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A Study Of AIDS Policies As Reported
By Practical Nursing Programs Of **Indiana**

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Abstract: Many of the nation's nursing schools have yet to develop AIDS policies. Without such policy implementation, nursing educators face many problems. A recent study of nursing programs in Nebraska revealed that none of the schools' policies met all of the twenty-one criteria set forth by the Centers for Disease Control (CDC) and the American College Health Association (ACHA). The purposes of this study were to determine how many of Indiana's practical nursing programs have created or implemented AIDS policies and to compare and contrast those policies with the criteria set by Witmer (1992), the CDC, and the ACHA. A self-reporting questionnaire was sent to 24 practical nursing programs in Indiana. Of the 24 surveys mailed, 13 (54%) were returned. All of the submitted policies were deficient in meeting the suggested criteria set forth by the CDC and the ACHA.

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In 1981 the nation was introduced to a new and deadly disease, now known as Acquired Immunodeficiency Syndrome or AIDS (Kerr, Allensworth, & Gayle, 1991). No one knew the impact this disease would have on the nation and its people. AIDS was **first** interpreted as a gay disease. However, AIDS cases were soon reported in IV drug abusers, hemophiliacs, and the heterosexual population (Curran et al., 1986; Shilts, 1987). AIDS has no boundaries. AIDS afflicts people who are **old** and young, wealthy and poor, black and white. men and women. The escalation in the incidence and prevalence is frightening. The total number of AIDS cases has increased each year in the United States. The numbers of new cases in adults, reported as diagnosed in given years to the Centers for Disease Control, are as follows: 1981 -291 cases, 1982- 1,079 cases, 1983-2,892 cases, 1984-5,877 cases. 1985 - 11,002 cases. 1986 - 17,879 cases, 1987 - 26,491 cases, 1988 - 31,722 cases and 1989-34,362 cases (Durham & Cohen, 1991). The annual count of diagnosed AIDS cases is predicted to increase to between 61,000 and 98,000 during 1993 (Kerr et al., 1991).

As reported by the Indiana State Department of Health (1993), Indiana has also seen a consistent increase in the number of AIDS cases. The numbers of new cases reported are as follows: 1982-6 cases. 1983 - 10 cases, 1984-28 cases, 1985-56 cases, 1986-94 cases, 1987- 161 cases, 1988-243 cases, 1989-290 cases, 1990-356 cases, 1991 -447 cases and 1992 - 509 cases.

Background of the Problem

Although AIDS has dominated the **headlines** over the last decade, many of the nation's nursing schools have not addressed the task of developing AIDS policies. **No** nursing school, regardless of location, can afford to be unresponsive to the need for AIDS-related

Miller and Gable: A Study of AIDS Policies as Reported by Indiana Nursing Programs policies (Chitty, 1989). Without such policy implementation, nursing educators continue to face many problems. Such problems **include**: instructor recourse when the student nurse refuses to care for AIDS patients (Carwein & Bowles, 1988), prevention of litigation due to exposure and seroconversion (Hodges & Poteet, 1989), allowance of students with AIDS to care for patients in the **clinical** setting, and sharing of information when a student or instructor has AIDS (Carwein & Bowles, 1988). Nursing **programs** can prevent such concerns by implementing policies and procedures regarding such issues. Policy statements serve an educational as well as a judicial function. A school's AIDS policy can be seen as an integral part of the AIDS curriculum, a means through which attitudes can be shaped (Silin, 1988). Although it is impossible to anticipate every eventuality, a policy should be developed.

Statement of the Problem

Many AIDS researchers have encouraged colleges and universities throughout the nation to be proactive and implement AIDS-related policies before a situation arises. Although many educational facilities agree that guidelines must be in place, there seems to be an apparent apathy about developing and implementing them (Witmer, 1992).

The reason why nursing schools have been slow in developing AIDS policies is unclear. Some factors may include their conservative nature, resistance to change, inadequate knowledge of gay health concerns and drug use, denial, **homophobia**, lack of interest, and fear of stigmatization (Durham & Cohen, 1991).

The implications of not having AIDS related policies in place include potential discrimination against the AIDS infected person, financial responsibility for testing following

accidental exposure. and breach of confidentiality due to poor record-keeping (Chitty, 1989). There is definitely a current need for such policies to be developed and implemented in educational institutions.

Purpose

The purposes of this study were to determine how many of the practical nursing programs in the state of Indiana have created or implemented policies to address HIV/AIDS and to compare and contrast these policies with the criteria set forth by Witmer (1992), the Centers for Disease Control (1987), and the American College Health Association (1986).

Between 1986 and 1987, the CDC and the ACHA developed guidelines to assist policy makers. The guidelines consist of twenty-one criteria that encourage policy makers to address such issues as consistency with the parent institution's policies, regular policy review and consistency with antidiscrimination laws. The criteria also recommend against antibody screening of prospective or current students and faculty members, but assurance of complete confidentiality for HIV-positive students, faculty or staff members.

Definition of Terms

To identify groups involved in this study and to avoid confusion, some definitions were established.

1. Centers for Disease Control (**CDC**): A major agency of the Department of Health and Human Services, with headquarters in Atlanta, Georgia, concerned with all phases of control of communicable, vector-borne, and occupational disease (Brown, 1992).

2. American College Health Association (**ACHA**): **Art organization in which** institutions of higher education and interested individuals may work together to promote

health in its broadest aspects for students and all other members of the college community (Burek, 1993).

3. **Practical Nursing Programs (PNP)**: The educational program for practical nurses which in most states is approximately twelve months long and is found in trade, technical, or vocational schools that are usually tax-supported public institutions, or in private schools. Theory is offered in the biological and behavioral sciences and nursing, in addition to clinical experience. Upon graduation, the practical nurse receives a diploma or **certificate** in nursing and is eligible to take the NCLEX-PN examination to become a licensed practical nurse (Hewlett, 1988).

4. **Acquired Immunodeficiency Syndrome (AIDS)**: The occurrence of a **clinical** illness consisting of opportunistic infections (such as pneumocystis **carinii** pneumonia) and/or neoplasias (such as Kaposi's sarcoma) associated with immunodeficiency and caused by the human immunodeficiency virus (Durham and Cohen, 1991).

5. **Human immunodeficiency virus (HIV)**: The **etiologic** agent of AIDS (Durham and Cohen, 1991).

6. **Policy**: A definite course or method of action selected from among alternatives and in light of given conditions to guide and determine present and future decisions (Woolf, 1981),

Review of literature

The existing **literature** reveals very little regarding HIV/AIDS policies, and focuses primarily on attitudes and education regarding the disease. **Carwein** and **Bowles** (1988) found that 86% of baccalaureate nursing schools had no guidelines/policies for dealing with

the students who are infected with HIV or have AIDS. Furthermore, 49% of the schools had no plans to develop such policies. The same study also found that 66% of the schools believed another assignment should be made if a student refused to care for the AIDS patient. In dealing with HIV antibody-positive students who were not ill, 84 % felt students should remain in theory classes and 64% said they should remain in clinical. When asked about students diagnosed as having AIDS, 79% would allow theory attendance and 31% would allow clinical attendance. Of those who should be notified, 67% indicated the student health center, 41% said only nursing faculty in direct contact with the student, and 61% said the nursing school administration.

A more recent survey of postsecondary institutions with health occupations programs in Nebraska (Witmer, 1992) revealed that none of the schools' policies met all of the criteria set forth by the CDC and the ACHA. Three schools met nine of the twenty-one criteria and one met ten. Specific criteria that were addressed by 50% or more of the institutions included confidentiality (58 %), continued employment (50 %), reasonable accommodation (50%) and use of a committee process for policy development (50%). Witmer found that the policy item seldom addressed was the implementation of the policies. Witmer reported that if the policy was not implemented and not communicated to the people it was designed to serve, it was ineffective.

Chitty (1989). in an article which has served as a guide for policy makers, suggested processes and guidelines whereby policies appropriate for each school's unique circumstances can be developed. Chitty calls upon the deans and directors of the nation's schools of nursing to create task forces to deal with policy formulation and to equip them with the

resources **needed** to accomplish their task. Administrators are encouraged to select task force members based on their unbiased attitudes toward antibody-positive individuals. The task force should also include members with infection control, legal, and ethical expertise. Guidelines for the policy statement include consistency with the parent institution's policies and with recent antidiscrimination laws, regular policy review, statements on antibody screening of students, faculty and staff, **assurances** of reasonable safety in the clinical setting, and complete confidentiality (Chitty, 1989).

Methodology

The research methodology chosen was a self-reporting survey. The research tool utilized was a questionnaire. The population consisted of the 24 practical nursing programs in Indiana as listed by the Indiana State Board of Nursing (1993). There were no previous data available from the state of Indiana or from practical nursing schools. The self-reporting survey questionnaire was used to obtain data for criteria analysis from Indiana only. **All** 24 practical nursing programs were used to create valid results. It was assumed that the administrators of the practical nursing programs would be willing to share their policy documents. The second assumption was that the administrators would be honest in their responses.

Questionnaire

The survey instrument used in this study consisted of three sections. Section I requested respondents to answer 26 questions regarding current policies and procedures concerning infectious disease. The questions were **all** "yes/no" or "not applicable." Section **II** asked respondents to provide short answers regarding the process of policy development

and to list the titles of the policy committee members. Section III asked respondents to submit a copy of their institution's policy with the institution's **name** removed to ensure confidentiality.

The questionnaire was adapted, with permission, from one originally developed by Witmer (1992). This particular instrument was designed to ensure that the questionnaire was congruent with the criteria of the CDC and the **ACHA**. The time **needed** to **fill** out the questionnaire was approximately 15-20 minutes.

Data Collection

The questionnaires were mailed with cover letters and self-addressed stamped envelopes to the 24 practical nursing schools in Indiana. Follow-up letters were mailed two weeks later. The results were recorded and maintained on a checklist. When a respondent indicated that a policy was in process but **did not** send a copy, a follow-up phone call was made to request a copy of the policy. Section **II** and **III** (short answer and submission of policy) were maintained separately and were compared to the criteria as set forth by the CDC and the **ACHA**.

Results and Discussion

Of the 24 surveys mailed, 13 (54 %) were returned. Eight respondents (62%) included copies of their policies and five programs (38%) did not. All of the submitted policies were deficient in meeting all of the criteria set forth by the CDC and **ACHA** (Table 1).

Table 1

Practical Nursing Programs' Policies and Matching Criteria

Criteria	PN Program												
	1	2	3	4	5	6	7	8	9	10	11	12	13
1	X	X	X	X	X	X	X	X	X	X	X	*	X
2	X	X	X	X	X	X	X	X	X	X	X	*	X
3	X	X	X	X	X	X	X	N	X	X	X	*	X
4	X	X	X	X	X	X	X	X	X	X	X	*	X
5	X	X	X	X	X	X	X	X	X	X	X	*	X
6	X	N	X	N	X	X	X	X	X	X	N	X	X
7	*	N	X	X	X	X	X	N	X	X	X	X	X
8	X	N	X	X	N	X	X	*	X	X	X	*	X
9	X	N	N	N	N	N	N	N	X	N	X	*	N
10	X	N	N	N	N	N	N	N	*	*	N	*	*
11	X	N	X	X	X	X	X	X	X	X	X	X	X
12	X	N	X	X	X	N	X	N	X	X	X	*	X
13	X	N	X	N	N	N	N	N	X	X	N	*	X
14	X	N	X	N	N	N	N	X	N	X	N	*	X
15	X	N	X	X	N	X	X	X	X	X	X	X	X
16	X	X	X	X	X	-	X	X	X	X	X	X	X
17	N	N	X	X	-	X	N	*	X	X	X	*	X
18	X	X	X	X	X	X	X	X	X	X	X	*	N
19	X	X	X	X	X	X	X	X	X	X	X	X	X
20	X	X	X	N	X	X	X	X	X	X	X	*	N
21	N	N	X	N	X	N	X	X	X	N	X	*	X

Key

X = Criterion met

* = Not applicable

N = Criterion not met

- = Not answered by respondent

The average number of criteria met was 15 of 21. Two schools met 19 (90%) of the criteria. An additional three schools met 17 (81%) of the criteria. Of the returned questionnaires, 11 (85%) met 10 or more of the criteria (Table 2).

Table 2

Number of Institutions and the Number of Criteria Met

Number of Institutions	Number of Criteria Met
2	19
1	18
3	17
1	16
1	15
1	14
2	13
1	8
1	4

All respondents (100 %) believed their policies were adequate (including the **program** that did not have a policy). The one program that did not have a policy for infectious disease, inclusive of AIDS, stated that they had no plans to develop such a policy.

Three (23%) of the policies stated specific procedures to follow in the event a student refuses to care for an HIV-positive client. This finding is problematic since refusal is not congruent with the Nurses Practice Act and could lead to potential problems. Chitty (1989) suggested that additional information, counseling, and support are needed as initial responses to student refusal; for those unable to overcome their anxieties, **re-evaluation** of career objectives should be part of the counseling process.

Only five (39 %) policies addressed the issue of continued employment or student status of HIV-positive individuals. Similarly, five policies provided for reasonable accommodations for the HIV-positive employee or student. Because persons with AIDS are now considered **legally handicapped**, the policy should comply with recent interpretations of Sections 503 and

504 of the Rehabilitation Act of 1973, which prohibits discrimination against handicapped individuals (Chitty, 1989). These issues are considered to be basic civil liberties.

Concurrent with these civil liberties is the issue of confidentiality. This study found only nine (69 %) of the policies required that the identity of any client, student, or employee who is HIV-positive be kept appropriately confidential. Policies should minimize the number of persons with access to such information, specify how confidentiality should be insured, and outline penalties for breach of confidence (Chitty, 1989).

Eight (62 %) of the policies were developed through the use of workshops on HIV/AIDS policy development. Policy-making committees included individuals from the areas of nursing, education, administration, radiology, phlebotomy, and infection control. Three of the respondents (23 %) had no idea who developed their policies. In support of Chitty's recommendations, there is an obvious need to include not only members with infection control, legal, and ethical expertise, but also those free of overt bias toward HIV-positive individuals. For optimal functioning, no more than five committee members should be chosen. Others can be consulted as needed (Chitty 1989).

Witmer (1992) posited that whether the individuals involved in the policy-making committee are utilized as actual members of the committee or as consultants, the lines of communication must remain open. The composition of the committee, the policy-making process, and the resources utilized must be shared with the individuals affected by the policy. The policy should be discussed by the entire faculty, student representatives, and the school's external constituencies--such as its policy-approving bodies, affiliating agencies and local

AIDS advocacy groups. The discussions and interactions that occur during the promulgation of such policies are an integral and irreplaceable part of the process (Chitty, 1989).

Nine (69 %) of the policies specified faculty must stay informed about HIV infection and serve as role models for students. In addition, three (23%) policies did not provide for on-going review of the policies based on new information received. Appointment of an HIV information coordinator, who is responsible for staying abreast of current CDC directives, can facilitate dissemination and integration of new information. This individual may also be charged with oversight of the AIDS-related curricula additions (Chitty 1989).

Twelve (92 %) policies stated mandatory testing for HIV antibodies should be required. However, mandatory screening can be considered discriminatory and is not currently recommended by the CDC for prospective or current students, faculty members, or staff members (Chitty 1989).

Three (23 %) policies did not address students mastery of appropriate techniques and skills before caring for a client in the clinical setting. Requiring students to master techniques and skills, such as the CDC's universal precautions, may alleviate student fears and anxieties as well as protect students and clients from the transmission of an infectious disease.

Conclusions and Recommendations

The findings of this study show the majority of practical nursing schools in Indiana have developed and/or implemented HIV/AIDS policies. Although this number is higher than the Bowles and Canvein (1988) study of registered nursing schools in the United States, none of the policies appear to meet all of the criteria set forth by the CDC and the ACHA. All but

one of the practical nursing **programs** reported no specific incident had precipitated the development of their policies. Thus, the majority of practical nursing schools are demonstrating accountability and responsibility by **being** proactive in establishing HIV/AIDS policies.

The communication process between administrators, educators, students, and the policy-making committee appears to be weak. Some policies are apparently being implemented without the administrators and educators being informed about the policy-making process or the composition of the committee.

As previously stated, many HIV/AIDS policies in the **practical** nursing schools are lacking key elements. Therefore, the following recommendations are provided.

1. Conduct workshops for administrators and nursing educators on HIV/AIDS policy development.
2. Publish the **HIV/AIDS** policies in student handbooks and related publications (i.e. ,faculty handbooks).
3. Provide routine educational in-services for **healthcare** educators on HIV/AIDS and make continuing education a necessity,
4. Counsel students who refuse to deliver care to known AIDS patients regarding the appropriateness of their career choice.
5. Prevent possible litigation by addressing issues considered to be basic civil liberties; such as confidentiality, the right to work, and the desire to continue employment as long as health and ability permit.
6. Explain the policy development process to administrators, educators, and students.

7. Share the criteria for evaluating HIV/AIDS policies with **all** programs.
8. Require mastery of appropriate techniques and skills (i.e., universal precautions) by students before caring for a client in the clinical setting,
9. Review policies on a continual basis as new information becomes available.
10. State specific testing procedures for situations with occupational exposure to infectious disease.

Limitations

Caution must be taken in **generalizing** the findings of this study. The research was conducted in a predominantly rural state with a low incidence of HIV/AIDS, which **litnits** its **generalibilit y** to other states. Another limitation is the status of the practical nursing programs with the Indiana State Board of Nursing. One program is no longer accredited and accreditations for two other programs are pending.

In conclusion, situations with the potential for conflict and litigation can be prevented by a proactive approach in HIV/AIDS policy development, implementation, and scheduled review. Policy implementation not only provides for a sense of security for the responsible officials in an institution, but also sends the vital message that current and continuing education about this frightening disease can be accomplished (Witmer, 1992).

The responsibility for HIV/AIDS policy development does not rest solely with the deans and directors of the schools of practical nursing. Practical nursing educators at every level must take responsibility to help create AIDS policies **in** every school. Currently, education is the key to preventing the spread of the **disease--to** provide the most appropriate care for the HIV/AIDS patient and to create a safe environment for students and faculty.

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