired patient, each waiting a turn to practice intubation. After watching one person intubate the esophagus and another person chip a tooth, I told my instructor that I felt uncomfortable and left. Please comment on the ethics of this situation.

Cindy
Berkeley, Calif.

Dear Cindy,

While practicing is an important learning experience for students, it should be done under very controlled and supervised circumstances. Anyone who has progressed to the point of readiness to practice intubation on a cadaver should be proficient at intubating a plastic practice model. The ones currently marketed are quite life-like and have signal lights and buzzers to indicate poor technique, such as too much pressure on the teeth.

The ethical aspect of your question is difficult, but most important. You obviously cannot hurt the body that has died, but the emotional trauma to the family must be considered. If the family had arrived while these students were practicing, their natural grief would have been compounded. To be both respectful of a dead person and ethical, and to avoid any legal repercussions, you need either the consent of the patient prior to death or the consent of the next of kin after death.

Intubation is an intrusive procedure, and if done on a dead body it is similar to an autopsy even though no incision is made. As with autopsies done without consent, the next of kin can sue for unauthorized mutilation of the body and the measure of damages will be the emotional harm caused to the next of kin. See, e.g., French v. Ochsner Clinic, 200 So.2d 371 (La. App. 1967).

GJA

Dear Mary,

I am a third year medical student and will finish my oncology rotation next week. The hospital is a large teaching hospital, and each patient has a private physician as well as an assigned intern and resident. Some patients are also assigned medical students.

One of my patients was a 55 year old woman with breast cancer metastasized to her liver, lungs, and spine. She was classified as "terminal" and there was a "no code" order on her chart.

On the first day of my rotation, the senior physician conducted rounds and led the entire group into this woman's room. Everyone examined her while the senior physician discussed her physical status in a very detached clinical manner. The woman became agitated and asked, "Doctor, am I going to die?" He patted her hand and said, "Of course not — everything will be fine." Later, when we were all outside the patient's room, he told the group that the woman has about three months to live.

The handling of this situation really bothered me, and although I never confronted the physician with my feelings, I made sure that my own relationship with the woman was different. When she told me that she knew she was dying, I listened and talked with her about it, and I always tried to give honest answers to her questions. Would you comment on this situation?

Tim
Cleveland, Ohio

Dear Tim,

A student — medical, nursing, respiratory therapy, or other — can do little in the situation that you describe. The fact that you later made up for what was an outright lie to the patient does much to alleviate the lack of trust that many people feel toward doctors. Physicians' attitudes seem to range from candor and honesty with dying patients to dishonesty such as you describe. A common practice seems to be avoiding patients' questions entirely.

Perhaps you could discuss your thoughts with the house officers who were involved in the situation — they may have had feelings similar to yours and been reluctant to speak out.

The situation points out the important role that the patient's primary nurse can play. The nurse can and should be active in making sure that the patient understands her condition, and in protecting the patient from uncaring and insensitive physicians and students who seem more concerned with their own feelings than with the patient's.

Dear Mary,

I am 38 years old and expecting my first child. When I saw my obstetrician for the first time, she suggested that I have an amniocentesis performed. This recommendation was based solely upon my age, since neither my husband nor I have any family history of genetic abnormalities. The obstetrician said the purpose of the test was to determine if the baby has Down's Syndrome.

Because I am a nurse and have read widely on the subject, I questioned the doctor about alternatives available should the test results be positive. It was only after my questioning that the word "abortion" was mentioned. I did not undergo amniocentesis because I would not consider having an abortion. But I am concerned about the practice of "recommending" amniocentesis without fully informing the patient of the implications.

Norma
Buffalo, N.Y.

Dear Norma,

The information you received was not complete — even though the amniocentesis is statistically safe, it is an intrusive procedure and carries some degree of risk. And I agree with you that the decision to undergo the procedure is complicated by the underlying abortion issue. It seems important that pregnant women or couples contemplating amniocentesis be encouraged to explore their feelings about abortion as well.

Because of these complex issues, there is an increasing trend to seek genetic counseling before a final decision is made about amniocentesis. Some genetic counselors believe that, in a situation like yours, a couple might still elect to undergo amniocentesis because it would eliminate the nine month wait to see if the baby is normal, and, if the baby does have Down's Syndrome, give the couple more time to prepare for a child who will probably need special medical and educational services.