NURSING EFFECTS IN POLICY-MAKING

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ABSTRACT
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Nursing effects in policy-making is a qualitative interview study about the effects of nursing as a professional entity in the policy-making process. The framework of the study included exploration of a perceived problem that nursing does not communicate effectively within the larger health care community. The research question asked was: What are the effects of the nursing profession in the policy-making process?

The question was answered through in-depth interviews with eight influential nursing leaders, and two non-nurse health care leaders. Respondents were chosen because of demonstrated excellence or leadership positions, political positions, non-traditional nursing experiences, attachment to service ideals, and/or outspokenness in nursing issues. The research question evolved into exploration of nursing effects, and effectiveness, in three broad categories: education, “professional politics,” and health care. The major findings of the study were:

1) The culture for change in nursing education is polarized by disparate professional entry positions, faculty issues and inadequate course development;
2) The innovative policy-making abilities of nursing as a profession are severely compromised due to internal dialectical tensions and contradiction; and
3) Nursing’s effect on national health policy-making has suffered, primarily because of a lack of understanding about economics, an unclear political mandate, and a failure to be bipartisan.
The recommendations include the continuation of two-year nursing programs, held to high standards of clinical training. Four-year programs, however, should move out of clinical nursing, to provide a liberal arts baccalaureate degree in a health services or nursing management specialty. In the model recommended, the four-year degree does not lead to becoming a RN, but instead provides a path to graduate training in administration or advanced clinical practice. Other recommendations regarding changes in accreditation, national organizations, faculty training, and managed care are outlined.
# TABLE OF CONTENTS

**TABLE OF CONTENTS**

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>1 - 11</td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>1</td>
</tr>
<tr>
<td>Theoretical Sensitivity</td>
<td>4</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>6</td>
</tr>
<tr>
<td>Limitations of the Study</td>
<td>7</td>
</tr>
<tr>
<td>Overview of this Project</td>
<td>8</td>
</tr>
<tr>
<td>BACKGROUND</td>
<td>12 - 29</td>
</tr>
<tr>
<td>Nursing</td>
<td>12</td>
</tr>
<tr>
<td>Health Policy</td>
<td>22</td>
</tr>
<tr>
<td>REVIEW OF THE LITERATURE</td>
<td>30 - 55</td>
</tr>
<tr>
<td>Education</td>
<td>31</td>
</tr>
<tr>
<td>Professional Politics</td>
<td>39</td>
</tr>
<tr>
<td>Health Policy</td>
<td>43</td>
</tr>
<tr>
<td>Summary of the Literature</td>
<td>52</td>
</tr>
<tr>
<td>METHODOLOGY</td>
<td>56 - 80</td>
</tr>
<tr>
<td>Phenomenology</td>
<td>57</td>
</tr>
<tr>
<td>Grounded Theory Methods</td>
<td>58</td>
</tr>
<tr>
<td>Research Process/Question</td>
<td>60</td>
</tr>
<tr>
<td>The Sample</td>
<td>62</td>
</tr>
<tr>
<td>The Interviews</td>
<td>70</td>
</tr>
<tr>
<td>Organizing the Data</td>
<td>71</td>
</tr>
<tr>
<td>The Data</td>
<td>77</td>
</tr>
<tr>
<td>Data Verification</td>
<td>80</td>
</tr>
</tbody>
</table>

i.
INTRODUCTION

You can only lead others where you yourself are willing to go.
- Lachlan McLean, Production Superintendent,
  Australian Paper Manufacturers

This is a document about the effectiveness of nursing as a professional entity in policy-making. These days, one can scarcely pick up a newspaper without reading something about health reform efforts in the United States. Constant debate is at hand about the benefits and drawbacks of private insurance versus a universal system, or managed care. Nursing's most visible response has been a call to increase the number of advanced practice nurses to care for patients in a more cost-effective fashion than doctors, and to break the mold that the traditional medical model dictates, which includes physicians as the gatekeepers of services. Just what is the scope of nursing's responsibility in relation to health care in the US? Can it contribute more than it does, and if so, how? Furthermore, what are some of the internal issues in nursing that distract it from dealing with broader health policy issues or, as some would claim, threaten its very existence?

STATEMENT OF THE PROBLEM

A root problem for nursing, many maintain, is lack of a professional voice to refresh itself, to re-examine current directions, and to communicate effectively within the larger health care community. In the context of health policy-making outside of its own circles, nurses are generally not taken seriously beyond the bedside. Meanwhile, inside the profession, too few nurses are finding a voice to speak the truth as they see it, in a way that is unafraid of unpopularity within the profession. This raises a question about the ability of nursing as an entity to find a collective voice, and to be prepared to use it to advance the profession toward new goals. Many nurses feel that nursing leadership (individuals with influence
and nursing organizations) is outdated, rigid, and ineffective. Some think that the process of recognition for professional and educational excellence is out of sync with modern times, or too inbred to find solutions to long-standing problems and present challenges. The concern is that nursing may not find a concerted voice to communicate how it might possess the potential to resolve many of the dilemmas facing health care delivery in the United States, nor how nurses may establish themselves as statesmen in health policy, instead of as lobbyists in the legislative policy arena.

The profession of nursing spans all health care settings. Everywhere in nursing literature, journals, and trade associations, the talk is of the need for leadership in this unprecedented environment of opportunity. In an era of health system changes, nursing has tried to stake out its territory within the advanced practice arena (for example, nurse practitioners). Consistently, talk gets back to the need for leadership, and the need for a courageous effort by nursing leaders to propel the profession to new heights. Meanwhile, primarily in populous urban areas, nurses are experiencing hospital layoffs for the first time in years. A cover story in Hospitals & Health Networks (Lumsdon, 1995) featured nursing in an article “Faded Glory: Will Nursing Ever be the Same?” The title of the article speaks for itself. In the article, the potential quality problems that could result from layoffs were acknowledged, but in it nursing was also noted for bickering, union activities, and the splintering of its national associations. The question was also raised by some long-time nurse constituents about the difference between fighting for quality care and simply protecting nursing’s turf.

Nurses, largely because of unions, have made strides in their economic and general welfare in hospitals. However, nurses (and therefore nursing) have also been successful at beginning to price themselves out of the health care marketplace. Many hospitals are rapidly replacing staff nurses with less expensive care providers. Nurses continue to argue
that this as an issue about the quality of patient care, but with little or no data to prove that less expensive nursing substitutes negatively affect patient outcomes, nursing positions will most likely continue to be expendable. The future for nursing may not be in the envisioned success of advanced practice nurses, nor with the production of more nurses with a four-year baccalaureate nursing degree (instead of the growing two-year associate degree). The real issue for nursing as a professional entity is not about arguments with hospital administrators over staffing either. It is about the broader strategic position of nursing within the legislative policy arena and within the health care system as a whole.

Nursing as a professional entity has come under criticism both internally (within nursing), and externally (by others in health care), for inflexibility and generally not keeping pace with current times in health care. One national organization, the American Nurses Association (ANA), responds that nursing is only trying to protect patients and patient care from harm. As managed care has become more prevalent, nursing has opposed it (managed care) because budget cuts have resulted in some nurses being laid off. Increasingly, hospital administrators are cutting nursing positions and replacing nurses with substitutes who have less training. Nurses offer plenty of anecdotes about the near misses this causes in patient care, but there is little direct evidence yet that the quality of hospital care is suffering at the hands of redesign.

This document will answer questions about why nursing as a professional entity seems conflicted in finding its collective voice. The assumption is that the answer lies in the formation of policy within the profession itself, within its policies about nursing education, and its own internal politics. Policy is defined on three levels: 1) political wisdom or
cunning; 2) wise, expedient, or prudent conduct or management; and/or 3) a principle, plan, or course of action, as pursued by a government, organization, individual, etc. (Neufeldt, 1988). These definitions form the basis for the questions that were asked in ten interviews conducted for this research project. The answers will provide insight into new directions for the profession to consider. The study intends to find the reasons for a real, or a perceived, loss of voice by nursing through the experiences of those interviewed, coupled with the researcher's own experience.

Many problems in nursing seem to be brought on by the profession itself. For decades, nursing has been unable to agree on one standard of education for entry into practice. To a large degree, the leadership of professional organizations already has the answers, and proclaims, for example, that a four-year education is the preferred entry into practice point. However, because of membership diversity in educational preparation, decisions about a firm stand carry financial considerations (loss of members). Unionization has been an internally divisive issue too, leaving many conflicted about the benefits of collective bargaining versus a perceived loss of professionalism by virtue of being associated with the AFL-CIO.

THEORETICAL SENSITIVITY

Methodology will be discussed in Chapter Three. However, theoretical sensitivity refers to the investigator's knowledge, so it is defined here as an opportunity to introduce the researcher. In grounded theory methods (aspects of grounded theory were used in this study), the understanding and skill of the researcher is necessary to foster the relevance
and fit of the data (Glaser, 1992). Conceptual insight provides depth and meaning to the data. The problem at hand, namely the future of nursing in the US health care system, is a source of both passion and pain for the researcher. Her experience spans 20 years of nursing, including staff nurse positions, to the Associate Director of the Community Health Accreditation Program (CHAP) at the National League for Nursing (NLN), to Chief Executive Officer of a Visiting Nurse Association, and most recently as an entrepreneur in home health care outcome studies. The researcher has witnessed countless episodes of nursing policy and politics. While the opportunities have been tremendous, at times the notion of becoming a “former nurse” also occurred because the perceived image of being a “nurse” was not necessarily helpful in obtaining executive positions outside of traditional nursing domains, and sometimes appeared to be a liability. Two persistent questions emerged: 1) Why is nursing not perceived to be powerful beyond the bedside to some people, and 2) Has a desire to forgo a nursing identity also occurred for others with similar career experience? If so, then what could be done to repair the damage (real or perceived liability) before more nurses experience the same thing? Are there ways nursing could become more powerful in perception and in reality? The researcher sought to know during interviews with ten respondents what they thought about these questions, and what could be done to improve the status (and the actions) of nursing intraprofessionally and extraprofessionally.

To be effective in nursing leadership, one must be prepared to leave nursing in order to be able to come back to it. New ideas or change may be unpopular at first. Leaders are required to provide conclusions and ideas that may be far too radical for mainstream
nursing. While most would prefer not to be ex-communicated from the profession, it needs to be embraced as a possibility. By breaking out of the mold of traditional nursing during her career (through administrative positions and starting her own company) the researcher has had the opportunity to look outside of the confines of the nursing profession and into the world of business and politics. The benefits of being a nurse always included being associated with the care and service to people. The challenges encountered included the need to “self-teach” many executive level skills, such as a business and political acumen. It could be argued that this is true in all professions and that higher level executive skills only come from experience. This study does not dispute that fact. Rather, it is an examination of the effectiveness of nursing policies that may instill the values and expectations necessary for nurses to grow into executive and policy-setting positions.

PURPOSE OF THE STUDY

The purpose of this study is to provide a contribution to the knowledge of nursing about itself, and to positively serve the profession. While the writing is sometimes critical of nursing, it is written out of the desire to contribute ideas that may preserve nursing as an important piece of the health care system. Nurses are typically a patient’s or patient family’s only link to knowledge about disease states, and negotiation of the medical system. Nurses, during the course of caring for patients, often provide the most memorable aspect of the health care experience, because of their (nurses) specialized knowledge, compassion, and genuine caring. This component of the nation’s health care system is worth preserving. While people exist in a data driven, numbers, and definition riddled society, it is the softer aspects of caring for fellow human beings that are often regarded as expendable. It is here that some of the researcher’s statements about what nursing does, and what she believes it needs may appear to be in conflict. However, it is
exactly to preserve this aspect of patient care that she will passionately challenge the profession. To preserve what is already known to be the best of nursing, the soft and more caring side must be complemented with the data driven, mostly cold business side. While the public may initially voice outrage if nursing services disappear in favor of less expensive substitutes, that outrage will soon turn into a whisper if out-of-pocket dollars are saved in health care premiums. This would clearly be misleading if promoted by insurance companies, when the cost effectiveness, especially of advanced practice nurses over physician care can be demonstrated. But realistically, if the American Medical Association (AMA) has its say, nursing’s role in a reformed health system would be minor at best, and would most likely keep nursing in a subordinate role to doctors. Therefore, if the value and efficiency of nursing is not strongly visible in the health economics debate, society stands to lose the cost effectiveness of nursing services, including the benefits of nursing “care” that are not so easily explained or quantified.

LIMITATIONS OF THE STUDY

What if nursing does not want to change? What if the public sees no need to go beyond existing acknowledgment, and the majority of the nursing profession is happy where it is? Change and reform do not come easily to any group, and nursing is no different. The concepts that will be presented are not intended to be negative. Rather, they are intended to speak the truth, and to provide a voice that may gather momentum if others choose to speak along similar lines. However the study has limitations. The perspective of the researcher and the expressions by the respondents represent a small sample and cross-section of nursing. Respondents were selected who most likely had experiences that exposed them to policy, politics, and politicians on levels outside of the traditional nursing
experience. They were selected as representatives because they traveled on paths that were, for one reason or another, extraordinary. This sample may not be considered representative of a majority of nursing, or reflective of majority views. Furthermore, this is a qualitative interview study and the reflective bias of the researcher, based on her experience, cannot be generalized outside of the evidence presented. A further limitation of the study is that it represents white nurses, and does not explore the relationship of race and class in nursing. Gender issues were not explicitly explored with the respondents, even though gender may be a reason for lack of power and influence. It could be that some or most of any discord in nursing is due to internalized oppression that is gender related, which is also a study limitation. The study provides a glimpse of the lived experiences of the respondents. Those reading this document will judge its merits and validity.

OVERVIEW OF THIS PROJECT

The question asked in the study was: **What are the effects of the nursing profession in the policy-making process?** The Project Demonstrating Excellence (PDE) will provide a critical look at nursing as a professional entity, to assess its effects in the policy-making process. In the researcher’s experience, and in the experiences of the respondents interviewed, it was clear that there is plenty in nursing that is not working very well in relation to the research question posed. While the nursing profession has many of the answers already to address its internal issues of entry into practice, and the need to position itself as a cost-effective solution in health care, it has suffered a fundamental
inability to implement solutions. To assume an effective voice, nursing as an entity must examine its own processes for policy-making to become more influential in national politics. Influence and power are still lacking in nursing’s efforts toward health reform, as well as in the bipartisan relationships so important to Capitol Hill politics. At the conclusion of this study, the reader will witness a snapshot view through the eyes of prominent experts about the current state of nursing, about issues that beg for resolution, and about nursing’s hope for the future.

The PDE is organized into seven chapters:

Chapter One. The Introduction introduces the problem, and the issues that the PDE will address. It discusses the project’s relevance for nurses and the public in general. It provides a description of how the researcher came to be interested in this topic, and the purpose of the study. It discusses the limitations of the study, and states the research question.

Chapter Two. The Background about Nursing and Health Policy chapter addresses the history of nursing and some of its current issues. It also provides a substantive discussion about the current health policy environment in general. This will help to put the study into context for readers who are not familiar with nursing and health policy issues, and will be important to read before proceeding with the rest of the study.

Chapter Three. The Literature Review will answer how this project fits with what is already known in the field of nursing. It provides the information available in the literature
about the question of nursing effects on the policy-making process. The literature is reviewed within the broad categories about policy-making and nursing that emerged from the interview data. These broad categories are policies in education, "professional politics," and health policy.

Chapter Four. The Methodology chapter describes how the data was collected, what the data was, and how sampling decisions were made. The characteristics and backgrounds of the respondents are described. Appendices contain the interview questions, inquiry letters, and consent forms. The relationship of the methods to the research question is provided, and how the question changed over time. The organization of the data is presented, including how the categories, properties and patterns were identified.

Chapter Five. The Findings chapter provides the final conceptualization of the data. The findings are organized according to the three broad properties that emerged from the interviews - education, professional politics, and health policy. For each broad category, a research claim is made, evidence from the data is presented, and then warrant statements about how the data support the research claims are made.

Chapter Six. The Discussion will give an analysis of the data presented in the findings. It reflects on the understanding and interpretation of the findings by the researcher. It is more intuitive than mechanical, and it attempts to make sense of the findings presented.
Chapter Seven. The Summary and Conclusions reflect on the original question and discuss how the data presented tie back to it. This chapter addresses the research tasks that were accomplished, and provides a future nursing model. It summarizes the primary research findings. Finally, it provides the conclusions of the researcher and questions for future research.
BACKGROUND: NURSING AND HEALTH POLICY

Where there is one nurse with a missionary spirit...there are forty-nine others who are obliged to make the humiliating confession: "I am a nurse because I must earn a living for myself and those dependent on me, because my nursing is well-paid, honorable, and to me, interesting."


NURSING: HISTORICAL TRENDS/CURRENT ISSUES

Issues around professionalization have been hotly debated among nurses for years. Most frequently, this is a debate between supporters of four year nursing programs as the point of professional entry, and supporters of two year programs that feel the Associate Degree should be sufficient to garner professional status. Another group of nurses from hospital Diploma (three year) programs, participate in the same debate. However, three-year programs have all but been eliminated over the last twenty years, and have been replaced for the most part with Associate Degree programs. To state licensing boards, a two or three year Registered Nurse (RN) is given the same license to practice as a four year RN. Perceived resistance to professionalization by not supporting the four-year degree as the professional entry point, is an expression of an occupational culture that developed in nursing outside of the professional associations. As leaders in nursing looked outward beyond the work experience, and into a broader social context and implication, some nurses felt threatened by the strategies adopted for rising standards of professionalization because that often meant downgrading those with less education.
In the early and mid 1900’s, it was a shared experience in nursing, not the hope of professionalization, that shaped ordinary nurses’ aspirations and ideology (Melosh, 1982). Rooted in the apprenticeship tradition of the hospital schools, nurses’ work culture valued careful craft methods, practical experience, and self-control. The was nursing’s mainstream; professional ideology was an influential but minority position, even an aberration. Many dissenting nurses felt that professional values represented the erosion of nursing’s traditional commitment to service. The word “profession” was used to denote paid work, and it was associated with narrow and self-seeking ambitions, while others argued that they were actuated by higher motives, even a ministry. Nursing was viewed by some as selfless women, nurturing mothers—not experts.

Even earlier, toward the end of the 19th century, as a way to bring health care to the slums of an urbanizing nation, community public health nursing (outside of institutions) became a prestigious service. These nurses had far more autonomy than hospital or private-duty nurses, and they became a nursing elite, along with nurse educators. By 1938 there were more that 19,000 public health nurses in the United States (Friedman, 1990). However, the shift of care from the home to the hospital competed with public health nursing’s non-institutional focus, and community nursing lost much of the power it had garnered in earlier decades.

By World War I, nursing experienced burgeoning growth, and was widely accepted as the province of experts. Wartime shortages and the ravages of influenza brought a vocal public demand for more trained nurses. At the same time, leaders lost control over the
management and mission of the schools. New programs were not established under careful guidance. Instead, hospital schools were set up to demonstrate the value of a trained worker, and hospital administrators seized on student nurses as a permanent source of labor. Training was given in return for two or three years of ward work. The leaders of this generation, Adelaide Nutting, Isabel Maitland Stewart, Lillian Wald, Isabel Hampton Robb, Lavinia Dock, were all firmly committed to a college education for nurses (Melosh, 1982, p. 34). As these famous names emerged, they were all affiliated with prestigious nursing schools, and shared little with the thousands of nurses trained at less elite institutions (Friedman, 1990, p. 2854). Many hospital graduates resisted standardization of education and practice, defending themselves against upgrading to a college level that would devalue their own skills and their hospital school diplomas.

The 1948 report, *Nursing for the Future* (Brown, 1948) marked a critical divide in nursing history. The report embodied the professional aspirations of nursing leaders and signaled the postwar intentions and direction of the professional associations. The report boldly asserted the goal of baccalaureate education for nurses, and most important as a turning point, it proposed removal of diploma schools (3-year hospital programs) from nursing's future. The report proposed a new hierarchy within nursing, with the “professional” or baccalaureate nurse on top and the “technical” nurse or hospital graduate as the subordinate. Some nurses strongly resisted the notion of collegiate liberal education, and believed that valuable technical skills would be lost in theoretical studies. The recommendations of the Brown report were never officially voted upon by the American Nurses Association or the then National League for Nursing Education, yet the report
became the basis for a new classification and accreditation program. Until 1971, the 
Diploma schools (three years) continued to graduate more new nurses than Associate 
programs (two years) and Baccalaureate programs (four years) combined. Even as late as 
1974, 76 percent of all active nurses held Diplomas from hospital schools (Melosh, 1982, 
p. 39). In 1992, the percentage of all active nurses holding diploma degrees was 33.7% 
(Kelly and Joel, 1995, p. 235). The reason the percentage became so much lower is 
because many Associate Degree or Diploma nurses returned to school to obtain 
Baccalaureate degrees.

Today, the dilemma in nursing continues between the need for technical skills of a 
practitioner (two and three-year programs) versus the need for theoretical knowledge 
(four-year programs) in becoming a practitioner.

A project aimed at developing nursing education programs in junior and community 
colleges was announced in January 1952 by Louise McManus, director of the Division of 
Nursing Education at Teachers College, Columbia University (Kalisch, 1986, p. 646). 
The purpose of the experiment was to determine if a two-year program, which would 
prepare bedside nurses for beginning, general-duty positions, was feasible. Such an 
approach would help reduce the critical shortage of nurses in the nation by producing 
more nurses faster. It worked. At the conclusion of a five-year study by Mildred Montag, 
the project coordinator, Associate Degree (AD) graduates were found by head nurses to 
be as good as or better than most of the graduates with whom they worked in 80 percent 
of the cases (p. 647). AD programs are two years in length and are typically offered by
junior or community colleges. Because AD nursing has been identified as technical
nursing practice, the description of technical practice is controversial because it is
considered to be a step down from the professional label that has been attached to all
nurses through licensing definitions and common usage over the years (Kelly, 1991, p.
264). AD programs are the fastest growing segment of nursing education, and will be an
important part of the nursing scene for years to come.

Nursing education became increasingly integrated into academic settings during the late
1960s and early 1970s. During the 1970s, it became too costly to operate an educational
program in a hospital, in which income for the operation of the school was derived in a
large part from patient revenues. Limits placed on allowable expenses by third-party
reimbursement agencies probably had a greater impact on closing hospital schools of
nursing than any other single factor (Kalisch, 1986 p. 705).

In 1965, the ANA precipitated an ongoing controversy when it issued its first Position
Paper on Education for Nursing (Kelly, 1991, p. 64). It stated that education for those
who work in nursing should be in institutions of higher learning, that minimum education
for professional nursing should be at least at the baccalaureate level; for technical nursing,
at the associate level; and for assistants, in the vocational setting. This battle is still a
divisive force in nursing. How much and what kind of clinical experience prepares nurses
best? The trend toward accepting baccalaureate education as the entry point in nursing
education continues. Although there seems to be little disagreement on the qualities,
knowledge, and skills nurses need, there is almost no agreement on how much of each and what level of competency is needed at graduation.

The beginning of the nurse practitioner movement (advanced practice nursing) has been divisive as well. Many nurse practitioners and other advanced practice nurses have master’s or higher degrees. The advanced practice nurse (APN) is an umbrella term used for nurses who have completed specialized education and experiential requirements beyond the basic nursing program. Today, preparation to practice as an (APN) requires the knowledge, skills, and supervised practice that can only be obtained through graduate study in nursing (master’s or doctorate). The APN includes the roles of the clinical nurse specialist (CNS), nurse practitioner (NP), nurse midwife, and nurse anesthetist. (Kelly and Joel, 1995, p. 319). There were nurses who feared advanced practice as pseudomedicine (nurses emulating doctors), and detracting from pure nursing professionalism. While many issues remain unresolved, the majority of state boards of nursing have now been granted the right to develop administrative rules and regulations for the nurse practitioner (NP). Prescriptive authority is an issue that is dealt with on the state level, as well as legal approval for third party reimbursement. The focus for these activities is on NPs, nurse-midwives, nurse anesthetists, and other kinds of nurse specialists. Certification for specialties will grow, but there will undoubtedly be a battle about which nursing group has authority, because of frequent overlapping functions.

Principles applied to credentialing in nursing (licensure, registration, certification, educational degrees, accreditation, charter, recognition, and approval) are too lengthy, and
frankly too confusing for the purposes of this study. They are mentioned here to make a note of the ongoing disagreement and/or confusion among nursing organizations, and their respective roles (and power) in the process of the granting of credentialing authority. Styles (1989) presented a comprehensive study on nursing specialties, that concluded with the recommendation for a National Board of Nurse Specialties to review and approve specialties and their certification programs. In 1991, the American Nurses Credentialing Center (ANCC) became a separately incorporated subsidiary of the ANA. Credentialing issues have been the basis for the creation of many nursing specialty groups. Currently, about 200,000 nurses are certified by the ANA or a nursing specialty organization (Kelly, 1991, p. 448).

Reverby (1987) contends that nursing's contemporary difficulties are shaped by the factors that created its historical obligation to care in a society that refuses to value caring. Nursing developed within the cultural expectation that caring would be part of a woman's duty to family and community. This transcended the hospital setting and limited nursing's ability to control or define its own future. Like Melosh, Reverby says that historically many in the nursing workforce were less convinced that problems stemmed from low educational standards and the need for professional status, and that the primary difficulties were seen as lack of respect for individual skill and efforts. To these nurses, the leadership's strategy (to force four-year education for professional entry to practice) was inappropriate, irrelevant, or threatening. In turn, hospital officials and physicians, who mainly saw the problems as caused by nursing's efforts to obtain professional autonomy, continually urged submission to their control.
Collective bargaining has proven to be a thorny issue for nurses. As unions gained power in the 1930's in the US, ANA's leadership created a committee on "Unions for Nurses" in January of 1937 (Reverby, 1987, p. 197). In June 1937, the ANA board voted against nurse membership in unions and urged nurses to use the professional association to improve their working and professional lives. Besides lower salaries, nurses received far fewer benefits than most other employees and often worked longer hours, which in many cases surpassed a forty-hour workweek. While the ANA equivocated, graduate nurses began to join labor unions in an effort to upgrade the status (and salary) of nursing positions. By 1946, the ANA, while disassociating itself from "labor unionism," formally sanctioned the concept of collective bargaining by state professional nurses' associations as exclusive spokespeople for their members in all matters affecting employment conditions and as their collective bargaining agents. However, passage of the Taft-Hartley Act in 1947 successfully blocked nurses' efforts to secure greater economic benefits by exempting nonprofit hospitals from the obligation to bargain collectively.

Labor unions not controlled by the ANA have become strong competitors to the nursing professional associations. Because of the belief that their professional association should represent nurses rather than outside labor unions, the ANA launched in late 1973 an aggressive campaign to organize the nation's 800,000-registered nurses. Several months later, in June 1974, two days before a record ANA conference crowd of more than 10,000 nurses gathered in San Francisco, 4,400 members of the California Nurses Association walked off their jobs. This strike attracted national attention and focused interest on the issues involved in collective bargaining. The ANA fully supported the strike. Six weeks
later, President Nixon signed into law amendments to the Taft-Hartley Act that permitted nurses in 3,500 non-profit hospitals to engage in collective bargaining (Kalisch, 1986).

Nurses and unions make for uneasy company by and large, but to their credit unions have had a big hand in lessening the debate over issues of staffing, layoffs and redesign. ANA and its state associations continue to compete with labor unions such as the Teamsters, or another union called 1199. Sometimes a nurse in a hospital pays dues or service fees to both the state association and the labor union. For example, even if the state nursing association (affiliated with ANA) is already representing the nurses in collective bargaining, the labor union can, through an election, win the right by a one-third vote to certify a new bargaining representative. In this case, the nurse may also choose to remain with the nursing association for “professional” reasons. The state nursing associations (SNAs) do the collective bargaining and it is also the SNAs who pay dues to the national organization (ANA). By joining the SNA, nurses automatically become members of the ANA. ANA eliminated the option for nurses to join ANA independent of membership in an SNA in 1982 (Kelly and Joel, 1995, p. 585).

The labor movement targeted hospitals and health care because they have not been traditionally well-organized about labor issues. Currently, only 17 percent of the nation’s nurses belong to unions (Lumsdon, 1995). However when 5,000 to 10,000 ANA supporting nurses march on Washington, DC, as they did in the Spring of 1995, protesting hospital layoffs and redesign, it does make a statement. At the same time, some question
the image of professional nursing status equated with demonstrators carrying placards and chanting "patients before profits."

Finally, the major accrediting body for all nursing schools is the National League for Nursing (NLN). Accreditation is defined as the process by which an agency or organization evaluates and recognizes an institution or program of study as meeting certain predetermined criteria or standards (Kelly, 1991, p. 255). Accreditation in this sense should not to be confused with individual credentialing of nurse specialists, which was discussed on page 17. Accreditation is a voluntary process, but it is the primary indicator that attracts students and faculty. The American Association of Colleges of Nursing (AACN) is an institutional organization, that most deans belong to, and there is growing disagreement among that group about who should set educational standards and accredit nursing programs. The current question is should ANA, NLN, AACN, or a new credentialing center control the accreditation of all nursing educational programs? Recently, the NLN has been under scrutiny by the Department of Education, and stands to lose its accrediting authority. While the three organizations publicly attempt to work out their differences (and their competition), considerable power and income is derived from activities related to accreditation, and each of them would like a substantial piece.
HEALTH POLICY ENVIRONMENT

To adequately examine the policy effects of nursing, a background of the current health policy environment is necessary. From 1992 - 1994 the American public seemed bent on debate about eliminating the status quo in health care. However, in the end, trust, the most fundamental ingredient for change was not present to win approval of major health reform. The primary dilemma in the social and political debate was one of values. What kind of value can be placed on human life, or extending it? It is difficult to argue the notion of supply and demand in the face of care for a dying cancer patient. And, when the discussion begins about “basic human needs” for health care or long-term care, providers of services are somehow expected to do their jobs in some part because of a love of it, and not in the assembly line spirit presumed to exist in non-service industries. At issue then, is allowing all health care workers, including the lowest salaried home health aides, to do the job they love of caring for people, and be able to make a good living doing so.

The electorate's desire for changes in health care may lessen the traditional dominance of physician provider groups in overall decision making. For years, physicians have enjoyed the virtual monopoly and prestige of being the last word in what is good for the health care of this country. These days, doctors have fallen from grace, and into a growing public skepticism colored by perceived greed. Once viewed as the most intimate of relationships, the doctor-patient level of trust has taken a noteworthy turn for the worse.

Often at odds in the country's system of health care is the attitude of many Americans who view health care as a basic right of all people, regardless of cost or ability to pay for it. Some would say that Americans suffer from terminal "entitlement." They want the best,
they want it now, and they do not want to pay for it. Perhaps this weakness stems from assumptions about the expectations of people versus real structural problems of health care access. The notion of solidarity as a society that values health, in relation to compassion about life and death are equally important to explore. Our culture gets conflicted between what is right and doing the right thing. Examples include issues such as balancing the right to die with the ability to keep someone alive.

The debate continues now about managed care, national health insurance, or retaining a fee-for-service mentality. Issues of competition remain in the forefront, and increasingly small providers are merging or being acquired by large conglomerates who claim to be more efficient. Managed care, once thought to be the solution to the country's health care cost crisis is coming under criticism for greediness, and for funnelling profits to administrators while cutting the quantity and quality of services to the consumer. Glaser (1991, p. 440) writes that competition increases the costs of the entire health sector, because of the increased cost of marketing (and administrators) to compete for market share, and disputes handled not by negotiation or government mediation, but by lawsuits.

During the Clinton Administration's attempt to reshape America's health care system, the national nursing organizations, especially the ANA, largely supported the endeavor because a larger role for advanced practice nursing was called for, and it appeared nursing would be solid within the emerging models of managed competition. The Clinton effort failed, and current policy debates now advocate an incremental approach of health reform. Lee and Benjamin (1994) identify incrementalism as one of five major dimensions of the health policy-making process. This supports the notion that policy is made in small steps, increments, and that policy is rarely modified in dramatic ways (evolution vs. revolution).
For now, however, the biggest issues in health care do not seem to be so much about how to restructure the system, but how to cut its costs. Medicare, now over 30 years old, is at the forefront of debate for cost cutting. At this point, the alternatives seem to be traditional fee-for-service versus managed care models of care delivery. Nursing has advocated for universal coverage for all Americans, and it holds itself out as one of the nation's most viable alternatives for providing cost-effective health care. According to the American Nurses Association (ANA, 1994), nursing's agenda must be guaranteed health care for all Americans, with direct access to a full range of services. The cornerstone of nursing's plan for reform in 1994 was the delivery of primary health care services to households, and individuals, in convenient and familiar places. The Agenda advocated increased use of advanced practice nurses, home services and case management, rooted in the patient-provider relationship. While the ANA's Agenda predicted considerable cost savings, it also wrote that any increased costs would be paid for through revenues derived from higher taxes (ANA, 1994, p. 475).

Efficiency has two important dimensions: 1) minimizing the cost of whatever services are provided, and 2) choosing the level, quality, and mixture of health services, relative to other goods and services that lead to the greatest excess of benefits over costs (Pauly, Danzon, Feldstein, and Hoff, 1992). An efficient system does not necessarily have the lowest cost. The correct focus is on how to achieve a system that enables and requires consumers to balance value and cost as they do in other sectors. Annual health care outlays are highly concentrated, with 1% of the population accounting for roughly 30% and 5% of the population accounting for more than half of acute care outlays (Aaron, 1996, p. 109). One change advocated to improve efficiency is the elimination of
employer covered health insurance, which is treated as tax-exempt income to employees, without limit and without regard to need. Employer covered health insurance encourages people to buy more insurance than they would otherwise purchase, thus fueling health care inflation.

Some people believe that many economists and policy makers are not grounded in reality when it come to planning health care reforms. In a recent book, Theda Skocpol (1996, p. 312) contributed a chapter and said: "In the face of political failures, moralists can simply redouble their shrill, absolutist cries for good versus evil, and technocrats can retreat to academia or to think tanks and continue working out perfect solutions for unnamed future politicians to adopt—without unforeseen consequences, for which the experts need take no responsibility."

Fuchs (1996) notices a tendency of economists to plant their feet firmly on the quantitative analysis of service industries, and to overlook the softer, more humanistic idea of services. Perhaps movement to a system of managed care, and insurance paid by the employee instead of the employer is the answer. It is not difficult to argue how the incentives would shift if consumers "felt" the payments for medical services received directly. However, there is a dichotomy between paying for service and knowledge of what those services are. If consumers directly purchase services, issues about what constitutes adequate knowledge to do so will undoubtedly arise.
A basic question to be addressed in the debate over changing the American health insurance system is whether the goal is simply (not so simple actually) to provide a means to control costs and increase access or to change the basic health care system. Much of the discussion around options seems to imply that changing the payment system will change the underlying system (Kane, 1995, p. 12). An important philosophical issue must be acknowledged which is responsibility to the collective good and the right to protect one's own interests. Americans are strongly predisposed to the latter. Wikler (1992, p. 5) argues for "the reconceptualization of the system as a whole as a health care system, as opposed to the present medical care system." This would involve primary emphasis on the non-medical determinants of health, such as poverty or lifestyle choices, which many have held to be far more powerful than health care, at least in the aggregate. However, one might be concerned that by making the provision, or the financing of health care primarily a government function, that a range of emotionally charged clinical issues – assisted suicide, abortion, sterilization - would be opened up to political meddling.

Health economist Paul Feldstein (1992, p. 56-57), claims that the purpose of a national health plan would be to redistribute wealth. He points to Medicare as an example of a massive redistribution of wealth that occurred in society. The beneficiaries were the aged and medical providers; the working population paid the bill. Medicare and Medicaid were designed to be both inefficient and inequitable, according to Feldstein, because they were in the economic interests of those with concentrated interests. To ensure that retirees would be eligible for Medicare, the unions insisted on Social Security financing. Additionally, Congress acceded to the demands of the medical and hospital associations to
create a cost-plus payment system (fee-for-service) that promoted inefficiency and limited competition. The result was a redistribution of the flow of money, that increased benefits to politically powerful groups (doctors, corporations, middle and upper class elderly), without having the beneficiaries pay the full costs.

Many believe the American system, for all of its flaws and greediness, is still the best system in the world, technologically. However, there can be no gain for society without some pain for individuals. Fuchs (1993, p. 162) states three possible routes to lower costs: reduce services, produce the services with fewer resources, or cut the prices paid to the resources. Each route involves pain. Physicians tend to boost patient demand for their services, and this helps to explain why an increase in the number of physicians in the 1970s and 1980s contributed to an escalation in health care costs. However, a limitation in the application of economics to health policy is apparent in the political and social domains. Limitations to policy arise from the fact that policy implies choices, and choices depend on values as well as analysis. One of the reasons why national health insurance has not been implemented in the United States is because Americans are not willing to obey centrally established rules for health expenditures. While candidates for public office loudly proclaim intentions to cover the uninsured while curbing runaway costs, their enthusiasm evaporates when they are confronted by the difficult choices necessary to achieve the objectives.

An important concept raised by Feldstein (1996) is the "Self-Interest Paradigm." The underlying assumptions of the Self-Interest Paradigm are that individuals, groups, and
legislators, act according to their self-interests and that legislation is a means of transferring wealth to those with political power from those without it (p. 196). In other words, groups and individuals including policy makers, act according to what will be to their own benefit. This may be in the form of re-election votes, subsidies, higher wages, increased market share, etc. The poor traditionally have no lobby, except to play on the conscience of the public. While a social conscience sounds good publicly, and politically, welfare plans often pass in the name of the poor when they are really promoting the prosperity of welfare workers and/or the legislators themselves.

Feldstein has two primary themes about the way that health legislation is created and enacted in this country. The themes belong to a theory of broad redistributive programs, either charitable or universal. Charitable programs are based on a desire of society to help the less fortunate. Most charitable programs are means tested for eligibility to receive benefits, and a prime example is Medicaid. Universal programs do not use income as a basis for determining beneficiary status. A prime example is Medicare.

The middle and upper class are not blameless either. While arguing for lower taxes, they have received the windfall of a huge tax subsidy in the form of tax-free health insurance, and tax supported higher education. State sponsored medical schools, and schools of nursing are heavily subsidized by taxes. The Self-Interest Paradigm takes in both producer and population groups. Producer groups are organizations such as the American Medical Association (AMA), the ANA or the AFL-CIO. Producer groups tend to use the political process to their own benefit, which may be at the expense of those with little political
influence. The self-interest role of producer groups (and labor unions) in promoting charitable redistributive programs cannot be underestimated.

Knowledge of the politics of health care legislation is crucial if nursing is to participate in reshaping America’s health care system. The complexities in the redesign of America’s system of health care are enormous. However, understanding the concepts of self-interest, in relation to nursing as a professional entity, and in relation to the care of patients, can position nursing in a pivotal role for future policy-making.
REVIEW OF THE LITERATURE

Although I am fully convinced of the truth of the views given in the volume,...I by no means expect to convince experienced naturalists whose minds are stocked with a multitude of facts all viewed, during a long course of years, from a point of view directly opposite to mine...But I look with confidence to the future, to young and rising naturalists, who will be able to view both sides of the question with impartiality.

- Charles Darwin

Nursing effectiveness in policy-making has been commonly identified as an important variable when discussing health reform, leadership, and the overall future of the nursing profession. To ascertain what is already known about the topic, relevant literature was consulted about nursing effects on policy-making in relation to health care at the legislative or regulatory level, education, and policy-making for leadership. Since leadership is such a broad category, the term “professional politics” was adopted. The term professional politics is defined in this study as issues of professional unity and collegial relationships among nurses and between organizations. Professional politics in this sense are revealed primarily in the attitudes of the “leadership” in nursing, which includes the heads of organizations and/or influential nurses. This is important to examine because of the tendency to equate politics with policy-making. Policy-making in education refers to policies about the preparation of nurses who will ultimately participate or lead in health policy formation. Policy-making in health care is directly related to the influence of nursing as an entity in the legislative and regulatory processes.

The literature was relatively rich in relation to nursing and policy-making within health care and education, but very little was found about “professional politics.” The primary
literature relevant to this category was found under the topic of leadership, therefore relevant literature pertaining to professional politics is generally discussed in the leadership perspective. There is some overlap between the notion of leadership as it relates to professional politics and education. Leadership in professional politics is viewed as actions or behavior of nurse leaders or organizations. Leadership within education has to do with the preparation of leaders within nursing education. This is not a literature review about leadership as a process; rather it is related to the notion of leadership in education, professional politics, and in a few instances, health policy.

The literature review on nurse policy-making is divided into the three aforementioned categories: education, professional politics, and health policy.

EDUCATION

The political awakening of nursing included the importance of health policy in nursing curricula (Cohen, Mason, Kovner, Leavitt, Pulcini, and Sochalski, 1996). The authors cite the need to integrate health policy and politics into the curriculum in such a way that it is no longer seen as an add-on (p. 264). In 1986, the National League for Nursing published a book that described how to integrate public policy into nursing curricula (Solomon & Roe, eds., 1986). In it, the study of health policy is defined broadly, including the instruments of power, politics and economic interests. In describing the importance of policy in chapter one, Maraldo notes that without better grounding in policy, “we will continue to send our graduates into a health care system that not only fails to appreciate
their ability to analyze and think but does not allow them to do so,” (p. 3). In chapter
two, Diers describes the study of policy as the study of decision-making (p. 8). She also
makes reference to the need to distinguish between policy and politics, and uses the move
to make the BSN the minimum qualification as an example of a long-standing nursing
issue that may have lost its policy goal to political interests. She notes, “if the policy goal
had been articulated, the legislature might not have been in the untenable position of
having to decide between future professional advancement and the votes of the 80 percent
of existing nurses who did not hold a BSN,” (p. 12). The book describes how to teach
policy and even provides a course syllabus that could still be relevant today. No recent
NLN publications on integrating health policy into the curriculum were found.

Anderson cites the need for nursing graduates to be able to think critically (Anderson,
1996), and says that clinical experiences should be redesigned to allow students to learn
about care across the continuum. She says nursing faculty must work to ensure that
graduates are prepared to understand and work with change. For community-based
nurses, a critical consideration in developing leaders is the ability to capitalize on
individual self-awareness, personal needs, interests, and self-esteem (Aroian, Meservey, &
Crockett, 1996). DeSimone (1996) proposes a method to strengthen transformational
leadership of students by incorporating perceptions of all course participants in the
curriculum of a nursing leadership course. Through transformational leadership strategies,
she intends to create change agents that can deal with complexity and uncertainty.
Students designed, implemented and evaluated a change project, supported by class
discussions to generate coping strategies for project difficulties. All students in the course
commented that team leading and mentoring were essential experiences to have as new graduates.

Broughn and Wang (1994) study the effects on the attitudes and beliefs of nursing students who take a feminist-oriented women's health course. The authors define feminism as, "both an ideology and a social-political movement for social change. As an ideology, it comprises a set of beliefs and values about women and gender relations. Fundamentally, feminism maintains that women are oppressed and that systematic injustices based on gender must be eliminated. As a social and political movement, it strives for social and political changes that would improve the lives of women and would promote gender equality in all facets of society (p. 32)." The authors propose that nursing education is uniquely positioned to use feminist teaching strategies to impart feminist principles for the purpose of empowering nursing students to more effectively deal with the problems encountered in the work setting. "It can be argued that traditional nursing education has not been and is unlikely to be able to help nursing achieve the full status of a profession," say the authors (p. 113). They suggest integrating feminist ideals and pedagogy into the entire nursing curriculum as a method to provide the impetus for change, and conclude that autonomy-related characteristics (e.g., advocacy and activism) are precisely what nurses need to thrive in the health care system.

Hussey (1996) comments on the need for nursing ethics in the educational process, and argues that the challenges to professional codes of conduct that result from social factors can guide the evolution of codes in response to wider social developments. He also notes
that in struggles to free themselves from the role of handmaidens to doctors, nurses need to exercise caution in their roles as patient advocates, and not become instead handmaidens to patients. "The skills and understanding required to identify moral issues, think about them clearly, and make reasonable decisions, are indispensable," he says (p. 257). Some knowledge of moral philosophy is necessary for the creation, continued development, and justification of codes of conduct in order to claim professional status according to Hussey, and since nursing does have a code of conduct, it will need to be prepared to deal with ethical dilemmas as it encounters situations of a moral kind.

Arthur and Baumann (1994) state that the half-life of most curricula is five years, which necessitates regular examination for both content and process. They state that the curriculum should be guided by the accurate identification of health issues arising from the community, but also caution against the tendency to address all issues, as opposed to prioritizing what the teaching staff deems important. The article provides a model for determining some of the essential components for nursing curricula, based on a fairly elaborate formula for scoring the burden of illness.

In the search for past, present and future messages for nursing leadership to guide the education of nursing leaders into the 21st century, Kelley (1996) examined the professional life histories provided by 40 participating members of the American Academy of Nursing in its early years. Members of the Academy were selected in recognition of excellence and leadership in the nursing profession. The composite profile of these nurse leaders was qualitatively derived as the private perceptions and evaluations of contributing
nurses through meaning analysis of stories within private letters. Within the profile, it is noted that nursing lacks prepared leaders in service, education and research. "The contributing nurse" [according to Kelley’s profile] "learns the high price for being a ‘rate breaker’ and is pressured to publish only favorable things about nursing" (p. 78). An excerpt from the data collected states: "My master’s thesis, which was seen as critical of the ANA, was sharply criticized by nursing leaders. Disclaimers to my book give some indication of the bureaucratic reaction" (p. 78). Another claim by Kelley states: "She [the contributing nurse] recognizes that changes are needed, not only in the direct delivery of nursing care but also in other areas" (p. 78). An excerpt from the data collected to support Kelley’s claim states: "Nursing has failed to establish itself as a critical factor in the health of the nation" (p. 78). A comment on how an unprepared nursing administrator has been perceived by a contributing nurse says, "...the better the idea or goal, the more threatening it is if the contributing nurse’s approach is direct, open, and honest," (p. 79).

Finally, as her composite findings were examined for futurist messages, Kelley found that contributing nurses are “building a work of nursing science and art that is visionary toward a generational contribution,” (p. 82) which appears to be an opinion based on the meaning patterns that Kelley identified. Kelley’s article does not indicate that nurses are prepared during the educational process to lead in an open, or non-threatening manner, and supports opinion that it [nursing] is not very open to constructive criticism.

In another collection of nurse leaders telling their stories, Schorr & Zimmerman (1988) compiled 46 nursing leaders’ stories to provide a reference for students, (or other nurses) who want to know more about the growth and development of a nursing leader. This
book is biographical about each leader’s career path. The stories may offer inspiration for students aspiring to learn to lead.

In a study of nurse faculty middle managers Larson, (1994) reported that the majority of them did not view their current position as a career step to deanship, nor did they have career aspirations to a higher leadership position. Larson believes that the continuation over the years of the lack of career aspirations in academic middle managers remains a serious problem for nursing, and that the work environment of faculty needs to change in order to assist, motivate and move people to a higher level of functioning. The lowest degrees of job satisfaction for the academic managers were in reference to parking space first, and then the leadership of the dean. Larson challenges that it is the deans of colleges of nursing who have the most crucial leadership positions that critically affect the future of the nursing profession. Womack (1993) measured leadership styles of department chairpersons and equated this with scholarly productivity of the faculty, to support the inclusion of nursing leadership studies in nursing education at the graduate level, and to increase the understanding of leadership styles. Womack (1996) subsequently wrote that nursing department chairperson leadership styles are comparable to deans and that greater insight [about how to lead] could be gained from studying faculty perceptions about the leader’s style. In a study of the leader behavior of new deans, Colyar (1996) found no specific leader behavior was significantly associated with faculty acceptance of change, and of the 44 nursing school deans surveyed, the lowest frequency of changes were related to evaluation (56.8%, p. 19). If evaluation activities are the least frequent area of change in other nursing programs as well, this could indicate that changes in curricula or other
aspects of nursing education are avoided. Quellet and Rush (1989) write about curriculum evaluation as wrought with unpleasant connotation; that is, often characterized by a lack of sufficient direction and support from administration. It notes that some faculty members exist in a “frightening anticipation inherent in curriculum review—critical analysis of one’s own work and teaching practice,” (p. 222). The authors recommend that readiness assessment, including flexibility of the nursing program is necessary for change during curriculum evaluation. However, the authors stop short of recommendations for non-readiness and inflexibility, which would be key issues.

In relation to attitudes regarding nursing education, Tritak (1996) found that senior students in baccalaureate programs were less cynical than beginning students in their attitudes, but that humanitarian attitudes of students were not increased significantly over time, suggesting the need to examine curricula in schools of professional nursing, to evaluate if and how humanitarian attitudes are being fostered. This is a surprising finding, since common sense would indicate that exactly the opposite should be true. The study included 307 generic baccalaureate students from three public programs in New Jersey. To generalize these findings, the study would need to be replicated on a larger scale. However, if this were the case for the majority of senior nursing students, it is indicative that nursing baccalaureate education is creating a positive self-image. Attitudes regarding basic nursing programs (Baccalaureate, Associate Degree, and Diploma) were also explored by Schumann (1990) to understand perceived negative attitudes of nurses toward their basic nursing education. In general, the findings reflected that individuals who graduated from Diploma programs tended to be more positive in their attitudes than
graduates from other programs. It also found a perceived need for nursing instructors to have more clinical experience, which is a criticism that is often heard about baccalaureate programs. This contradicts Tritak’s finding because cynicism and negative attitudes are often closely related. Furthermore, criticism about basic nursing education is more commonly heard when talking with baccalaureate or AD nurses, in the researcher’s own experience. This may be generational, because graduates from Diploma programs tend to be over 40 years old, and have different attitudes about the education they received 20 to 30 years ago. Many nurses of that era felt their training was an honor, and look back on their education with great pride. Finally, McKenna (1994) studied the attitudes of students in the United Kingdom about nursing models [e.g., the use of nursing diagnosis], finding that while in the early and mid 1980s nurses in the UK accepted the introduction of nursing models without question, in the 1990s a growing body of nurses is taking a more measured view, and that criticism of nursing models is becoming more common and more acceptable. He suggests that university students, who have a higher theoretical input in their courses, are more aware of the inherent limitation of nursing models and therefore more likely to question them. This is interesting, because more education would seem to have a positive impact on the student’s ability to critically analyze the system of nursing education, however questioning theoretical content, nursing models, or leadership has not been supported by the literature.

There have been many voices calling out for change in nursing education. The curriculum revolution literature in the early 1990’s presented innovative and creative thinking in nursing education. Bevis and Murray (1990) wrote that, “Teaching is a political activity.”
They discuss the concept of co-scholarship with students and a focus on teacher-student interactions and learning experiences. The authors describe the oppressive nature of lecture as a strategy to achieve goals, noting that lecture reflects the authoritarian philosophy of a behavioral curriculum. Allen (1990) discusses the burden of responsibility, and the tendency for educators to align themselves with content instead of with students. He also notes that occupational requirements in nursing, in combination with responsibilities for life and health, create a sometimes morally overwhelming burden for educators. Consequently, educators assume the burden of trying to create a fail-safe system. He recommends a democratization of nursing schools, skepticism about all fixed solutions, and movement away from a content commitment, back to a caring one about students and educators. Allen’s comments are important in considering the educational issues presented within a system that ultimately prepares students for a licensing exam. The occupational requirement of passing the state licensing exam after graduation does require an emphasis on training to pass a test.

PROFESSIONAL POLITICS

The foremost references to professional unity occur in discussions around nursing’s involvement in the Clinton health reform plan and the involvement of the American Nurses Association (Keepnews & Marullo, 1996; Cohen et al, 1996; Mundt, 1997; Harrington & Estes, 1994). Virginia Trotter Betts (1995), while President of the ANA, asserted that true nursing leadership must be identified by the national and state nursing associations. She was upset that non-nurse speakers at the 1995 nurses march on Washington, DC,
"omitted nurses’ dramatic outcry that profits, stock prices and market share are negatively
influencing professional nursing, safe patient care and healing," (p. 5). She calls for
leaders in nursing to have a common core of leadership characteristics, coupled with
professional values about nursing and the people nursing serves.

Cohen, et al (1996) note that individual nurses develop politically at different stages, in a
manner distinct from the development of the profession as a whole. These nurses often
serve as role models, and not necessarily through the efforts of their professional
organizations. Joel (1996) writes that nursing needs a stable practice environment, and
reduction of middle or front-line managers is bad because they have traditionally been the
stabilizing force in the practice environment. She worries that the trend to consolidate
executive positions and decrease middle management in business and industry is not
transferable to health care, and that if nurses stand by quietly, they are guilty by
association of negatively impacting quality nursing practice.

Political development can also take place in the form of collegial relationships, or within
organizations. Fagin (1996) draws comparisons between educational and practice
administrators and the similarities and differences between the two. She notes that there
seems to be an absence of the visionary, transforming nursing and medical leaders who
respond to challenges and speak for their professions and the public. She sees differences
in the cultures of academia and practice, with the nurse executive in educational
institutions recognized in parity with other top professionals, while the executive in a
practice setting may not be. She wonders if nurse executives in practice may see

40
themselves as increasing their scope and prestige by minimizing or obliterating their nursing identification. She recognizes the potential for advanced practice nurses (APNs) to reduce health care costs significantly, but also stresses the need to maintain accountability in order not to lose nursing as a discipline. She also sees an example of “dysfunctionality among nursing leaders,” (p. 36) in the poor record of implementing research-based innovations into practice. Beyers (1996) writes that the American Association of Nurse Executives (AONE) is moving forward to define nursing/patient care and to measure outcomes with researchers at the University of Iowa. Wilson (1997) wrote that in a review article about home health care outcomes, the University of Iowa overlooked a well established nurse-developed outcome measurement system. This example demonstrates how while a national association speaks about its accomplishments “leading” nursing, other realities may be present when the facts are examined.

In a study of nurse executive characteristics, Rozier (1996) surveyed 1500 AONE members to help to clarify whether male nurse executives are at an advantage when being selected for an administrative position. The study found that the lack of gender differences for the nurse executives may indicate that the male nurses have been socialized into the dominant culture, which is feminine [predominately female], and thus adopted more of the female leadership attributes. It also found that male nurse executives made significantly more money than female nurse executives, demonstrating that even in a female-dominated profession, male nurse administrators appear to benefit from a favored position. This is particularly disturbing, and indicates that even in a female-dominated profession, higher wages for males still predominate. Intrinsically, the marketplace may
put a higher value on male nurse administrators. Since many hospital CEOs are also male, preferences in hiring male nurse administrators is a valid concern.

Kelly (1991) reviews concepts of power and influence in nursing. She mentions the concept of reputational power, in which power is equated with a person’s reputation for being influential. While some nursing leaders have reputational or positional power extending to the national level by virtue of position or perceived influential status, nurses themselves may not seek power because they lack the self-confidence, or perhaps because they take the power they do have for granted (p. 350). It is also possible that people who choose to be a nurse are generally not those who seek power.

Jacano & Jacano (1993) write that everywhere nurses turn they are confronted with the idea that they must become leaders, and that human beings have a natural tendency to shun leadership roles. Since the literature portrays leadership skills as very complex, it can seem like an impossible dream for the nurse. They conclude with saying that the only significant obstacle to success as a leader is and always was lack of self confidence. This may be true in some instances, but a nurse must also have the opportunity for leadership. Self confidence does little for nurses who are not in a position to assert leadership, do not want to assert it, or do not know how. In addition to self confidence, attitude is also a critical component of a successful leader. An effective attitude means exuding the right feeling or emotion in leadership. This may be a factor of self confidence, but it is also related to style. Style can also be a common obstacle, or asset, to becoming an effective leader. In another view about leadership, Porter-O’Grady (1995) provides the message of
recognizing one's inner self and unleashing personal potential to help others to do the same. He later describes how quantum mechanics (Porter-O’Grady, 1997) will provide the answers to future health care leadership, and explains changes between the industrial age and the quantum age. This provides a framework for an evolving leadership theory in which all roles and behaviors must model the context into which systems are moving, not those which organizations are leaving. While this may have relevance in leadership theory, quantum mechanics provide a macro viewpoint to pressing micro leadership issues.

HEALTH POLICY

The most comprehensive recent review of nursing involvement in health policy appears in an article by Cohen, et al (1996). As a political body, four stages of nursing’s political development are identified, and recommended strategies are provided for the fourth stage termed “leading the way.” In this systematic analysis of the evolution of nursing as a body politic, the American Nurses Association (ANA) is described as the major voice for nursing at the federal level. Stage one is described as the “buy-in” stage, and represents the profession’s recognition of the importance of political activism. Stage two, reflects the “self-interest” stage, where nursing develops and uses its political expertise as it relates to the profession’s self-interests. Stage three, the “political sophistication” stage is when the profession goes beyond self-interest and recognizes the importance of activism on behalf of the public. Stage one is linked to the late 1970s and early 1980s. During the self-interest stage two, most of nursing’s attention at the federal level focused on lobbying for legislation to authorize and fund nursing education and research, in the face of the
continued insistence of presidents from Nixon through Bush to underbudget for funds for nursing education and research (p. 261). The authors state that a major difference between the first and second stages is the growing acknowledgment of the importance of nurses working together, or at least showing a united front (which was considered previously under professional politics). This sense of identity is credited to the establishment of the National Center for Nursing Research in 1985, which Congress upgraded to the Institute of Nursing Research in 1993. In addition, the Tri-Council was formed for Nursing, consisting of the ANA, the American Association of Colleges of Nursing (AACN), the National League for Nursing (NLN), and the American Organization of Nurse Executives (AONE). The authors credit the second stage as the point when nurses had to explain to legislators the meaning of nursing diagnosis, which impeded nursing’s ability to move its agenda forward and to be a part of important health policy discussions (p. 261). There were also achievements such as prescriptive authority for advanced practice registered nurses (APRNs) and the enactment of laws and promulgation of regulations that recognized the unique aspects of APRN practice.

Between 1992 and 1993, the ANA Political Action Committee (PAC) had the second largest increase in contributions to federal candidates of all PACs in the United States (p. 262). By 1994, it ranked third among health-related PACs in contributions made to federal candidates, surpassing the American Medical Association. By 1996, 71 nurses held elected positions in state legislatures. In addition, a number of nurses have held important legislative staff positions with influence in health care issues that enhance the image of nurses. These include the Chief of Staff for a leading Republican Senator, an administrator of the Health Care Financing Administration (HCFA), the national AIDS
Czar, and the top position in the Social Security Administration. Nurses are increasing their numbers in political office and top positions in the US. The Cohen article points to the need for developing political “mentorships” to enhance leadership development to continue to move the nursing body politic to shape health and public policy in some notable ways (p. 264). The authors create a superb model for continued development of nursing in the health policy-making. By specifying the stages of political development, the authors provide a concrete description for course development, and realistic ideas that stimulate critical analyses to promote nursing’s political growth. However, within the sophisticated view of political development, the authors did not question the Democratic partisanship of nursing in the health reform process of 1993. This is interesting since there have been public criticisms by Republican nurses that the ANA has made serious mistakes in a Democratic allegiance, that may have alienated many key and powerful Republicans. It is surprising that this was not cogent in their discussion of nursing as a political body.

The American Academy of Nursing (1982) published a book that presents the keynote and other papers from the 1981 Scientific Session. The editor of the publication places a challenge to nursing to develop the body of knowledge to “shape and improve the balance of power in health care policy development,” (p. 2). He notes that for many years nurses have been poised in the political wings, observing as others played major roles in the formation of health policy. The American Academy of Nursing was established in 1973 under the aegis of the ANA. Fellows of the American Academy of Nursing (FAAN) are noted as nursing leaders. In her keynote speech, Claire Fagin, PhD, RN, FAAN presented a clear vision of nursing’s then (and remaining) needs if it is to achieve prominence in
health policy. She notes its struggle for a unique identity, she addresses issues related to reimbursement, and she recommends that nursing services be included in minimum benefit packages. Fagin also acknowledges the need to confront constraints of state laws and regulations, and recommends a national network of state leaders to address the state law issues. She foresees the need to develop alternatives to high-cost technological care, and the tremendous opportunity for maximizing nursing's potential.

The ANA Executive Director co-authored an article in 1996 that discusses the policy imperatives for nursing during health care restructuring (Keepnews & Marullo, 1996). Here the authors note an extreme change in the health policy environment in 1995, compared to 1993 and 1994 when the Clinton reform plan was in the forefront of policy discussions. Describing ANA's accomplishments and activity in the health reform process in 1993, the authors use the concept of managed care to demonstrate almost demonistic [profit-oriented] motives of cost cutting in the removal of RNs from the bedside. In the article, the authors discuss plans for nursing to demonstrate accountability through nursing report cards, and how these efforts will dovetail with those of other groups like the Health Plan Employer Data and Information Set (HEDIS). The article advocates for public disclosure by health care institutions regarding staffing levels and patient outcome data. Finally, it talks about efforts to educate consumers to help create a consistent consumer demand for RN services. The authors assert the right to organize and to bargain collectively in the same paragraph that they position nurses' role as patient advocates. The above statement appears somewhat self-serving on the part of ANA. Since collective bargaining benefits nurses (and the ANA in its own union activities), patient advocacy as a
vehicle to facilitate bargaining activities could also be interpreted as a conflict of interest. The article calls for demonstration of professional unity (also relevant under professional politics), by activities such as participation by “more aggressive action in some sphere, such as the March 1995 Nurses’ March on Washington, or the negotiation of clearer patient care standards through collective bargaining” (p. 30).

Mundt (1997) provides a review of 35 books written by authors from 13 disciplinary perspectives to determine how the nursing profession has been represented in discussions of health system reform. Approximately one half of the books contained no references to nursing, 39 percent had less than ten references to nursing, and only four books had more than ten references to nursing. The references noted how the role of advanced practice nurses in a reformed health care system began to be viewed by some as a high-quality solution to the health care crisis. However, with the failure of national reform efforts, the initiative for major restructuring now appears dormant. The most prevalent author perspectives were political science (eight books), economics (six books), and medicine (five books). Two books were edited by nurses, and dealt specifically with nursing and health policy. One was edited by Kos-Munson (1994), and states that access to health care is the problem, and issues of social justice in the distribution of health care resources. The second, by Harrington and Estes (1994) is multidisciplinary, and points to the positive contributions of nurses, spelling out the political agenda of organized nursing for a reformed health care system. Mundt (1997) states that when references were made to the nursing profession in the books she reviewed, they were most likely to refer to 1) nurses in conflict with physicians, 2) concerns regarding shortage or, 3) oversupply, or nurses as
substitutes for physicians. These three categories persisted as themes regardless of author orientation. Mundt's findings validate an invisibility of nursing in the review of books on American health care policy published during the health care reform era (p. 24). She implores nurse authors to publish for a broader audience, integrating nursing frameworks into solutions to the health care crisis that will apply across disciplines.

Milio (1989) writes about developing leadership in policy. She notes that nurses have become increasingly interested in policy, yet their concerns have focused on issues affecting nursing as a profession instead of substantive health questions. She recommends clinical placements for students in policy settings, as well as support for changes in faculty development. She also recommends that nursing professional organizations and leaders in nursing service reexamine the health relevance of the policy agenda they seek to move in state and national legislatures.

However, policy decisions that reform health professional education, the regulation of insurance, or the provision of Medicaid are primarily made by individual states (Weissert, Knott & Stieber, 1994). States have been on the center policy stage in the last few years with innovative and comprehensive policies to enhance access, improve quality, and control costs of health care. As the chief licensers and regulators of health professionals, they set the parameters for who can practice and what that practice can include. The political dynamics of the policy-making process in the health arena also give preferential treatment to organized groups. Traditionally and uniformly, physician groups organize better and exercise more power than do nurses' groups (Weissert, et al, 1994, p. 366).
Nursing issues become key because of the importance of nurses in meeting health needs in underserved areas. Therefore, regulatory oversight and scope of practice issues related to nurses and advanced nursing can play an important role in explaining the geographical distribution and career choices of health professionals. For example, direct reimbursement to nurse practitioners (NPs) under Medicare is limited to rural areas and must be under physician supervision, so rural areas may attract more NPs because of job availability. Also, states may influence the priorities of health profession's schools. Strategies can include setting quotas for percentages of medical and nursing school graduates who must enter primary care, or to make curriculum changes to increase the production of primary care physicians and nurse practitioners to practice in medically underserved areas. Regulation and reimbursement can best be viewed as policies that prohibit or mandate an activity (p. 370). The Democratic leanings of organized nursing can also be explained on a state regulatory level. The rationale is simple self-interest. Nurse practitioners benefit from regulations in states that make them more independent and able to compete with physicians. The numbers of nurse practitioners is positively related to the adoption of regulatory activity. The number of primary care physicians and all physicians is negatively related to the adoption of regulatory policy (p. 378). This is particularly true in rural areas that have trouble attracting physicians. Consequently, nurse practitioners may be granted considerable independence in practice. Since states with liberal, Democratic leanings and leadership are more conducive to regulation than more conservative Republican states, the authors expected to see Democratic states more supportive of those policies. Therefore, the power of the medical and nursing lobbies can be important in predicting state support. Need is a significant predictor of state support in
only one policy area, that affecting rural and underserved areas (p. 383). Politics is a somewhat stronger predictor of policy. Ideology and partisan leadership, and in particular, the presence of primary care physicians and nurse practitioners were important variables explaining the adoption of several policies encouraging primary care (p. 384). In policy reform, federal policy will have to confront the array of policy environments in the states.

One of the most frequently discussed themes in nurse practitioner circles is the importance of being identified as a primary care provider on managed care panels or rosters (Cohen and Juszczak, 1997). Particularly in managed care organizations, credentialing is the first step in establishing arrangements. Credentialing is the process whereby organizations review providers’ qualifications in areas such as licensure, certification, malpractice insurance, malpractice history and hospital privileges. By understanding the financing of managed care, nurse practitioners are in a good position to negotiate contracts. To continue to become independent in practice and in reimbursement for services, nurse practitioners will need to be well versed in managed care, state initiatives, and research data to hold on to past achievements.

Complex linkages between politics and policy are not well addressed. Politics constitutes a means, while policy is an end or outcome according to Helms, Anderson, & Hanson, (1996). The result is a failure to understand how the environment in which policy is made both mediates and constrains the content of policy. Helms, et al (1996), describe the merits of incremental policy-making to move policy in the desired direction through
limited serial shifts to minimize adverse effects on existing players. They note the “art” of
effective policy-making requires advocates to define problems based on solutions available
within the range of available policy mechanisms (p. 36). Nursing leadership may overlook
the very real constraints of the policy environment and be lured into formulating specific
policy objectives too broadly (p. 39). For example, the concept of “caring” is an
ambiguous criterion to translate into measurable policy outcomes. As a matter of policy-
making, too much emphasis on the importance of caring by nurses, unless it is balanced by
available (and quantifiable) nursing solutions to policy problems, can deflect attention
from more obtainable objectives. The logic of timing and policy density suggests that
missed opportunities cannot be resurrected later. Diers (1993) writes, “The first step in
policy-making, like dealing with the stubborn mule, is to get its attention: get on the
agenda.”

In a discussion of her experience as the AIDS policy coordinator from August 1993 to
July 1994, Kristine Gebbie describes the “Washington insider” phenomenon (Gebbie,
1996). “As these people [the network of insiders] move into higher positions, and in and
out of government with changes in administration, their years of negotiation, debate, or
collaboration lead to relationships that can be difficult to understand and penetrate [for the
newcomer],” (p. 15).

In an article that focuses on the potential contribution of meta-analysis research methods
(summarizing pooled results of multiple previously conducted primary studies) Conn &
Armer (1996) discuss the role of value decisions in relation to influencing the political
process. The authors state that since policy-making is a political process, nurses must remember that political processes have their own rationale, where decisions are often driven by values at the local level. Their advice is that since politicians are always seeking allies, nurse scientists need to be very shrewd in the consideration of local ramifications of policy, regardless of empirical findings. In terms of research as a vehicle for influencing policy change, Tamlyn and Myrick (1995) promote joint nursing appointments between education, practice and policy settings as a method to shape public policy. Kjervik (1996) sees this period of health policy change as an opportunity to question the values underlying health policy choices, to inform policy makers of alternative approaches, and to improve responsibility to the community in an evolution of nursing’s commitment to society.

SUMMARY OF THE LITERATURE

Policy-making and nursing effects on the policy-making process have been reviewed from the aspects of education, professional politics, and health policy. It would be logical to assume that policies should be controllable within education and inside of the professional politics of nursing. However, in education, there is ongoing debate about the entry into practice issue. Dier’s statement (in Solomon and Roe, 1986) summed up the issue nicely, saying that with the move to make the BSN the minimum qualification the policy goal may have been lost to political interests. This comment is now eleven years old, but still applicable. The NLN and the ANA, while publicly supporting the need to have the entry level to professional nursing be at the 4-year BSN, have not been able to cement that into
policy. While it continues to be a matter of debate and embarrassment for many nurses (and respondents interviewed in this PDE), entry into practice continues to be a long-standing, unresolved issue, and the likelihood of any real change in policy seems distant.

Several good articles and books have been written about the need to integrate health policy into nursing curricula. However, the most comprehensive literature was found to be 10 years old, or older. The ability of 2-year nursing programs to integrate health policy into curricula is unclear, but comprehensiveness would be nearly impossible, given the time constraint of the program. Articles continue to mention the importance of policy, but little has been written recently about how to integrate and teach it as an integral component to nursing education, and not as an add-on. No documentation was found that studied the results in the subsequent careers of students who received a strong health policy focus in the curriculum.

The literature does continue to point to the need to educate nurses about “leadership,” but it also points to perceived problems in the confidence level, or self-esteem of nurses in general. Some experiments in teaching leadership were documented, with positive results. The need to evaluate curricula is evident, pointing to the need to examine the content and process at least every five years. The need for substantial change in the content of education is something that was raised during interviews with the respondents in this study. Technically, change and evaluation in nursing curricula may be addressed in the accreditation process, but functionally, how that impacts policy in education is unclear.
The literature does support the notion of exclusivity in the professional politics of nursing, which also came up with the respondents interviewed in this study. In her guide to nursing leaders of the 21st century, Kelley (1996) noted the "high price" for breaking ranks with leadership. Feeling shunned, and not endorsed by peers is a powerful deterrent to creativity and innovation. While leadership requires courage to be different, the fear of being different for lack of acceptance needs to be explored.

In the last five years, writing by and about nursing organizations was prevalent. However, these articles were a documentary about the organizations’ benefits, or their achievements in health reform or leadership.

Literature regarding the curriculum revolution is creative and inspiring. It encapsulates the need for change and acknowledges the oppressive nature of traditional behavioral models of teaching. Perhaps some to the difficulty in implementing changes within nursing education stems from the need to guarantee that graduates pass a licensing exam, which supports training and not education.

More information is needed about the positive and negative effects of nursing in the policy-making process. What is confusing in the literature is that no one has written to answer specific questions about why or why not nursing has effects in policy-making, or whom to address about policy-making issues in education, professional politics, or health care. Instead, there is a smattering of ideas about teaching health policy, or how to provide leadership. While many others have dealt with questions about the involvement of
nursing in health reform, and a future reformed health system, progress by nursing as an entity after its extensive involvement in the failed Clinton reform plan, was not evident.

Initially, this study intended to address the gaps in the literature about nursing effects in the process of policy-making only at the level of health care regulation and legislation. During the literature review, in combination with the respondent interviews, other gaps appeared that were different, and yet seemed related. These were in the areas of policy-making in relation to education and professional politics. Logically, one might assume that if nursing policies in education and professional politics were managed well, that a positive effect on the influence of nursing in health care policy-making would result. Conversely, if policy in education and professional politics were problematic, the opposite could also be true—having a negative impact on the influence of nursing. Since the researcher knew that problems existed (whether real or perceived) in the influence of nursing in health care policy-making, exploring the domains of education and professional policy also made sense. The literature reviewed did not provide a full body of knowledge to address the above issues. This study is an effort to begin to fill that gap.
METHODOLOGY

We are all so imbued with the tenets of science that we take its assumptions utterly for granted, so much so that we almost cannot comprehend the possibility that there might be other ways of thinking. And when other ways are suggested, we are inclined to shut our ears, feeling that merely to listen to them is, quite literally, a heresy.
- Egon G. Guba

This is a qualitative interview study, seeking to understand more about the effects of nursing as a professional entity on the policy-making process in health care. Ten interviews were conducted with people who have substantive experience in high level or influential positions in organizations, institutions, or in government. To understand the experiences of the interviewees selected, aspects of phenomenology were used to provide the written descriptions of the respondents’ experiences. Grounded theory methods were also used to group statements from the interviews, and to find relationships that the statements had with one another.

According to Guba (1985), naturalistic (qualitative) inquiry demands a human instrument to build on tacit (intuitive, felt) knowledge in addition to prepositional knowledge (knowledge expressible in language form). The term “natural inquiry” reflects the initial work done by qualitative researchers. It implies the acquisition of knowledge in a manner other than empirical research (Bailey, 1997). An important development for science in general was the realization that all science is relatively subjective (Davis, 1978). The scientific method is a reconciling of the rational with the empirical. Positivism, or the positive view of the scientific method, leads to an incomplete conceptualization of what
science is. Critical examinations of the positivistic approach, particularly psychology and sociology, have presented alternative views using qualitative methods. In this study, qualitative methods were used to find the meaning of the knowledge expressed by the respondents during the interviews.

The qualitative paradigm is increasingly used in nursing research. Within the qualitative paradigm in the nursing community, phenomenology and grounded theory are presented as distinct divisions, and consensus regarding their definition does not exist across the discipline (Lowenberg, 1993). In this study, phenomenology was used to capture the lived experience of the respondents studied, and grounded theory was used as a technique to organize and to understand the textual data, not to develop a theory.

**Phenomenology**

The work of Amedeo Giorgi (1970) is a major early reference in the development of phenomenology. As Giorgi redefined the meaning of science and psychology, he used the meaning of the term “paradigm,” employed by Kuhn (1962) meaning the set of rules, theories, facts, problems, etc., which guide research activities. In his discussion, Giorgi argues that as psychology was conceived as a human science, it should have gone to life-world phenomena in a more direct fashion to formulate its questions, problems, methods, and procedures independently of what the natural sciences were doing (Giorgi, 1970). Giorgi articulated a paradigm for psychology—a paradigm without assuming commonality
with the natural sciences. His methods seek to solve problems rather than to defend answers. In reflecting on paradigms that nurses have adhered to in the past, and considering how these “rules” could change in the future, Giorgi’s concepts provide a foundation to study phenomena specific to nursing.

Philosophical in nature, the phenomenological approach is an attempt to understand empirical matters from the perspective of those who are being studied. Phenomenology recognizes the subjectivity of all knowledge. It does not eliminate bias but, rather, it attempts to recognize and incorporate it (Davis, 1978). At the most basic level, this means that the phenomenon being studied must be experienced in everyday life, and not created by, or strained through, experimental situations. This stance makes central the idea that human actions are highly situational and human actors act in accord with their constructions of meaning for the concrete situations they face.

GROUNDED THEORY METHODS

To make science more relevant, writing needs to be grounded in the philosophical and epistemological literature. Morse (1995) describes the essence of grounded theory as symbolic interactionalism, stressing that human behavior is developed through interaction with others, in the rough continuous processes of negotiation and renegotiations. Strauss (1987) describes it as a style of doing qualitative analysis that includes a number of distinct features, such as theoretical sampling, and certain methodological guidelines, such as the making of constant comparisons and the use of a coding paradigm, to ensure conceptual
development and density. Morse (1995) also stresses that methods should be thought of as operational tools, which are to be developed and changed in response to changing work contexts. Lowenberg (1993) points out that grounded theory for some nursing researchers is almost synonymous with qualitative research. However, Lowenberg asserts, in an attempt to increase control and decrease the inherently high level of ambiguity in grounded theory, nurse researchers began to structure the method, to “prove” scientific merit within academia. Nursing wants its work respected by the scientific and medical communities. Grounded theory is concrete, mirroring in some ways the rigid rules of quantitative methods. Yet grounded theory can miss aspects of meaning that are important to understanding the issues. For that reason, this study has included aspects of phenomenology.

Grounded theory in the current study was used primarily for its techniques to categorize and code the data by identification of the recurring themes, while listening to the interview tapes and reading and re-reading the interview transcripts. Furthermore, it provided a tool to help the researcher make sense of the data through the identification of the main properties (characteristics), patterns (issues), and profiles (representation of the issues). This provided a documented path to lead into the analysis and a foundation to build upon for replication.
THE RESEARCH PROCESS/ THE RESEARCH QUESTION

Geertz (1973), an anthropologist, proposes the term “thick description” for data obtained in qualitative inquiry from interview transcripts, because he considers the data rich and deep. However, he also recognizes that these data are difficult to transform into numeric codes, and are therefore considered to be “soft.” On the other hand, if we describe a phenomenon based purely out of systemic rules, we may appear to look like a native, but later enter into debate about whether or not the description reflects what natives really think, as opposed to merely clever simulations that are logically equivalent but substantively different, from what they think.

The inductive process was allowed to work before finalizing the research question, or any specific categories for examination. The research question itself emerged from the clues and flows of the interviews conducted, and by engaging in conversations with the respondents. Initial questions that were asked about the effects of nursing as a professional entity in the health policy-making process, allowed the respondents to provide a description of their opinions as an object of their own experience. However, questions about the “effects” of nursing as a professional entity within health care policy-making, also called into question its “effectiveness” within the policy-making process in general. Whether or not the nursing profession appears effective in policy-making, needed to be transformed in such a way to interpret whether it (the profession) produced results and had influence (effects) within overall health care system policies, or that it produced a desired, decisive or desired effect (effectiveness) in the policy-making process—or both.
The terms effects and effectiveness needed to be defined. According to the dictionary, effectiveness means having an effect, producing a result, actual and not merely potential. The antonym of effectiveness is futility. Effect means anything brought about by a cause or agent, the power or ability to bring about results, or the impression produced in the mind of an observer. The antonym of effect is cause. After considering the definitions carefully, it made sense to think about nursing in relation to its effects rather than to its effectiveness. Policy was defined in the Introduction on three levels: 1) political wisdom or cunning; 2) wise, expedient, or prudent conduct or management; and/or 3) a principle, plan, or course of action, as pursued by a government, organization, individual, etc., (Neufeldt 1988).

Logically, to get results (effects) in health policy, the nursing profession needs to be effective in the policy-making process. If it (the profession) is not getting results, it is also important to try to understand why it is not effective in getting them. The basic interview questions (Appendix A) and conversations were semi-structured to allow the respondents to talk about the nursing profession's effects or effectiveness in policy-making, including health care policy, educational policy, and policy within its leadership. The goal was to get as much of the “feeling” and opinion of the respondents as possible in the areas mentioned above and to subsequently find the themes present in the data. The goal during each interview was to gain information that could help to explain how the effects of the nursing profession in policy-making were associated with the perception of the respondents. Through this process, the research question changed from what are the effects of nursing in the health policy-making process, to: What are the effects of the

61
nursing profession in the policy-making process? Specifically, the question was answered in relation to health policy, education and professional politics. The change in the question became necessary because it was clear during the interviews that the effects of nursing in health care policy-making were often discussed in relation to issues within nursing education and nursing professional politics. “Professional politics” per se does not have a definition, but it was used by one of the respondents to describe issues regarding nursing national organizations and leadership, which were also brought up by the other respondents. Examples of professional politics include issues about professional unity and collegial relationships (e.g., attitudes) among nurses and between organizations. Therefore, examination of nursing effects in the areas of health policy, professional politics, and policy in education may provide more context to the qualities of the phenomenon (effects of nursing in the policy-making process) being examined. In order to address the inherent complexity of the issues within the broader term of policy, examination in each of these categories might also provide answers about the concept of the nursing profession’s “effectiveness” in the policy-making process.

THE SAMPLE

Members of the sample were selected based on the criteria listed below. In addition, all respondents selected had substantive experience in high level or influential positions in organizations, institutions, or in government. Furthermore, pursuing interviews with the “right” sample of individuals would allow the researcher to experience first hand the life-world of the individuals, and to see and experience the world as they do themselves. For
these reasons, it was determined that the interviews would be the best method of seeking data geared to contributing to a better qualitative understanding of the effects of nursing in the policy-making process.

The selection of respondents was made by the construction of a sample of people with the experience and education necessary to explore in-depth the terrain of nursing and its effects in policy-making. Each person was selected based upon meeting one or more of the following criteria:

1) Demonstrated excellence: Demonstrated excellence refers to honors or prestige within nursing or the health care arena—people known for their professional success in organizations, education, or in politics.

2) Non-traditional experiences: This refers to people known to move out of the definitional "box" of nursing and health care. Such an individual may have initially been ostracized, and subsequently honored after achieving success. This category may also include individuals who did not pursue a traditional track professionally, meaning they chose different paths from the mainstream of nursing.

3) Political positions: Political positions may be related to the national policy level, or organizational positions of significant power in political arenas.

4) Attachment to ideals of service in an adverse environment: Individuals in this category are primarily people who "hang in there" contrary to popular beliefs, or in the midst of adverse professional consequences.
5) Outspoken on issues: As noted above, individuals in this category “speak the truth” regardless of the consequences, because of a belief in a greater good, or by matter of conscience.

Morse (1995) states that in the phenomenology research strategy, a sample size of approximately six participants is appropriate, whereas in grounded theory a sample size of about thirty is recommended. In selecting the size of the sample the principle “less is more” was utilized. It was more important to work with greater care with a few people, than to more superficially work with many of them. This offered an opportunity to glimpse the complicated character, organization, and logic of the individuals interviewed. Initially, four to six people meeting one or more of the above criteria were going to be interviewed (Appendix B, sample inquiry letter). Eleven people were contacted, and ten responded to accept the request. The decision was made to interview all ten people provide added depth to the study. Eight of the ten were interviewed in person, and two were interviewed over the telephone. The two who had telephone interviews would have accepted an on-site interview, but by the time they responded, there was no more money available for travel.

Somewhat surprisingly, the two interviews that were conducted over the telephone were as rich in content and openness as the interviews that were in person. This could be due, in part, to the fact that they were the last two interviews conducted, and by that time, the questions, probes and general interview skills were well practiced by the researcher. In addition, both of the subjects appeared very interested in the subject matter, and were
willing to share their genuine thinking, or at least that is how it appeared. The sample included the following people:

<table>
<thead>
<tr>
<th>Subject</th>
<th>Occupation</th>
<th>Education</th>
<th>&lt;50/&gt;50 y.o.</th>
<th>Gender</th>
<th>Nurse?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Professor/Editor</td>
<td>Ph.D.</td>
<td>&gt;50</td>
<td>F</td>
<td>Yes</td>
</tr>
<tr>
<td>B</td>
<td>Professor</td>
<td>Ph.D.</td>
<td>&lt;50</td>
<td>M</td>
<td>Yes</td>
</tr>
<tr>
<td>C</td>
<td>Prof./Entrepreneur</td>
<td>Ph.D.</td>
<td>&lt;50</td>
<td>F</td>
<td>Yes</td>
</tr>
<tr>
<td>D</td>
<td>Professor</td>
<td>Ph.D.</td>
<td>&gt;50</td>
<td>M</td>
<td>No</td>
</tr>
<tr>
<td>E</td>
<td>Executive Dean</td>
<td>MPA</td>
<td>&lt;50</td>
<td>F</td>
<td>Yes</td>
</tr>
<tr>
<td>F</td>
<td>Dean (Ret.)</td>
<td>Ph.D.</td>
<td>&gt;50</td>
<td>F</td>
<td>Yes</td>
</tr>
<tr>
<td>G</td>
<td>Dean (former)</td>
<td>Ph.D.</td>
<td>&gt;50</td>
<td>F</td>
<td>Yes</td>
</tr>
<tr>
<td>H</td>
<td>Professor</td>
<td>Ph.D.</td>
<td>&gt;50</td>
<td>F</td>
<td>Yes</td>
</tr>
<tr>
<td>I</td>
<td>Dean</td>
<td>Ph.D.</td>
<td>&gt;50</td>
<td>F</td>
<td>Yes</td>
</tr>
<tr>
<td>J</td>
<td>Consultant</td>
<td>MA</td>
<td>&gt;50</td>
<td>F</td>
<td>No</td>
</tr>
</tbody>
</table>
Respondents were not chosen because of their credentials alone. Having a Ph.D. was not a criterion to the sample population, yet all but two respondents had one. Being in academe was not a criterion, yet all but one was (although two entered it within the past year). Time during the interviews was not spent on whether or not academic positions were tenured, or about full or associate professor positions. Age was not an important criteria to selection either, yet all were above forty, and over half were more than fifty years old. All of the nurses in the sample were members of the Fellows of the American Academy of Nursing (FAAN), which is one of the highest forms of recognition offered by the nursing profession. That was not sought in the sample. Seven out of ten of the respondents were married. All were white, although race was only known at the time of the interview request for five of them.

To provide a brief narrative about each respondent:

A. Respondent A has a Master's degree in nursing, but her Bachelor and Doctorate degrees are not in nursing. Her initial nursing degree was at the Associate level. She has been a Division Director in nursing at Teachers College, and she managed a doctoral program in nursing administration in Chicago. She presently considers herself retired, but spends part of her time teaching nurses at Columbia University School of Nursing, and she is the editor of a nursing journal. She is known to say what she thinks, and writes out of her interest in communication. Although she has held many positions in academe, and as the editor of major nursing publications, she responds to Director of Nursing as her role, as opposed to Dean or Editor. She has been politically active within nursing and health care, and brings a rounded view to organizations, to practice, and to education.
B. Respondent B is a nurse with extensive experience in health policy and economics. B served as a consultant to the American Nurses Association during the 1993 health reform process, attending meetings that included Hillary Clinton and Ira Magaziner. He initially went into nursing to become a nurse anesthetist, and by his second job went into administration. In graduate school he was introduced to economics instead of a clinical focus. He served as a policy analyst with the University of Michigan hospitals, and became very involved in Washington DC circles during the implementation of Diagnosis Related Groupings (DRGs). Although his Ph.D. is technically in nursing, it had a strong economic focus. He is an Assistant Professor at Harvard School of Public Health.

C. Respondent C is a Ph.D. prepared nurse who believes that politics are personal and that politics are the answer to having nursing’s view of the world become more accepted among patients and the American people. She has been the head of two major national organizations. She has also worked as a nursing lobbyist on the national level. She has been hired and admired because of her vision for nursing and health care. She is currently on faculty at Columbia University School of Nursing, in addition to starting a venture to establish women’s health care clinics across the country.

D. Respondent D is a Ph.D. prepared economist, who started in health care over 30 years ago. He is presently a Professor in the Graduate School of Management, University of California, Irvine, CA. He is the author of several books and articles on economic and health policy issues. His most recent book (1996) is about politics and health legislation, and provides insight into how health legislation arises from individuals, groups, and
legislators acting in their own self-interest, usually economic self-interest. He started the first Health Care Executive MBA program in the county, which has been filled primarily with physicians.

E. Respondent E worked for a prominent Senate Republican for almost 20 years. Joining his staff in 1977 as a legislative assistant, she quickly moved up to join the Senate Finance Committee staff as a professional staff member in health policy, and became Deputy Chief of Staff. When her boss became Senate Leader in 1985, she moved to the Leader’s office as Deputy, and became Chief of Staff in 1986 (before she was forty years old). Her undergraduate degree is in nursing; her Master’s is not. Recently, she has joined the Kennedy School of Government at Harvard as an Executive Dean.

F. Respondent F obtained her first degree in biology and chemistry. Her first nursing education is at the Master’s level. Most of her career has been in academic nursing. Her doctorate is in curriculum and instruction with a minor in nursing. She has held positions as Associate Dean and Dean. She’s held two positions in nursing service administration. She is past President of the American Nurses Association. She has been President of the International Council of Nurses and the American Nurses Credentialing Center. She is interested in the concept of “Professional Politics.” Her specialty is in the area of credentialing. She is described as a conceptualizer and a consensus builder around the structure of the profession.
G. Respondent G is a leadership professor and former dean at a prestigious Northeast private university and nursing school. She has been the innovator of new programs to keep pace with community need and market demand. She is a past president of the National League for Nursing. She is a well-known author, speaker and noted leader within the nursing profession. She promotes other nurses in the interest of their personal growth and success. She speaks to the heart of politically sensitive matters.

H. Respondent H has her roots in public health. Her undergraduate degree is in nursing, but her graduate degrees, MA and Ph.D. are in Sociology. She travels the world as Visiting Professor and Fellow. She demonstrates courage in her writing and has held true to her principles of education and leadership in nursing, despite taking unpopular or under-recognized political stands. She is a prolific writer, with nine books, and over 100 articles. Currently, she holds a joint appointment as a Professor in the Schools of Nursing and Public Health at a University in North Carolina.

I. Respondent I is the Dean at Vanderbilt University School of Nursing in Tennessee. She is a certified Nurse Midwife. Her keen interest in reimbursement comes primarily out of frustration during the period before payment was allowed for midwifery services. She has been active in nursing service and nursing education. In 1987, her school phased out the baccalaureate degree in nursing, and made the first nursing degree a master’s. Under her leadership, faculty practice nursing outside of the university, in addition to teaching in classes, in an effort to keep pace with integrated delivery networks and a managed care environment.
J. Respondent J is well known to the nursing community. She has served as the
Executive of a state nurses association, and as a parliamentary consultant for the American
Nurses Association (ANA). She has a consulting business and does special projects with
state nursing associations and other non-profit groups. Her educational background is in
political science. She is extremely knowledgeable about unions in nursing and
unionization issues. Although she is not a nurse, she is frequently assumed to be one
because of her broad exposure to nursing and political issues.

THE INTERVIEWS

Nine of the ten interviews took place in the respondent’s office (seven in person and two
over the phone); one was in a hotel room. Of the ten respondents, only one seemed to be
intimidated by the tape recorder, and expressed concern that negative statements could
cause her professional harm. All of the others appeared to take the tape recorder in stride,
and virtually ignored it. Respondents were sent a consent form prior to the interview, or it
was presented at the time of the interview (Appendix C). Of the ten respondents, only
two stated that they wanted to preview transcripts, and any quotes related to them for
approval before releasing the dissertation.

Basic initial questions were developed before any interviews were conducted (Appendix
A), but the questions evolved over the course of the interviews (Appendix D). This was
due largely to the comfort level of the researcher, and as the responses emerged from the
respondents. Overall, it was found that respondents were much more inclined to speak
freely if the interview took on a conversational quality rather than a scripted discussion. The data obtained were often the richest during the final moments of conversation, or when an issue of personal importance came up. It was also more efficient for the researcher to have four or five topic areas that did not require reference to a piece of paper, or reading a question. The key task in each of the interviews was identified as the ability of the researcher to put the respondents at ease and to communicate with them in a fashion, and about topics, that they found of particular interest or significance.

Engaging the respect and the interest of each respondent was deemed an important task to the development of a substantive conversation. One of the tasks in the interview process was to create an atmosphere of camaraderie that to a certain extent could position the interview as a conversation between peers.

Although the initial conversation during the interviews was geared toward health policy, it typically migrated to issues about nursing leadership, unity, and education, when a question such as why or why not nursing is effective, was posed.

ORGANIZING THE DATA

The data was organized using the following process:

1) First some broad categories were outlined on a piece of paper, categories the researcher thought might come from the interviews, based upon the content of the
prepared questions. Several categories (pertaining to nursing as a professional entity) that
were initially jotted down were: major accomplishments, contributions, national
organizations, vision, uniqueness, leadership, understanding of health policy, and
education strengths/weakness.

2) On the sixth interview, a respondent brought up the term professional politics. This
term (which she defined as issues around professional unity) seemed to encompass many
of the comments made by other respondents in relation to leadership, vision, and
strengths/weaknesses, so it was added as a broad category of the data.

3) The typed transcripts were read while listening to the interviews. Statements that the
respondent stressed, or which appeared important to the researcher were written down
according to the initial categories mentioned above, or any new categories mentioned
during the interview. The central themes discussed by the respondents were identified
after listening to all of the interviews and reading all of the transcripts. These central, or
recurring themes from the data were health policy, education and professional politics.

4) The researcher re-read each transcript, highlighting the statements for each respondent
that were more frequent, or seemed generally important in the interview.

5) A new set of large newsprint sheets was prepared, with the three major themes (from #
3 above) written across the top as three separate columns. The highlighted statements
from # 4 above, were subsequently written down under the major themes. This exercise (step) produced the following summary of issues for the three themes:

*Education*: Addressed primarily in relation to the merits/deterrents in curriculum policies preparing nurses at the two year, four year, and graduate levels.

*Professional Politics*: Appeared in relation to the politics of leadership, as well as perceived attitudes within nursing and its national organizations; and

*Health Policy*: In reference to the national sphere of legislative policy influence.

6) Next, for each written statement the main properties (characteristics) were identified and labeled. The initial properties within each category were:

*Education*: Change (needed), curriculum (problems, needs), technical vs. professional preparation (differences), personal values, socialization, and mentors (effects of).

*Professional Politics*: (Politics regarding) technical vs. professional preparation, individual point of view (importance of), (overall) “attitude”, alienation issues (by nursing as an entity), professional competition, national organizations (good or bad), unions (good or bad), and the politics of innovation and accreditation.

*Health Policy*: Vision, partisanship (Democrat/Republican), goals (present/absent), level of understanding of policy process (good or bad), economics (knowledge of), market forces, and scope of influence (federal and local).
7) All of the statements under each category were color coded by the above properties, according to the best fit. At this point, all respondents could still be identified by the comments they had made, but it was the color-coding, not the individuals making the statements, that was examined. There were a few statements that did not fit into a category and were not used.

8) At this point, considerable time was spent with the data, looking at it, thinking about it, and trying to identify a central property within each category that could be dimensionalized on a continuum. The task was to find the central property that could also represent each of the initial properties within each category. The central properties appearing within each category were:

1) *Curriculum* - Curriculum was mentioned by all respondents in relation to education;

2) *Attitude* - Attitude was mentioned by all respondents in relation to professional politics; and

3) *Influence* - Influence was mentioned by all respondents in relation to health policy.

The central properties were dimensionalized according to the primary topics mentioned by a majority (six or more of the respondents) within each central property. Curriculum was dimensionalized and placed on a continuum of technical to professional preparation; attitude was dimensionalized and placed on a continuum of discord to unity; and influence was dimensionalized and placed on a continuum of low to high. The continuums helped to organize the data further, and to put the responses into a perspective that would make
more sense when the data were further analyzed. The continuums were also tested by
determining that all of the individual properties within each category maintained relevance
in the category's continuum, and in the context of the interviews that were conducted.

Please see Figure 1.

**Figure 1**

<table>
<thead>
<tr>
<th>Category</th>
<th>Properties</th>
<th>Central Property</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Dimensional Range</td>
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<td></td>
<td>change</td>
<td>curriculum</td>
</tr>
<tr>
<td></td>
<td>curriculum</td>
<td>tech—prof</td>
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<td></td>
<td>preparation (tech vs. prof)</td>
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<td>personal values</td>
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<td>socialization</td>
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<tr>
<td></td>
<td>mentors</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td>politics (tech vs. prof)</td>
<td>attitude</td>
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<tr>
<td></td>
<td>point of view</td>
<td>discord—unity</td>
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<tr>
<td></td>
<td>attitude</td>
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<td></td>
<td>alienation issues</td>
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<td></td>
<td>competition</td>
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<td></td>
<td>national organizations</td>
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<td></td>
<td>unions</td>
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<td></td>
<td>innovation</td>
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<td></td>
<td>accreditation</td>
<td></td>
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<tr>
<td>Professional Politics</td>
<td>vision</td>
<td>influence</td>
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<tr>
<td></td>
<td>partisanship</td>
<td>low—high</td>
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<td></td>
<td>goals</td>
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<td>level of understanding</td>
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<td>economics</td>
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<td></td>
<td>market forces</td>
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<td></td>
<td>influence</td>
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</tbody>
</table>

75
Next, the data were studied to find patterns for each category that appeared to have a relationship to the properties (characteristics) within the same category. During this phase, relationships within the categories began to emerge, pointing to the main issues that were brought up by each of the respondents at least once, or more, during the interviews. The patterns represent what the main issues, or focus of the statements were about the central property. Faculty issues, professional entry, and course development were mentioned most frequently in relation to curriculum. National organizations, leadership, and exclusivity issues were mentioned most frequently in relation to attitudes. Economics, political mandate, and partisanship were most frequently mentioned in relationship to influence. Please see Figure 2.

**Figure 2**

<table>
<thead>
<tr>
<th>Category</th>
<th>Central Property</th>
<th>Pattern</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Dimensional Range</td>
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</tr>
<tr>
<td>Education</td>
<td>curriculum</td>
<td>Faculty Issues</td>
</tr>
<tr>
<td></td>
<td>tech----prof</td>
<td>Professional Entry</td>
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<tr>
<td></td>
<td></td>
<td>Course Development</td>
</tr>
<tr>
<td>Professional Politics</td>
<td>attitude</td>
<td>National Organizations</td>
</tr>
<tr>
<td></td>
<td>discord----unity</td>
<td>Leadership</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exclusivity</td>
</tr>
<tr>
<td>Health Policy</td>
<td>influence</td>
<td>Economics</td>
</tr>
<tr>
<td></td>
<td>low----high</td>
<td>Political Mandate</td>
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<td></td>
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<td>Partisanship</td>
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</tbody>
</table>
10) Finally, the patterns (main issues) were used for the analysis and presentation of the data, in conjunction with the central property for the categories (education, professional politics, and health policy).

**THE DATA**

Excerpts from the interviews provide the evidence to demonstrate the characteristics of the central properties (curriculum, attitude, and influence respectively), within the three categories education, professional politics, and health policy. The patterns for each category appeared to have a relationship to the properties (characteristics) within the same category. The relationships could be established because the issues were brought up by each of the respondents at least once, or more, during the interviews, pointing to the patterns. The patterns represent the main issues, or focus of the *statements*, about the central properties (curriculum, attitude, and influence). Faculty issues, professional entry, and course development were mentioned most frequently in relation to curriculum. National organizations, leadership, and exclusivity issues were mentioned most frequently in relation to attitudes. Economics, political mandate, and partisanship were most frequently mentioned in relationship to influence (refer to Figure 2). These patterns formed the basis for presentation and analysis of the data within each central category (education, professional politics and health policy). The patterns were:

- **Curriculum** - Faculty Issues, Professional Entry, and Course Development;
- **Attitude** - National Organizations, Leadership, and Exclusivity; and
- **Influence** - Economics, Political Mandate, and Partisanship.
As the evidence was further examined, a profile (outline) began to emerge from the properties within each broad category to represent a recurring subject brought up by respondents during the course of the interviews. The profiles within each category were: 

*Change* emerged from the Education category (e.g., faculty needs to change, change is needed in professional entry, and change is needed in course development); 

*Innovation* emerged from the Professional Politics category (e.g., innovation is needed in the national organizations and within professional leadership, or innovation is impeded by exclusivity); and 

*Lack of understanding* emerged from the Health Policy category (e.g., influence is diminished because of a general lack of understanding about economics in the marketplace, or lack of understanding [conceptualization] about the need for a consistent policy focus [political mandate] that is bipartisan).

This provided a context for examination of the data extending back to the dimensional range of each central property, the individual properties, and the initial categories. The profiles also provided a basis to begin to understand the contributing factors within the patterns that were identified in the data. A model depicting the profiles in relation to data organization is found in Figure 3.
Figure 3

Category                        Properties
Education                       change
curriculum
preparation (tech. vs. prof.)
personal values
socialization
mentors

Professional Politics           politics (tech. vs. prof.)
point of view
attitude
alienation issues
competition
national organizations
unions
innovation
accreditation

Health Policy                   vision
partisanship
goals
level of understanding
economics
market forces
influence

Central Property                Dimensional Range
Change                           curriculum
tech-----prof

Profile                          Change
Faculty Issues
Professional Entry
Course Development

Pattern                          Innovation
National Organizations
Leadership
Exclusivity

Lack of Understanding
Economics
Political Mandate
Partisanship
DATA VERIFICATION

The data were verified by sending the Methodology (including Sample descriptions) and the Findings to all respondents for verification. An opportunity was provided for them to correct any interpretation that they felt was incorrect.
THE FINDINGS

There's a period of life when we swallow a knowledge of ourselves and it becomes either good or sour inside.
- Pearl Bailey

INTRODUCTION

The use of language is central to reasoning out, or making sense of the data presented. According to Toulmin (1979), the basic instruments needed to understand what is involved in the rational criticism of arguments are the claims made by the researcher, the evidence or grounds on which they are made, and the warrants upon what grounds a claim is made. The profiles (change, innovation, lack of understanding - see Fig. 3) became the basis for the researcher's claims. Excerpts from the data (statements by the respondents) to provide evidence to support the research claims are organized according to the patterns within each central property identified in Chapter Four (p. 76). Finally, the researcher presents a brief analysis of the data in supporting warrants, by making further statements upon what grounds the data support the claim being made. The notion of warrants in this context is written in a broad and rather soft sense to support the plausibility of each claim.

To provide an accurate description of the effects of nursing (as a professional entity) in policy-making in the areas of education, professional politics, and health policy, an analysis of the data is provided to: 1) Identify and describe research claims; 2) Present evidence in the data to support claims; and 3) Provide warrants to make more explicit how the data support the claims being made.
The format for each central property in the data (curriculum, attitude, and influence) is presented in the following manner:

1) The research claim is made;

2) Each pattern is identified and described briefly. The evidence is presented in *italics*. Each excerpt is numbered to represent a different statement made by respondents. More than one statement may be made by a respondent; however, each respondent is represented for each claim.* Contextualization and/or clarification of meaning are located in [brackets] within some of the excerpts.

3) The warrant is provided to support the plausibility of the claim.

Note: Reference to Figure 3 on page 79 is recommended to review the organization of the patterns, profiles, and central properties.

* Due to the recognizability of some of the respondents, individuals are not identified by their statements to protect anonymity.

**ACRONYMS**

The following acronyms are used in the Findings:

ANA: American Nurses Association

NLN: National League for Nursing

BSN: Bachelor of Science in Nursing

AD: Associate Degree (in Nursing)

LPN: Licensed Practical Nurse

FAAN: Fellow of the American Academy of Nursing

AAN: American Academy of Nursing

AONE: American Association of Nurse Executives

AACN: American Association of Colleges of Nursing

82
Curriculum

Claim:

The culture for change in nursing education is polarized by disparate professional entry positions, faculty issues and inadequate course development.

Evidence:

FACULTY ISSUES

Faculty issues were discussed primarily as problems that needed to be remedied in the nursing faculties of universities.

1. My sense is that the curricula and the faculty are way behind. There are very few primary care faculty who have really worked successfully in a managed care organization, in an interdisciplinary setting, in an ambulatory care site, who can really teach and be comfortable in it. I think some places are making some real effort, but I think probably the biggest critical need for nursing is somehow to rapidly bring talent into nursing education and get the curriculum focused on the future...I think there's talent, but it has to be better managed...I think that people outside of academia underestimate how difficult it is to get faculties to change...[Could faculty be taught new skills as opposed to gaining the practical experience?] I don't know...But I would hope it would be part of a larger program that would include other disciplines, too.
2. I would start institutes for nursing faculty nationwide and make sure they understood what the big picture was in health care, that they understood what health care financing was about, health care economics, politics, and let them know that they are teaching our nurses to take risks, teaching them to be bold and proud of what they know, and health care is their responsibility.

3. Nursing faculty in general (with some exceptions) nationwide are the problem. And it's not their fault. They don't know. They haven't been educated. [About how to prepare nurses for today and tomorrow's marketplace.]

4. [Comments on the nursing faculty within the educational process] It's very narrow, and it's very specialized. I think it's very safe in general...a lot of the problem understandably resides in the faculty...I mean it has become very, very ingrown..."navel gazing" - that's what we do. Now, they're stilled [stopped] at methodological minutia in a classical scientific mode because they're so uncertain about being accepted as scientists that they research trivial questions that they can never do anything about. It has no relevance in the real world.

5. I think a lot of nursing faculty are still sort of flogging themselves nightly with a whip, walking on coals to prove that they're good enough. [Why are they so insecure?] I think part of it is the field has been insecure, it seems, forever. I think it gets translated to students and people get warped a little bit. There's a segment of that out there. And then there's a segment of very good people in nursing.
PROFESSIONAL ENTRY

Professional entry refers to the level that a nurse is considered to be a professional, and whether or not that should be at the level of two-year preparation, four-year preparation, or graduate level preparation.

6. There is too much emphasis on filling programs instead of asking should the program still exist?...We have never solved our basic problems...the issue of should BSN be the first professional degree...Here we are, 20 years after it was first raised, we're still asking that. If we can't answer a single question in 20 years, how can we lead anything?

7. There's part of me that says that there should not have been this associate degree nurse. The reason for that is that it kind of has a negative economic effect on the baccalaureate nurse...It scares me a little bit because probably they [ADs] will be able to adapt their curricula sooner, because it's a two year curriculum, to produce the nurse that's needed in community care and home care, all these other settings, faster than the baccalaureate program...and until nursing, if it ever can distinguish between the two, the difference between those two views, then an associate degree nurse is always going to be potentially preferable in the eyes of the employer... I don't think we will ever get this one figured out. It will have to be with machine guns. But maybe the market will help solve that by giving signals that we're not interested in associate degree nurses.

8. ...I would push the bachelor's through to the master's degree, for professional entry...you can't do anything without a master's degree if you're a professional person.
9. All I'm saying is that if they can't sell the four year at a much higher price, and that's been the problem with the four year [degree]...if they were really valued that much more in the marketplace, more people would do that [get the four year degree] than are doing it. If the marketplace doesn't value it that much, I don't think the outcome is different from what we teach them in those two years [two-year degree programs (AD)]. I think maybe the potential of someone who went to a four year, and then moved on to a graduate degree where they learn more managed care management [would be beneficial]. So why would a nurse go four years unless they really want to become a college graduate? They get a better rate of return from a two year. So, to get a better rate of return, they have to be able to do more things, have more responsibilities. I think that's possible if they move into areas of managed care more. I think they can supplant the primary care physicians - they'll be less expensive and have a different kind of training.

10. I'm not sure I want somebody taking care of me in the hospital with only two years of technical training...I don't want an ICU [intensive care unit] nurse who's had two years of knowing how to do it but not why...that would trouble me greatly...I don't know if that will help people understand or differentiate between nurses [if nursing took a united stand about 2-year vs. 4-year preparation]. I think they'll still think a nurse is a nurse...and in fact it will be dramatically different.

11. I would expand the legal scope of practice, commensurate with the education...we cannot ask for an unlimited scope of practice with the current minimal educational level that enables one to be licensed.
12. The answer to most any problem that you can put on the table regarding nursing's development or status, the underlying element is education. That is the very root of it. My first nursing education is at the master's level. This has influenced not only my career path, but also influenced my beliefs about nursing education. I would like to see the education system completely revised, putting nursing education at the graduate level...

...the incremental leap between the associate degree and the baccalaureate has not been great enough...It just got out of hand once they started to develop. I think it would be feasible to have nursing technicians prepared at the associate level and then master's degree prepared nurses...one would have no difficulty in making an argument for a different licensure and different credential for the two...I don't think its going to happen...they [Baccalaureate programs] aren't going to want to give up baccalaureate programs in nursing any more than the community colleges want to give up associate degree programs in nursing.

13. ...when I talk about baccalaureate...I mean at the basic entry level. There shouldn't be anything below that. So here we are preparing for one of the most difficult jobs in the world, dealing with the most vulnerable people in the world and we're still preparing with levels below the baccalaureate. There is something different that happens to you in an undergraduate program, not necessarily in the nursing piece, but in everything else that you do... If you go from an associate degree, which is very narrow, into a fast bridge to the master's, they never get a rounded education. I'm opposed to that in general.
14. If once you put a stop to it, and said this is real, ...and no more [on eliminating associate degree] and do everything we can for people to get the bachelor's degrees in any way imaginable...as long as I knew it was over...even if I just blessed them with my hands and said OK, its a BSN.

15. I am a minority of one, more or less, certainly in terms of what I do, what I know, what I teach, and it's a struggle to even teach what I teach. [On 2 year vs. 4 year degree] In fact, the matter is not going to be decided by nurses. It's going to be decided by the budget deficit, by the economics of the managed care environment. Period.

16. In many ways we have taken the position that the BSN is the professional level of nursing and it ain't. Every other member of the health care team has a professional education based on a liberal arts degree. Some of us go to baccalaureate programs and take a two year liberal arts education which doesn't prepare us - historically, geographically, economically, philosophically, for some of the tough issues that get tossed around at the policy level. I think the baccalaureate's dead. I think we're going to have a lot of programs with options where you can get your first major, then your degree, then drop back in to re-tool in a related area or different area as you go along.

17. I talk about three circles: advanced practice, unlicensed assistive personnel, then you've got the middle circle, smush, which is LPN, AD, Diplomas, BSN, and I think that smush is going to jump out because the [big health systems] of the world won't put up with this nonsense.
18. *The big question* [about differentiating between two-year and four-year nurse] is about licensure laws. *Education has a great challenge facing it right now...because I believe health care is going to be delivered where the person is.*

19. *One of the problems with it* [state licensure laws that would differentiate between 2 year and 4 year prepared nurses] is *that it splits nursing right down the middle.* So you have one group arguing one way and another group arguing the other way. *My experience with legislatures is that if you bring a bill before them and there's high opposition and hostility they tell you to go back and work out your differences.* So, it has to get healed within nursing...*the decision I think was made [by ANA] that the market place would take care of doing it.*

20. ...*But for some it's a refrigerator nurse mentality that's the problem.* [This refers to a term called “appliance nurse” which implies someone who only works long enough to pay off or to buy a new appliance.] *You come in, you collect your paycheck, you go home, it's 5:00. You know you work for the refrigerator. It's not a professional mindset.*

**COURSE DEVELOPMENT**

Course development refers to the content of courses offered by schools of nursing, or courses that were felt to be necessary within nursing programs.
21. Very few programs have much orientation of graduates on any level to policy, to trends, to the nature of the organizations in nursing. I have always found that anything I learned reflected back on nursing, enhanced what I knew about nursing, and the way I perceived it.

22. I would probably make economics and health policy a requirement—undergraduate—and I would (because nurses need to be socialized differently)...I would work hard to educate leaders.

23. I think to be liberally educated is the mark of an intelligent person and provides you with a foundation for critical thinking later on.

24. And since a lot of discussion is at that level [economic], I think nurses have to learn how to communicate at that level. I think people who go into there [nursing] have to be caring, more caring than the physician or specialist. But I think they've had not very high expectations of what they could achieve. They're taught to be a nurse and not think beyond that.

25. ...the kinds of skills most important to me, clearly my interpersonal skills, my ability to communicate with people both in written word as well as spoken, I think is critical. I think the ability to think fast on your feet, the ability to work in a very confused environment and put some order in the place...ability to gather complicated information and assess it and then translate it into a language that people understand...all those were
critical components of my nursing education. But I think if anything, I think if you could just bless people with self-assurance. I think mentoring is a very important responsibility.

26. I think that our fundamentals in nursing help us apply things differently in health with our understanding, which is critical. If you don't do anything other than serve as a role model for other nurses, if you don't do anything other than push the envelope in terms of what nursing can do...[it creates a positive model for students].

27. I would see changes in education, and the changes in education are to some extent liberalizing it, and secondly raising its value. I think a well rounded education makes a person a professional - period...we produce the best scientists in the United States and to some extent the best scholars, because we have a more liberal education, and I would like to see that happen for nursing.

28. You have to maintain whatever is good about nursing at the clinical level [in nursing education]. I think we have a fairly good model, but I think we have to be very alert to what the changes in the community [marketplace needs] are. If you don't have students you don't survive. You need to move with the market.

29. I don't have any doubts that certain kinds of skills that are needed can be taught at any level. On the other hand, people with an understanding of what they're doing do a better job.
30. *...and students are not being taught how to make it relevant, how to apply what they know...even when they say policy they don't know what they mean...and a policy course so called simply lists certain nursing policies on the books. More than once I went through all the hoops and it [a proposed nursing course] was turned down [by the nursing school] because there wasn’t enough “nursing” in it [the course expanded into other disciplines].*

31. *We need to educate for a career in nursing, not for a particular job interview.*

**Warrant:**

Issues regarding professional entry are described by the respondents in a range of feelings about the necessary level of preparation needed for a professional nurse—two-year, four-year, or graduate level. It may be that the marketplace will determine what is valued by society in relation to the level of nursing preparation (two-year or four-year). If no appreciable differences in practice can be demonstrated, the value of a two or four-year program may come down to salary demands. It could be argued that outside of this data the differences are evident in practice, and that cost issues are driving the demand for lower salaried nurses while the true differences are ignored. Overall, the data provide a sense that most nursing faculty are “behind the times,” are not preparing students for a managed care environment, and are not experienced in current policy issues. The comments indicate that faculty is removed from the real world, and many are insecure,
which is reflected in their teaching. Questions here could be raised about why the institutions themselves do not seek a higher standard in faculty preparation, or provide continuing education to upgrade teaching skills. Perhaps if a culture for change in recent years had supported course development or seminars that were more reflective of a changing health care environment, nursing’s response to managed care would have been entirely different. Some respondents mentioned that nursing research does not have practical relevance, perhaps from trying to adhere to rigid principles. This has also been said to be true for research in many other academic settings outside of nursing.

Undoubtedly, the two-year/four-year dilemma will be resolved one way or the other (by nursing or the marketplace) because it is confusing to state legislators who deal with nurse licensure issues, and it is confusing to the public who aren’t sure what “a nurse” really does anymore. There was frustration expressed at the ambiguity and lack of ability by nursing as a professional entity to solve issues about nursing preparation. While it was stated that there is not enough information available to the public (or other professionals) to differentiate the difference in functions between the 2-year and 4-year graduates, it was also mentioned that some skills that are needed can be taught at any level. If this is true, it seems reasonable to expect that skill levels could be more clearly differentiated. However, an advocate of 4-year preparation might add that skills of assessment and judgement can simply not be conveyed in a 2-year curriculum. Of particular interest was a comment about the level of expectations present in today’s nurses, suggesting that many nurses do not have high career expectations, regardless of the level of preparation. This could also be a statement reflecting a change in the general work ethic, which is under debate in many aspects of society.
Attitude

Claim:

The innovative policy-making abilities of nursing as a profession are severely compromised due to internal dialectical tensions and contradiction.

Evidence:

NATIONAL ORGANIZATIONS

The national nursing organizations most frequently referred to in the evidence (and in the literature) are the National League for Nursing (NLN), and the American Nurses Association (ANA). The NLN accredits schools of nursing, and is highly influential in that respect. The ANA was very active in the health reform effort by the Clinton Administration, and is well known for its lobbying activities. The ANA’s legislative endeavors are concentrated on matters affecting nurses, nursing, and health, but in today’s society these matters represent an extremely broad area of activity, ranging from child care to gun control (Kelly and Joel, 1995, p. 595). Sometimes, the NLN is referenced as the representative of “nursing,” and the ANA of “nurses.” The organizations are publicly courteous to each other, but privately they are often competitive. AACN (American Association of Colleges of Nursing) is currently interested in a move into the nursing school accreditation arena, since the NLN has come under fire from the Department of Education, and may lose its status as the nursing school accrediting body. Both ANA and AACN may make movement toward becoming a new nursing school accreditation entity
or entities. The Tri-Council was originally established to bring the national nursing organizations together. It includes the ANA, NLN, AACN, and the AONE (American Association of Nurse Executives). Fellows of the American Academy of Nursing (FAAN), established in the 1970s by the ANA, are inducted into membership in recognition for excellence, and as influential nurses in the profession. In the past several years, many other nursing specialty organizations have been established, largely to fill gaps in representation felt by multiple nursing groups.

1. *I think at the moment that our organizations on the whole, the real world in which most of them operate most of the time, is a world made up of each other. And if you ask them who the opposition is, with ANA, NLN, AACN, and so forth, I think a lot of their positions are couched in how we advance our own organization over the organizations that are seen as the competition. But maybe I’m cynical. Maybe the Tri-Council has helped.*

2. *...and the way the splintering has occurred is the fault of our major organizations a while back. If you look at the history of ANA...we have a history of really stupid decisions...I’m not sure anyone is all-wise, and we have to have tolerance, but we’ve made some real lulus.*

3. *Should there be an ANA and a League [NLN]? Should there be? Because there are other organizations that have virtually equal clout these days.*
4. What's happening at the League is so incredibly painful to watch...and ANA is not -
they're doing some good things - but they're not great shakes either. You can't make
change if you don't have some managerial control of the situation. You have to have
some kind of control and a national perspective about what goes on, and that's not the
case with ANA...Right now it looks pretty dismal from wherever you sit in terms of
organized nursing.

5. The problem with specialization always is it sometimes divides a profession, because
the specialists want to kind of control more themselves. The conflict is always at the
pushing apart. I think they [specialty nursing groups] have such large specialty
organizations, I think they probably lobby for themselves. The question then becomes
what is the ANA's role, who does it really represent? My sense is that nursing has always
been sort of torn between different goals. Some associations, like the AMA, have been
clear about what its economic goals are...I don't think nursing has been that way.

6. The third aspect of my career is what I call "professional politics," which is working
to unify the profession through the use of organizations. I think it's time to renew
nursing's organizational structure in the US. I would like to see that happen. One of
the fundamental problems with nursing organizations in this country is that nurses by
and large suffer from what I call "galloping egalitarianism" and just will not
acknowledge distinctions between people, between educational levels.

7. ...nursing was extremely well unified around that [1993 health reform].
8. I do think that nursing achieved a lot in the area of socio-economic welfare through the union movement within ANA...so I can stake a lot on the side of why we should have a union. On the other hand, it tears us apart [because some feel that unions have no place in professional nursing].

9. When they're [national nursing organizations] good, they can be very, very good. When they're bad, and they don't communicate, and they don't do a lot of the right things, which I frankly think is happening now, they are less effective. Right now for example, the relationships among what were considered the linkage organizations [NLN, AACN, AONE, ANA] that were members of the Tri-Council...why it's not viable...because of such negativity by the other members of the Tri-Council [referring to NLN] that you certainly can't get the four of them together on many issues. So that really hampers us. I don't think that we do wrong things. I think we're not unified around issues. Doing the right things is when you're unified about an issue...and do it all together. And then and in a unified way, and that's the right thing. The wrong thing is to not do it.

10. You know, the Academy [AAN] is truly a bunch of very competent women, but it is just devoid of energy and initiative. It's a very discouraging process to work with some of these national organizations. It's no wonder that they can't do more in the political arena because they never do anything that's timely. It either kills you or you learn, OK,
let's put it in context...because there have been times when it's gotten so bad that it really distressed me, and to me that's destructive.

11. There's not one group [national nursing organization] that speaks for nursing...that's very divisive in and of itself. And it's very divisive internally.

12. [What will the AAN do about the state of nursing?] I don't know. As long as it is associated with the ANA I think it's going to continue to go around in circles. It can't be an elite research think tank and tied to labor. If it could break loose it [AAN] could possibly be focused on the leadership role, but the problem is that there's - it's very insular. There's a lot of belly button gazing. And that doesn't prepare you to deal with the rich docs of the world.

13. [On accreditation] I'll probably spend $300,000 writing this report, and it will go on the shelf the day the visitors leave, and probably never be looked at again, unless I want to find a quick place to look at my terminal objectives, my philosophy, and my goals. I think it's a terrible way, and schools are going to stop paying for it [accreditation]. The market forces are going to drive it [value of accreditation]. Accreditation is out of the 1920's; it doesn't do anything for us in terms of observing quality. I can name any number of schools that are fully accredited by the NLN who should close their doors. [Could AACN bring a new philosophy?] It's possible. The problem is that they don't have any associate degree or diploma program - diploma programs are going to be gone, but associate degrees are not going away...now they are beginning to make noises about
some kind of affiliation...but I don't know, then it seems to me you're recreating the NLN. Why go to all that trouble?

LEADERSHIP

Leadership refers to the ability of people in powerful, or influential positions to lead nursing as a professional entity in policy-making activities. The attitude of nursing leadership is likely to have an effect on how united the profession is as it moves, or does not move, toward new policy initiatives.

14. *I think there's a big gap in nursing, between Nancy Nurse and the nursing leadership. Leadership has one image of nursing, Nancy Nurse has another.*

15. *We really have an identity problem. We don't know if we're professional or blue collar.*

16. *80% of nursing leadership knows only their little dimension.*

17. *Some deans still think the dean group is the elite group. That is not true any more. Are the deans sophisticated enough to know that? The top deans, yes. But as a whole, not yet.*
18. *The biggest complaint I have is that nursing research tends to be published only in nursing research journals and it’s not for the other disciplines. In the other disciplines you rarely see nursing stuff, so I think the other people that do health services research just don’t see nursing in a research way.*

19. *I know that we always talk about the fact that we’re hard on ourselves and we’re our own worst enemies, and we don’t realize our full potential, and we’re oppressed and we turn on each other, and so on and so forth - those are all unfortunately true things. They’re not so different though from other groups.*

20. [On how to “fix” things] *I would pick a leader who understood that now is the time to develop private sector initiatives. I would put aside collective bargaining and would work out a transition phase to get rid of it completely. I would give nurses some strength and control over quality in the managed care setting.*

21. *There really is no identifiable leadership in organized nursing at the national level...nobody’s coming up with any new approaches and new perspectives. That’s a fundamental problem.*

22. [Observation about a nurse in business] *She’s very innovative on controlling health benefits. I have her talk to my class. She’s an ex-nurse - well, she’s a nurse.*
23. I never, ever in my life have ever believed that I couldn't do whatever it is that I was doing...and I avoided the risks that a lot of other women have faced in being a little insecure...I also had some terrific mentors.

24. ...there are enormous opportunities out there for nursing if we've got the courage to take them and get beyond our own world. Quit talking to each other and talk to other people for a change.

25. It's [nursing leadership] limp, it's too cautious, it's not responsive, it won't admit that the empress has no clothes. I just get tired of the rhetoric.

26. ...so they don't even speak in courageous terms. I have had the leadership not support me in public but behind the scenes say, "I really go along with what you say, but I can't say it." Only in nursing.

27. A lot of us are very politically active. It's the body politic that's the problem, and unifying them is a problem. I think since the Cold War ended, all our anxieties and fears that had an external enemy are now turned inward...Women don't like all that mudslinging and negative campaigning and all that attacking...I think that kind of cooperation and understanding and ability to rise above is the kind of thing that we as nurses can bring to our political situation. I think that maybe as leaders, the leaders in place haven't managed to advance that perspective. You see fear, and you see an inability to get access, you see a lot of infighting among the national organizations.
EXCLUSIVITY

Exclusivity refers to limited possession, or control by some individuals in nursing of the leadership or membership of certain organizations, or professional activities, including professional recognition. It means the power to exclude certain people, or certain groups from participation, or accepting or soliciting participation only from a selected patronage in professional activities, which may affect policy-making.

28. [Will nursing as a profession survive?] First you have to say should it? And to be able to say that without a vested interest - my job - a difficult point for nurses or any group...And the higher you go...the more vested they are in high paying jobs, so it's not going to be a happy question...Every time I see another fight in nursing, I say, more chicken pecking.

29. I don't feel like I've ever left nursing. I think nursing left me at times.

30. I've always been very careful, when asked, to identify myself as a nurse, my view being once a nurse, always a nurse. I have remained committed to nursing as a profession...I have had mixed experiences staying involved in organized nursing...there seems to be no particular effort to involve us [nurses who work on Capitol Hill] into the Associations...I never felt that there was any real effort to keep us engaged or involved or
up to speed. I don't know whether there was some aspect of jealousy among the organized leadership that I was more prominent than some of them were...I don't think that's it, but it's certainly an option.

31. ...there are some nurses who have moved into I call it "up and out" because they extend their influence beyond nursing...some have done that and have lost their nursing identity. It depends on what identity they have chosen...it depends on how they do it. In some instances I'm pleased at it and in other instances I'm not, because I think they sort of left the profession and chose another path.

32. A lot of people have been "former nurses." And if you let them get away with that, they keep doing it. But if no nurse ever allowed it, they wouldn't do it.

33. We're pendulum swingers of the worst order in nursing.

34. [Nursing's] biggest asset is a small group of nurses who know what needs to be done, but are frustrated at not being able to do it. And as has happened for decades, I think nursing loses those folks as they get burnt out and frustrated. It's unfortunate because minority views are simply not tolerated, are not supported, are not even given an audience, publication, so on and so on.

35. Nursing is worried about earning their stripes while rich docs and attorneys and business people are buying, merging and affiliating.
36. [On creation of an innovative educational program, how did this go over with your peers?] Oh, it was awful. Now [that it's survived] it's a lot better. It's hard to argue with success.

Warrant:

The data show a sense of proliferation of organizations that are not working together. Even the Tri-Council, which was organized to bring the nursing organizations together, is not felt to be very effective. There is consensus among many of the respondents that organizations are lacking new ideas, and initiative. Whether or not the large national organizations (NLN & ANA) should continue to exist was raised. While it was felt that nursing had unity around health care reform in 1993, there is also hopelessness about cooperation and decisive leadership stands. The lack of agreement and cohesion seems to carry over into concerns about leadership. There is a sense of narrow focus, and the need to open up to realities that are external to strictly nursing viewpoints. Overall, a big focus in this section seems to be reaction by respondents that include personal difficulties and successes of being leaders in nursing, and experiencing professional dissension, apathy, and in some instances being excluded themselves. There is a sense that competence is not being utilized and will be lost potentially to other disciplines, or to business. Some nurses will choose to become “former nurses,” and move away altogether into new career directions, which is a loss on the whole to nursing as a profession. There is also a perceived fear about speaking up in non-supportive terms within professional nursing

104
circles, for reasons that may stem from a fear of retribution. The disillusionment expressed about the politics of professional nursing is reported to stem from internal divisiveness in nursing organizations, and by conflicting policies among nursing organizations, and a general lack of innovation to provide new direction and leadership. An outsider could argue that conflict in nursing is self-imposed, by an inability to constructively exchange ideas. If this is true, than the ability to restore innovation in policy-making is impaired. On the other hand, the causes of dialectical tension are not easily explained. Discussion and reasoning by dialogue is a method of intellectual investigation and a systematic way to resolve conflict. Perhaps innovation will ultimately stem from the tensions currently perceived. It could similarly be argued that nursing’s problems in this area are the result of oppression as a predominately female profession, and the result of a larger societal problem, rather than simply internal bickering. However this argument would be more compelling if the majority of respondents were talking from a male perspective. Since the observers are primarily women, the perspective may be of a different sort. Different judgments about the image of nursing imply different ideas about human development, different ways of imagining it, and different notions of what nursing’s value is in society. Theories about discrimination, social equality and justice will consistently reflect an observational and evaluative bias.
**Influence**

**Claim:**
Nursing’s effect on national health policy-making has suffered, primarily because of a lack of understanding about economics, an unclear political mandate, and a failure to be bipartisan.

**Evidence:**

**ECONOMICS**
Economics refers to understanding the production, distribution and consumption of goods and services in relation to health care services in the United States. Within this context, the value understanding an economic perspective is important for nurses, and the ability to understand scarcity issues, tradeoffs and the link with positive or negative incentives.

1. *Most nurses don’t understand economics. And what they do understand is usually very negative.*

2. *I think the market place is going to drive everything and people who are going to respond quicker to that will be those outside the field. They’re not bound by traditional vision, of roles and how you provide care...And that’s where all the change will come.*
The money will be taken away from existing people. And they’re going to be innovative, and that’s where all innovation in health care is coming from, outside the field.

3. To the extent that [nurse] practitioners like that [as substitutes for physicians], again, denuded of the rhetoric, are shown to be cheaper [economically speaking], then nursing can push for that, and if you want to call that having an impact on health policy, OK.

POLITICAL MANDATE

Political mandate refers to the authorization to act given to a representative. In this instance, political mandate refers to nursing as a professional entity’s actions (and the resulting effects) on policy-making, or the administration of policies within the legislative political arena. Political mandate, in the context of the interviews, refers primarily to the ANA and NLN, although occasionally specialty nursing groups (midwives and nurse anesthetists) were mentioned.

4. Nursing can get away with, it seems to me right now, a lot at the policy level, by putting out nice agendas that everybody likes. The members of ANA and other groups say, “Yeah, that’s great, that’s great, that’s great.” And we’re for that, and we’re joining this group and we’re joining that group. 90% of it never gets done, and everyone feels good about it. And it’s always some other guy, or the Republicans, or Clinton or somebody prevented us from having this accomplished.
5. The problem is as soon as a nurse starts speaking only nursing advocacy she marks herself as an amateur. An amateur in politics. Because when you are playing from an advocacy position, you are a lobbyist...They are known as lobbyists, not as statesmen.

6. I think politically we are adolescents at this stage. We're better than we were but we are learning that we're not grown up yet.

7. My feeling is that nursing is making a mistake by putting too much emphasis in a national effort in terms of Washington to achieve health reform, when I think that there could be more effective areas to do the reform. Like doing it at the local level.

8. [Does nursing “get it” in terms of policy?] I think they “get it” in the sense that they [ANA] are effective in terms of the technical aspects of policy...where they are weak is: a) overrelying on the political process to give them timely solutions; and b) they often fail, in my opinion, to understand the real problem in the first place.

9. Nursing has looked at broader issues of its members...I think they’ve [nursing as a professional entity] hurt themselves that way. My feeling is that once managed care started coming on the horizon, nurses should have really jumped on the movement instead of fighting it.

10. It’s not all clear to me that the rank and file [as opposed to nursing as a professional entity through national associations and leadership] feel as similarly consistent in terms of
a single point of view. I would never want to suggest that ANA or anyone else [should] become less than enthusiastic about political activity. But it would seem to me that there ought to be a conscious effort to make sure that they are in fact dealing with both sides [associations/leadership with the rank and file].

11. [On nursing influence on health policy] Yes. Nurse anesthetists were spectacular. The nurse midwives were remarkably successful.

12. They [nursing as a professional entity] certainly were not critical in their involvement in the health reform debate [for the Republicans]. Some of the work in nursing research...the establishment of the Center [National Center for Nursing Research]...But I think they [nursing as a professional entity] would be the best judge of whether or not they've succeeded in whatever their legislative goals were, and on a yearly basis I couldn't tell you what their goals were. The next four years will be an opportunity for women really to engage these folks.

13. Until they [nursing as a professional entity] in some way remedy the educational base, or strengthen the educational base, it weakens to a substantial extent, the political activism. On the other hand, one can make the argument that with the numbers we [nursing as a professional entity] have, we're more effective politically. Now when I say politically, I'm talking about with government, influencing governmental policy.
14. We [nursing as a professional entity] are more or less effective depending upon the period of time. There was a period of time when I thought we were really exceedingly effective, but there was a tremendous effort to get together on major issues. The organizations' power with Congress, particularly with the ANA, is really quite outstanding. Whether or not they maximize on that all the time is a major question.

15. [Has nursing as a profession been effective in health policy?] You have to show me what it's done. What nursing has done is that it has managed to get funding for itself. Period. The rhetoric sounds wonderful, but when you look at the actual proposal and the things that really nursing has pushed, that is to say, where they put their lobbying resources - that's all that I look at. It goes into lobbying for education and research... I look at where they put their resources. They don't go where they talk...and I just don't pay attention to it.

16. ...When I say health policy, I mean policy that affects our health. And nursing virtually does not deal with that. ...If you really care about the health of the population...you must address the broader based health problems. There is no vision of that in nursing.

17. [Effective as a professional entity?] No. It doesn't surprise me that we've been left out of the, not been at the table, or been at the table in very small numbers...you have many times a blue collar mentality among large groups of nurses that lend themselves
very easily to unionization and that doesn't help in terms of forming policy, because that
tries to make things status quo.

18. ...they [nursing] argue from a very emotional, non-data driven basis, such as ANA
stating that every patient needs a nurse. That's nonsense. Every patient needs care.
And a whole variety of people may give care.

19. So it seems to me that the American Nurses Association has over the years managed
to have very influential nurses in places where they could help influence health policy.
One of the things ANA, and nursing has done, is to form a PAC [Political Action
Committee], and that PAC, I believe has been among the top three of contributing funds
and carrying their story and some money with it to help get people elected who
understood nursing's concerns about delivery of health care and about nursing education
and research.

PARTISANSHIP

Partisanship refers to supporting one or another political party. In particular, partisanship
is referred to in relation to the American Nurses Association.

20. We don't use people like we should have, could have and she [referring to a top
Republican nurse], sometimes is blamed for having a larger view than nursing, but that's
what makes her effective.
21. [On nursing's contribution to policy] It's hard to pull out any central thing that nursing has done...I think nursing participated [in health reform] but we know what happened to the plan [Clinton's health reform plan that was not implemented]...So, as a result, nursing hasn't had a direct bearing in - they can't claim that we had this outcome as a result of this...It seems to me that nursing gets clustered together with other groups of like-minded people and joins the consumer unions or the unions here or this group there. So our agenda kind of gets swept up and included with a larger group.

22. The only way you can change a thing like this [Medicare solvency] is do a bipartisan thing. They won't do anything really drastic until after the next presidential election. Clinton lost an opportunity from his negative campaign ads about Republicans cutting it [Medicare].

23. The unions have been very much in control of health policy with the Democrats for years now.

24. I continue to be very disappointed at what appears to be the consistent behavior on the part of the [nursing] leadership to get engaged in Democratic politics, but not in Republican...but there seems to be a fair hostility to Republicans as a general matter.
25. ...had I talked with my boss [a prominent Republican], his instinct would be that the ANA was not an organization with a bipartisan or broad view...Now some of the specialty groups [e.g., nurse midwives, nurse anesthetists] are somewhat different.

26. [On support of one political party or candidate] I was not in favor of that...and I still have some reluctance about it.

27. I think it's a mistake to put all your eggs in one party basket and the ANA has endorsed a Democratic candidate for years. One of the successes of actually being successful at policy is being able to step across both sides.

Warrant:

Overall, there was less focus on the influence that nursing as a professional entity has achieved in health policy and many more comments about the work that remains to be done. While it was recognized by respondents that the ANA was very successful in working with the Clinton administration during the health reform process of 1993, there are also concerns about what that has actually accomplished in terms of influence now in health policy by the nursing profession. It was mentioned that nursing viewpoints on the subject of economics are frequently negative, suggesting that nursing may not, as a whole, like dealing with economic issues. Although economics emerged as a pattern within the data, there are minimal direct excerpts specifically about economics. However, the economic aspect of the claim remains plausible by its impact on the influence of
professional groups, including nursing. A service tradition may be impeding professional nursing, which as an entity has fought managed care instead of embracing the potential for innovation within managed care. A respondent made the comment that, while technically capable in policy-making, professional nursing may not fully understand what the actual health policy issues are. Another respondent commented that nursing may have a narrow focus about overall health policy, and too much focus on issues that relate only to nursing. There may be a communication problem between nurses at the staff nurse level, and nursing at the national organization, or leadership level, creating confusion about what the political mandate of nursing really is. Perhaps nursing as a professional group has been too focused on the national level when they should pay more attention to local policy and politics. There is a definite sense of frustration in several comments about the partisanship of the ANA, and its extensive involvement with the Democrats, with next to no involvement with the Republicans. On the other hand, nursing, and especially the ANA has been very successful in obtaining access to the Clinton Administration. If the 1993 process of health reform been implemented, nursing would undoubtedly have secured a role for itself, perhaps of significance. Through its Political Action Committee, and substantial contributions to politicians sympathetic to nursing, it could be said that nursing has exerted influence in national policy-making. The issue may lie in the benefits of nursing’s efforts in Washington DC, compared to the benefits of a greater effort in local politics, which would quite likely be more bipartisan.
DISCUSSION

Fail to honor people, they fail to honor you;
But of a good leader, who talks little,
When the work is done, and the aim fulfilled,
they will all say, “We did this ourselves.”
- Lao Tzu

OVERVIEW

In the third phase of the interviews, during the second review of written transcripts, the broad categories emerged about the effects of nursing in relation to health policy, professional politics, and policy pertaining to education. The Discussion will be organized according to those original three broad categories - Education, Professional Politics and Health Policy. (The reader may find it helpful to refer to Figure 3 again, next page, to review the broad categories, properties, patterns and profiles.) The properties (e.g., curriculum, attitude and influence) within the categories began to shed light on the complexity of issues about policy-making in nursing, a perceived malaise present in many of the respondents themselves, and a general perception that nursing is not as effective as it could be in policy-making. The malaise could be summed up as a concern that if nursing does not educate its students about current marketplace issues and provide strong, unified leadership at the national level, the effects of nursing in national policy-making would not be felt, and nursing would not have the opportunity to influence the broader legislative level. In the discussion that follows, key issues from the findings are elaborated, based on statements from the literature on nursing and health policy, as well as the researcher’s own experience.
EDUCATION

Several references were made by the respondents suggesting that the market place will prevail if nursing does not prevail upon itself to standardize RN educational standards (2-year vs. 4-year preparation). In support of the research claim that the culture for change in nursing education is polarized, nurses and the professional organizations have not been able to unify around broad changes in educational policy, and have instead adopted a narrower focus on general funding for nursing education and research. A certain malaise was expressed by respondents regarding educational leadership within nursing schools. Some respondents point the finger of responsibility directly to the deans, while others express faculty ignorance of the educational needs and necessary course development (e.g., in policy and economics) for students to function in the current marketplace. Unresolved issues in professional entry continue to encumber thinking between what a nurse is, or should be from a four-year baccalaureate program, versus a two-year associate degree program. Until there is a clear distinction between the functions and legal scope of practice between the two-year and the four-year RN, the culture for change in nursing education will remain polarized.

Larson (1994) cited the lack of career aspirations in academic middle managers as a serious problem for nursing. Maybe the majority of nurses both in education and practice just don’t really care, trying only to make a living and to support their families (supporting the “refrigerator nurse” example in the evidence). Or perhaps a malaise exists because of a lack of confidence or self-esteem, and a corresponding lack of unity and concerted purpose or action. While confidence does not appear to be a problem with any of the
respondents, it could be a problem in with others, especially in the rank and file. This becomes a paradox during a period of time that many call an unprecedented opportunity for nursing, where roles are expanding, especially roles in advanced practice. Broughn and Wang (1994) proposed (Literature Review, p.33) that nursing education is uniquely positioned to use feminist teaching strategies to impart principles to empower nursing students, and to help nursing achieve full professional status. They suggest that teaching independence-related characteristics are precisely what nurses need to thrive in the current health care system.

Nursing education has critical choices to make. Change is necessary to produce the nursing “product” that will be viable in the marketplace. While a four-year (BSN) prepared nurse would be a logical choice over a two-year (AD) prepared nurse by most patients, at present the marketplace is largely unable to distinguish a BSN from an AD prepared nurse. Public health and home visiting nurses used to be distinguished by a four-year degree requirement for hire, but public sector nursing numbers are dwindling, in favor of the private sector and/or non-profit organization’s community health nurses. In community health and home health care these days, a four-year degree is desired, but usually not a requirement. The primary determinant for hiring nurses is based on cost. Until quality of care becomes more quantifiable, nursing may need to offer clear distinctions for licensure and practice, to eliminate the blur between the two-year and four-year RNs, or eliminate one or the other altogether. History shows that nursing has not been able to resolve this issue so far, since it continues to license both as “RN,” so the marketplace is left to provide the distinction. Even if nursing wanted to make some
radical change in support of one degree level or another, there is probably not enough time to effect real change (especially in the baccalaureate programs, where change is especially slow). AD programs have grown to the point that they represent a large force in organizational membership, if not the financial strongholds. They can also adapt quickly to environmental changes because they are not deeply steeped in nursing theory, which contains abstract principles about the unique body of nursing knowledge. And, there is not much evidence to indicate that at the bedside AD nurses cannot do just as good a job as the BSN. While it is probably true that many BSNs provide a higher standard of care to patients because of a better theoretical sense, and interpersonal and critical thinking skills, there is little or no data to prove it. Sometimes there may be local recognition. For example, one school may be known to produce a higher caliber nurse than another in the same area. In areas where the market for nurses is saturated, the BSN will still find preference in hiring, but the more important question for nursing is whether that really serves the profession. In other words, so what if a BSN is hired, if the salary and responsibilities are the same as for the AD prepared nurse? There does not appear to be any compelling reason why the AD programs should not be left in place to thrive.

According to some respondents, higher education in nursing might better serve the profession if it focuses on a liberal arts education first, and then entry into a master’s program for graduate level preparation in nursing. This is controversial, because it calls into question the value of continued baccalaureate nursing education and points instead to the value of an interdisciplinary undergraduate approach. In consideration of the need to integrate health policy into the curricula for undergraduate programs, Solomon and Roe
(eds., 1986) edited a book that provided an excellent blueprint. Works like that provide a solid contribution to interdisciplinary, market-based, policy-oriented concepts, but it is noteworthy that this book is where contemporary tools (and ideas) on the topic appear to have stopped. If more nurses continue to be trained at the 2-year level, the ability to integrate health policy (or any other interdisciplinary studies) will be difficult, due to time constraints in a two-year curriculum.

With regard to the integration of leadership theory into nursing curricula, it is of concern that the evidence points to inflexibility, and resistance to change. This concern is supported, in part, by the findings of Kelley (1996) in her study about messages for nursing leadership to guide the education of nursing leaders. In her findings she notes that nurse leaders pay a high price for being “rate breakers” (p. 78) and are pressured to publish only favorable things about the profession. This indicates that if a nurse has aspirations of moving up the nursing leadership ladder, s/he had better not speak in an uncomplimentary fashion. Higher education as a method to combat the tendency by nurses not to speak up is supported by McKenna’s (1994) study of nurses in the United Kingdom, who have higher theoretical content in their courses, and become more aware of the inherent limitation of nursing models; therefore they are more likely to question them. It has been the experience of the researcher that many baccalaureate students in school, and almost all nurses in practice have a strong dislike for nursing diagnoses (which seek to state patient problems in a unique nursing language), and do not use them unless they have to. In the last couple of years, more nurses are recognizing the value of “speaking the
same language” as other disciplines, yet it is very rare to see criticism of nursing diagnoses by nurses in print.

The evidence points to the viability of technical nursing at the AD level, and professional nursing at the graduate (master’s) level. This is not a new concept, but it is one that nursing has not yet implemented. Currently, the “profession” of nursing spans the AD level to the master’s (and even doctoral) levels. Perhaps this appears oversimplified, but in daily hospital practice it is often close to the truth. Patients may not be aware of the level of practitioner who cares for them and when staff is short, the lines can quickly become blurred. In theory, professional nursing is differentiated primarily by autonomy of practice and specialized expertise. The AD nurse assists in the planning of nursing care for patients, gives general care with supervision, and assists in the evaluation of the nursing care given. Differentiating technical and professional nurses would be the clearest way to distinguish between and solve the long-standing dilemma about licensing two-year RNs differently from a master’s prepared RN manager (practitioner or administrative).

The evidence points to the integration of critical thinking skills as an apparent benefit of the four-year professional nursing degree, but integration of critical thinking into the two-year programs is unclear. The need to think critically was also addressed as an essential component for nursing graduates by Anderson (1996) in the Literature Review. However, this is subject to different interpretations about just what critical thinking skills should be. Increasingly, the positioning of the baccalaureate prepared nurse is difficult to posture within the technical and professional dilemma. The question has been raised in the evidence whether or not BSN programs should provide the first professional degree, or if
it should just be applied at the master’s level to provide a greater incremental leap between
the AD and master’s prepared nurses. There is a good case for that by other disciplines in
health care, which have professional educations that are based on a liberal arts degree.

University faculty need to be re-indoctrinated, or certified perhaps for teaching into the
next decade. Deans that allow courses, and faculty, to remain “status quo” without a
serious appraisal of the teaching skills and research focus of the school, could be setting
their programs up for failure, either through the attrition of students, or by lack of demand
for their graduates. Respondents expressed the need for special efforts in faculty
continuing education, either to mix clinical skills with theory, and/or to gain a better grasp
of policy and economics. Womack (1996) noted that the least frequency of changes made
by 44 new nursing school deans surveyed were changes related to evaluation. In an
evolving health care environment, almost constant evaluation of nursing programs would
be indicated. However, much, (not all) of nursing education appears to have insulated
itself from a broad worldview, and the place nursing can have in today’s health care
market. The evidence suggests it is because of ignorance. It may be just as likely that it is
out of arrogance, or even fear of uncharted territory, or threatened jobs because of lack of
competence. If it is out of ignorance, then futuristic leaders are critical to the re-
development of continuing faculty education, which may need to be mandatory. If it is out
of fear or arrogance, then strong managerial skills are necessary for deanships in order to
“clean out the dead wood.” Educational leadership that understands the market place may
need to be in a partnership with non-academic nursing leadership in order to facilitate
relevance between the practice world and the world of academe.
The evidence indicates that accreditation has fallen out of usefulness to most educational institutions. It may be true that a significant problem for education is that accreditation has not remained current with business trends or market place issues. Standards for accreditation appear to foster a narrow viewpoint in education, which in turn may fuel the lack of relevance in many education programs. Arthur and Baumann (1994) stated that the half-life of most curricula is five years. If that is true, then accreditation is long overdue for a complete overhaul.

If it is true, as the evidence indicates, that nursing students have low expectations about themselves in school, so will expectations be low in practice. If technical nurses are being taught to provide the day to day routine clinical care of patients, then nurses prepared at the graduate level could be directly prepared for a career of management, for example as case managers for groups of patients, or other types of positions in inpatient or community-based health services, or for clinical practice in all environments. With the added theoretical knowledge that baccalaureate nurses receive, they should be better prepared than the two-year RN to care more effectively for seriously ill or complex patients in the hospital or in the community. This could also become managing the care provided to patients and not, necessarily, providing that care themselves.

Notwithstanding, some nurses will want to remain clinicians only and will not be interested in management of any sort. These nurses will always be needed for complex patient care. In the opinion of the researcher, this strengthens a case to increase the focus of baccalaureate education for nurses aspiring to graduate school to include an economic
perspective, management (patient or administrative) and health policy as part of a health services career preparation. Finally, the use of mentors remains an elusive and yet apparently important ingredient to the students' self-assurance and confidence. This is well documented in Kelly's (1991) book, and is often mentioned in the literature. There is no argument that mentorship is a very important component of preparing nurses and leaders. The issue raised most frequently about mentorship is the lack of qualified and willing mentors.

PROFESSIONAL POLITICS

In the current health care market, nurses' roles are said to be increasing as entrepreneurs, policy analysts, advocates, and information specialists. If this is true, then the attitudes of the nurses in these roles will become critical in relation to whether or not the current behavioral trends in the professional politics of nursing will continue to be tolerated, or be ignored. The evidence does indicate that the innovative policy-making abilities of nursing are severely compromised due to internal dialectical tensions and contradiction, as stated in the research claim. Dialectical tension refers to the examination of opinions or ideas, which may or may not be contradictory. However, it may include the contradictions about what nursing "says" compared to what it "does." For example, issues of entry into practice have gone unresolved for many years, despite the constant discussion about the need to correct it. Another example is the silent conflict that appears evident when nurses are afraid to speak the truth, as they believe it to be because of a fear of retribution, or a lack of acceptance by their peers. The literature supports the need for more focus in
health policy (e.g., understanding and participation), as well as market trends in nursing curricula, but evidence of substantive changes is not evident. Generally, the evidence points to the lack of a common identity in nursing, which appears to be due to incohesive goals and expectations. And, while this document has not addressed the details of conflicts and competition that are evident among nursing organizations, they exist, and the respondents point to it.

Nursing organizations were not highly thought of by the respondents interviewed. This is rarely evident in the literature, probably because no one wants to write about it. In nursing (as in most other professions), it is not considered good taste to air dirty laundry, so to speak. However, the organizations write plenty that is positive about themselves. Meanwhile, interview statements made by the respondents about the lack of creative leadership, and a “dismal” outlook in terms of professional nursing, support the claim that innovation in policy-making for nursing is severely compromised, and is probably due to internal tensions and contradictions.

Cohen (1996) noted that some nurses develop faster politically than the rest of the profession, and often serve as role models, however not necessarily through the efforts of their professional organizations. This supports the notion of exclusivity felt by some of the respondents who have gone forward to become role models and leaders outside of a traditional professional nursing path. This also supports the example mentioned by Fagin (1996) of “dysfunctionality among nursing leaders.”
In the evidence, a fundamental problem for nursing is that there is little identifiable leadership at the national level, and there seem to be no new approaches or perspectives. In relation to power and influence, Kelly (1991) mentions a concept of reputational power extending to the national level by virtue of position or perceived influential status. She raises the suggestion that nurses may not seek power because they lack self-confidence, or take their power for granted. This may be true in concept, but it appears more likely that the problem with nursing leadership at the national level is due primarily to a lack of innovation, rather than a lack of influence or opportunity to lead. It takes a special individual to use her/his power and influence to “grow” new leaders to replace them. Too often, it appears that nurses in positions of power may use that power to protect themselves rather than to promote someone else.

Issues of exclusivity were mentioned by several of the respondents. Exclusivity refers to feeling left out, or shunned by peers. It also implies that some in nursing tend to feel like they are an elite group, or maybe a “cut above” others in the profession. Regardless of the level of success in the marketplace, politics, business or otherwise, the nurses interviewed that are successful on the “outside” of nursing (e.g., in business or other arenas), or who have chosen paths not in the mainstream, have experienced non-acceptance by nursing peers. Sometimes these nurses are accepted later, when the endeavors they have undertaken suddenly come into favor. This could be because of jealousy, or perhaps their peers fear being different, or maybe it’s because success outside of a certain comfort zone for nursing becomes threatening. Some of the respondents felt that nursing has excluded them for no particular reason, except perhaps for being different. Fear, or non-acceptance
of differences, also supports the innovation profile (please refer to Figure 3) in the category of professional politics. It is likely that nursing suffers from fear related to innovation as much as it does from a lack of innovation.

It is also possible that nursing conflicts are due to nurses (particularly female nurses) being part of an "oppressed" group. This could be due to patterns of gendered behavior or some kind of victimization of a group not in power politically or economically. Jacano and Jacano (1993) write that nurses are confronted everywhere with the idea that they must become leaders, and that humans have a natural tendency to shun leadership roles. It is possible that that could explain some attitudinal issues in general, but that concept does not hold up in the context of the internal divisiveness cited by some respondents, in addition to statements about a leadership "devoid of energy and initiative." This suggests that the leadership problems in nursing stem from the existing leadership itself.

HEALTH POLICY

The research claim is that nursing's effect on national health policy-making has suffered, primarily because of a lack of understanding about economics, an unclear political mandate, and a failure to be bipartisan. The American Nurses Association has been very proud of its record in health policy, and reported influence with the Clinton administration. This accomplishment should not be diminished. However, according to the evidence, the goals of national nursing in relation to overall policy from a national health care legislative perspective, seem to be narrowly focused on lobbying for education and research. This
was supported in the article by Cohen, et al (1996), when the ANA's Political Action Committee ranked third in 1994 among health-related PACs in contributions made to federal candidates, and when the National Center for Nursing Research, was upgraded to the Institute of Nursing Research in 1993. However, Cohen's article also acknowledges that in the 1970s and 1980s presidents Nixon through Bush consistently sought to underbudget funds for nursing education and research, which lends support the strong PAC presence, assuming that funding in these areas was the best place to put nursing's resources.

At the same time, nursing has fought the market trend toward managed care, primarily because of a perceived negative impact on patient-to-nurse staffing ratios in hospitals, or loss of nursing jobs. The issue of cutting nurse positions to lower hospital costs is serious to the extent that patient care is compromised, but there is little data to refute the cost saving issue. Therefore, it may be difficult to use nursing staff reductions as a policy issue in the long term, unless the reductions are clearly tied to poor quality care. There are some opinions that the ANA appears unable to remain neutral on this issue because of its interest in the labor movement. The ANA Executive Director co-authored an article (Keepnews and Marullo 1996), which painted the concept of managed care with almost demonistic [profit-oriented] motives of cost cutting, and the removal of RNs from the bedside. This limits the ANA's potential to solve problems. Instead, ANA fights for nurses' "rightful" place in health care by placing blame for jobs lost on managed care and hospital executives. This places nursing in a strategically adversarial position with managed care instead of partnering with it to offer solutions with a nursing workforce.
Cohen and Juszczak (1997) stress the importance of understanding the financing of managed care to position nurse practitioners to negotiate contracts. The latter attitude is more consistent with the opinions of the respondents, that nursing needs to embrace managed care as an opportunity, rather than to fight it. Regardless of the merits or the detriments of managed care, the concepts within cost containment are going to remain. Understanding the financing (economic) issues would position nursing to offer constructive solutions to the health care cost crisis, and at the same time further its (nursing's) interests in providing quality patient care.

The specialty organizations (e.g., midwives, and nurse anesthetists) are well recognized, well organized, and have represented their members well in policy matters. Specialty services have been recognized as a cost-effective alternative to traditional medicine, primarily visible by their prescriptive authority and/or ability to bill independently. However, the specialty groups also tend to splinter nursing by creating their own national associations and lobby groups, which ultimately has a negative impact on nursing as a whole. Common sense dictates that if the specialty groups felt they had adequate representation with the existing national associations (ANA, NLN) they would not have felt the need to create specialty organizations in the first place. Splintering issues, therefore, also contribute (at least in part) to an unclear political mandate on behalf of organized nursing.

The issue of bipartisanship is of significant consequence for future influence by nursing in health policy. Alienating the Republican leadership by maintaining a Democratic affiliation
may prove damaging to nursing influence in national health policy in the coming years. Regardless of which party is in power in the White House, the other party will need to be dealt with in the House and Senate, which is likely to be controlled by the opposite party. No matter how entrenched nursing is with the Democrats, patients and nurses come in both party types. And, it must be noted that at least two nurse respondents are active Republicans. However, the ability of nursing to influence legislation that promotes nurses as cost-effective physician substitutes will make as much sense to a Republican leadership as it does to the Democrats. This particular issue (cost-effectiveness) will remain compatible with both a labor and non-labor orientation, which makes the value in health policy negotiation a golden one for the profession. While ‘lack of understanding’ was a profile (recurring subject) in the analysis of the data within the category of health policy, it is worthwhile to consider if it is really lack of understanding, or a more reasonable avoidance of a bipartisan viewpoint. After all, the Clinton Administration was responsive and very inclusive to nursing in 1992 health reform. Historically, the Democrats have also been more sensitive to labor and women’s issues. It was also suggested by respondents that nursing would be well served to focus more on a local level, instead of expending so much energy with the Clinton administration. Several references in the literature review in Chapter 3 discuss the need for nursing to develop leadership and savvy in health policy-making (Milio, 1989; Cohen et al, 1996; Weisert, 1994; Helms, et al., 1996; Conn and Armer, 1996). The American Academy of Nursing (1982) presented an excellent blueprint to improve the balance of power in health care policy development, but no one seems to have followed it.
Overall, it would appear that nursing's primary influence in policy is the result of political action committees, with significant money for lobbying activities focused on employment and funding. In addition, regulation at the state or federal levels has authorized reimbursement of advanced practice nurses to meet the health needs in underserved areas. In some states, for example, direct reimbursement to nurse practitioners under Medicare is limited to rural areas and must be under physician supervision (Weissert, 1994). This, however, is not so much the result of nursing influence, as it is the result of a lack of enough physicians in rural areas.

Nursing's effects on national health policy have suffered because of an imbalance between politics and policy. In the evidence, a respondent mentioned that nursing behaves like lobbyists more than statesmen. Lobbyists are known for their shrewdness in promoting a particular policy and a keen ability to penetrate, even manipulate, the political process. Statesmen are known for their wisdom, prudent conduct, and principles in the course of action. Perhaps if a balance could be found through understanding the differences between lobbyists and statesmen, and acting on them deliberately, nursing could position itself to have greater influence within the politics of health legislation, as well as in the making of health policy.
SUMMARY AND CONCLUSIONS

If you want one year of prosperity, grow grain.
If you want ten years of prosperity, grow trees.
If you want one hundred years of prosperity,
grow people.
- Chinese Proverb

SUMMARY

This chapter will begin with a general summary, and proceed to issues around the research question asked about nursing effects in policy-making. Twenty years ago, when a person went into the hospital, it was considered by many to be one of the safest places in the world. Times have changed. Now, some families will not allow a loved one to stay in a hospital without a private-duty nurse, or other relative present because they fear poor quality care. Concern about quality is scary for the public, and painful for many practitioners, including doctors. Many believe the costs of medical care in America have gone out of control, and that “fixing” the problem will take the brightest minds and the utmost commitment by all involved, including the public, the politicians and the professionals. At the same time, other people are re-thinking cost escalation, and believe in consideration of an aging population, perhaps the growing medical costs are simply unavoidable. Nonetheless, there is a present focus on cost containment, and issues relating to quality are paramount. A race is on to see who can standardize the care (and quality) that patients receive, while outcome studies about the results of that care are just barely beginning.
There are studies that document positive patient outcomes from nursing care. Hospitals identified as good places to practice nursing are associated with lower mortality among Medicare patients (Aiken, Smith, and Lake, 1994). There is also evidence to suggest that hospitals with a higher ratio of nurses to patients have fewer deaths than hospitals with fewer RNs on staff (Hartz, Krakauer, Kuhn, Young, Jacobsen, Gay, Nuenz, Katzoff, Bailey, Rimm, 1990). This brings into question whether issues of quality stem from poor education, inadequate resources, or both. Nurses need to be taught the differences and, more importantly, how to deal with different practice scenarios. Some scenarios, for example low RN staffing in hospitals, may require a court of public opinion to document poor quality. Other times, fixing quality problems may require internal strategic maneuvering by nurses within the politics of an institution. These days, administrators are cutting costs wherever they can, which often includes cutting nurses and replacing them with assistive personnel. Nursing as a profession is at a critical juncture in the role it chooses to assume in politics, as well as in education to adequately prepare nurses to deal with quality issues, especially when nurse to patient ratios decrease.

A report funded by the PEW Charitable Trusts in 1993 noted that there was a need to have vision within the educational institutions, a significant number of leaders accepting new beliefs, a commitment by state and federal governments, and the support of professional organizations and the private sector, before the appropriate changes can be made (Kelly and Joel, 1995, p. 89-90). This was a follow up to an earlier report in 1991 that had already declared that education and training of health professions (including nursing) was not adequate to meet the health care needs of the American people. The
Commission proposed six strategies for nursing education, and two are particularly relevant to this study. One was to develop programs at the various levels of nursing education that reflect the contributions that are needed in the changing patient care system. The second strategy recommends the restructuring of faculty positions in nursing schools and programs to involve them more directly with the patient care system and nursing practice. The other strategies reflect the importance of interdisciplines, redirection of education to a community-based focus, development of graduate-level training where health services can reduce cost and improve access and quality, and an emphasis on strategic planning in nursing programs. The importance of the PEW strategies lie in the vision and direction they provide.

The primary dilemmas in the social and political debate about health policy are largely about values. A health care system cannot legislate value systems for people, but it can legislate incentives. In a debate about values, truthfulness becomes important. Staying above the fray of politics for the sake of politics, and escaping the influence of special interest groups, would go far to position the nursing profession on the level of statesmen, and not lobbyists. If the self-serving notion of “how this or that health policy affects me, and my interests” is eliminated, nursing may find its way out of politics and into true policy. At the same time, it is important to understand the political feasibility of different alternatives. Support of an incremental approach to policy changes is probably the most effective. An incremental approach would maintain the basic benefits in place, while trying to find the waste and mediocrity to alleviate the health care “crisis.” Every dollar spent on administration is a dollar of income to someone, and it should come as no
surprise that where one stands on the issue of "administrative waste" depends on where one sits.

The primary challenge for a national system of health care is building in the incentive for improvement in patient care, perhaps with innovation rewards. Even in a capitated, or managed care system, the right incentives can be put in place that reward quality. Truthfulness is also a by-product of professional standards adhered to out of a professional ethic, or value system. Perhaps the place for nursing to start in defining a new, unified political mandate would be re-identification of its own values within the nation's system of health care.

In the current managed care system, there is little understanding of the concept of a coordinated continuum of care. An emerging role for nursing in health policy is a role that defines the standards of care that a family could count on. Furthermore, if care were managed from the community as opposed to an institution, dollars would be saved. The unfortunate circumstance is that, in many cases, a person has to be hospitalized in order to access the care system. Although emphasis in community-based models of care is receiving a lot of attention, most medical care (including home care) is still accessed by institutionalization. If hospitalization became the "tail" instead of the "dog" in health care, a different incentive would exist to save dollars. Community-based nursing care has not been addressed in any detail in this study because the nursing effects in policy-making for community health are not that different from the issues facing the profession as a whole. This is not to say that there are not education and training issues specific to the community
health setting. However, the intensity of nursing issues in an inpatient setting when examined beside the intensity of issues in the community setting are not really all that different. Today's community health care nurse is caring for patients that require much the same clinical nursing skills that are required in the hospital. The primary advantage of the 4-year program is the added time to integrate community care, as well as other concepts into the baccalaureate curriculum. Some would argue that care in the community is a primary reason to expand the number of 4-year nursing programs as opposed to 2-year nursing educational programs. Furthermore, community health within the curriculum is a requirement for NLN accredited BSN programs. However in the experience of the researcher as a home health agency administrator, the quality and the depth vary greatly among programs, and the content is not standardized. In home health care, many urban areas are using two-year RNs and even LPNs very successfully—as long as they are provided with adequate orientation and supervision. And, since the model of public health nurses visiting homes to provide family-focused services has all but been eliminated from present day health departments, the concepts that have been taught in baccalaureate programs may go largely unused in practice. Unfortunately, care delivered in the community at this point in time can rarely provide services with a "community as client" focus, because of health care cost cutbacks and shrinking federal and local moneys. Although care delivered in the community will likely increase, home visits are getting shorter with a much more technical, and procedural focus. However, as the pendulum swings back to realize the benefits of preventative and restorative services, nursing will have a large role to play in community-based care management and services.
If nurses could position themselves as gatekeepers of community-based models of care, perhaps Medicare could afford to provide more needed long-term care if the system is reordered from the community instead of from institutions. This will require nursing professionals who can not only manage patient care, but also manage the business of providing patient care. The cost savings from this type of model could have policy effects that are far-reaching.

REFLECTIONS ON THE ORIGINAL QUESTION

The question asked in the study was: **What are the effects of the nursing profession in the policy-making process?** Policy was defined as political wisdom, wise management, and/or a course of action. Nursing effects in policy were considered in three areas: education, professional politics, and health care. Effects in policy mean something produced, as in cause and effect, in the three above areas. Overall, the desired effects are NOT taking place in nursing according to the literature review, and the respondents interviewed.

Faculty issues, agreement on the right point of professional entry, and course development are the primary causes that have not allowed substantive changes in curriculum for modern nursing education. National organizations, nursing leadership, and issues of exclusivity have created conflicts that have not allowed innovation in the attitudes of professional nursing as an entity (professional politics). Finally, lack of sufficient knowledge about
economics, and lack of a bipartisan political focus or political mandate, have diminished the influence of nursing in the health policy-making process.

RESEARCH TASKS ACCOMPLISHED

Three primary tasks were identified (see Chapter One). The first task outlined was to determine the scope of responsibility of nursing in relation to health care in the United States. Nursing seems to have its work cut out for it in understanding what its role will be in health care, and finding a way to achieve continuing recognition within the health systems that exist. In the opinion of the researcher, if nursing is truly concerned about the care of patients, it needs to become an active participant in a solution-oriented approach, and not a problem-oriented approach. At the two-year AD level this means setting and maintaining high clinical standards. At the four-year BSN level, an understanding of economics, and political systems need to be an integral component of the curriculum. These students will need to be embraced by faculty who possess an attitude toward success, and leave students with the expectation that they will make a difference in the health care system. Students must be encouraged to speak their minds with courage and intelligence, but also to understand the potential consequences of their actions, either by their peers or superiors, and act strategically. The scope of nursing's responsibility is to use its voice to facilitate an expanded role as cost-effective substitutes for physicians, an expanded role in the "management" of managed care, and to improve use of preventive services by the public.
The second issue was to try to understand why nursing seems to have lost its "voice" within the profession and outside of it. The issues that distract nursing are largely issues within its own professional politics. Nursing has an inferiority complex, which it must overcome. Some believe nursing is not taken seriously beyond the bedside because nursing has not extended its influence (voice) beyond the point of care. Part of nursing's identity rightly belongs there, but not all of it. For example, organized nursing has fought the growing managed care mandate in the country with a very loud "voice". So has the AMA. This does not mean that the AMA tactics are appropriate for nursing. Perhaps nursing could consider a higher road (and influence) that uses more logic within the realities of health care and emerging managed care systems. This may serve to mold health care to the benefit of nursing stature, nursing practice, and patient care. While it is perfectly appropriate to find faults with the emerging systems of managed care, using patients' fear and public insecurity as a mechanism (voice) to hold onto hospital nursing jobs, especially when no substantive data exist to support the issue, are not the actions of an influential profession. However, if the matter of "voice" is incorporated into the nursing curricula constructively, it will be demystified, and the "whole voice" of nursing can begin to emerge. This will not be a natural process. In other words, a new voice will not emerge by itself. A new voice will require changes not just in curricula but also in attitudes about teaching. Ultimately, nursing's responsibility is to use its voice to continue to provide high quality patient care on the clinical level, and to expand policy influence on the state and national levels. By preparing nurses in school to enter the administrative and policy environments, nursing will be able to provide viable alternatives and use a constructive voice to cut costs, and to provide a high standard of care.
Education is where nursing can begin to re-tool its voice. However, nursing's own professional politics must set the example, by changing its own voice first.

The third task was to identify actions that could help nursing to find a broader strategic position within health care and legislative policy arenas. A broader strategic position that enables participation in decisions instead of only reacting to them may demonstrate nursing in a different light to the public and to the politicians. There are two primary ways that this can be accomplished. One is to educate students to understand management, not solely the management of patients and other nurses, but strategic management within health care systems. The second is to provide the data necessary to understand the difference that nurses make in the outcomes of patient functioning, and the costs associated with the outcomes achieved. Some nurse scholars believe that the vehicle to accomplish this is through a diagnostic taxonomy called nursing diagnosis. The idea is to point out nursing diagnosis as the patient problems nurses try to solve. Nursing diagnosis is the title given to the act of identifying a problem and labeling it to describe the unique work of nurses and to facilitate public understanding of what nurses do (Kelly and Joel, 1995, p. 201). However, others believe that research using a taxonomy of nursing diagnoses does not make sense even in outcome studies, because it is a language only nursing understands and it does not contribute to interdisciplinary research communities. Using its own language, some believe nursing tends to alienate itself from the broader research community. The use of data, and the value of nurses who can speak eloquently to present the data to administrators, politicians, and to the public, in a language that they
understand, will provide a strong voice for nursing in the country’s health care system. It may also prevent the loss of nursing services to less expensive substitutes.

RECOMMENDATIONS

The following recommendations are the opinions of the researcher. They reflect the information gathered during the study from the literature review, the interviews, and the research’s experience with the data. In addition, the recommendations are based on the statements offered and the issues that arose from the group of respondents as a whole.

1) Restructure the current accreditation process with an interdisciplinary and market-oriented focus. To a large degree, this opportunity has now presented itself because of the pending loss of approval from the Department of Education for the National League for Nursing’s accreditation program. Accreditation does not have to be under nursing’s direct control if it is set up to include effective nursing consultation and content. Nurse representation on the governing body is essential, but operationally nurses do not need to control it. The composition of the board should include representatives from outside nursing, including educators, consumers, and business. Continuing education for nursing faculty could also be a division of the new body, to organize local programs for faculty in conjunction with local service organizations.

2) A required faculty characteristic must be a passion for excellence and enthusiasm for change. Higher degree education typically requires research and publication for
promotion and tenure. Sometimes to survive, faculty must "publish or perish." The emphasis (and not just in nursing) in academe is often away from students and teaching. However, this does not condone a common faculty drift away from students. Students will emulate faculty and their expectations. Mentorship is not always an option for students; however, colloquia, or small group discussions about the relevance of nursing and politics, health care and leadership could be integrated into the curricula, once sufficient faculty were prepared and/or selected to lead them. Hiring new faculty will be driven by an ability to teach first, and develop research second. Senior nursing faculty in many universities suffer from arrogance, and distance from students. Tenure should not be a reward to faculty for writing and research, without the above requisite characteristics.

3) Nursing faculty (at the 4-yr. and graduate levels) should be required to participate in ongoing continuing education. An independent evaluation (i.e., not done by nurse educators) will need to be done to evaluate the current learning needs of faculty in relation to business and management skills, including health care policy trends and issues.

4) The current leadership of the national organizations (NLN, ANA, American Academy of Nursing, AONE, AACN) should consolidate into one large coalition, without ties to labor. An independent organization can still represent nursing in collective bargaining activities, but it should be separate from the national nursing policy-making entity. The point is to keep them separate to avoid financial conflicts of interest. Conflicts of interest occur when labor threatens strikes, or withdrawal of member dues for issues that are labor, and not policy driven. Of course labor issues are also often policy issues, but labor
or collective bargaining activities should not have a direct financial influence or the ability to hold the larger coalition hostage with the threat of financial consequences. It was noted in the Background chapter of this document that it is the state nursing associations (SNAs) that do the collective bargaining, but it is also the SNAs that pay dues to the national organization (ANA). Therefore, if the national organization makes a move that the state organizations feel is bad for the economic and general welfare of rank and file nurses, they can threaten to stop paying dues. This connection needs to be eliminated in the new coalition. As a completely separate entity, the coalition will still need to pay attention to the SNAs for obvious reasons, but the ANA will need to either remain supported by the states (and therefore not a voting member of the coalition) or eliminate that conflict by becoming independent of the state membership influence. In terms of representation, participation of the SNAs on an advisory board would keep the national entity abreast of labor and bargaining issues. A separate accrediting entity has already been discussed above. Individual group interests can be represented as councils or divisions, but consolidation of nursing national representation in policy will unify nursing’s voice, and eliminate the competition between organizations. It will also help to curb certain “elitist” attitudes by some organizations.

5) **Two-year nursing programs should continue to expand, and be held to high standards of clinical training.** Four-year programs should move out of clinical nursing and provide a liberal arts baccalaureate degree in a health services or nursing management specialty. It is time to stop the battle between two-year and four-year clinical nursing preparation. Two-year programs are growing at a faster rate, and are competitive in the market. To avoid
the ongoing public confusion about the differences between the two types of RN, the two-
year nurse could continue to be licensed with the RN credential, and the advanced nursing
degree would be licensed separately, distinguished by the obvious difference in preparation
(master's degree), and in some instances prescriptive authority and billing privileges.
Baccalaureate graduates would be prepared to enter graduate level nursing studies in an
administrative or advanced clinical track. In effect, the RNs prepared at the BSN level
will be phased out. In this case, the four-year baccalaureate prepared "nurse" would NOT
be qualified as an RN to practice nursing. They would come out of school with a degree
in health services management (or some such title). They would have to sell themselves in
the marketplace much as a history, english, or biology graduate would have to. The 4-
year degree would be more like a pre-med or law degree, in preparation for graduate
education, and not a terminal degree. Some, not all, would logically go on to graduate
school to get the advanced nursing degree as a nurse clinician or nurse administrator—the
point being that in order to practice as a "professional" a master's degree would be
required. The two-year RN would be a technical preparation leading directly to a
licensing exam for an RN (just as it does now), but they would be considered to have a
technical and not a professional nursing preparation. The four-year preparation is the
undergraduate degree that would be required for application to graduate study leading to
an advanced nursing practice specialty (clinical or managerial). Graduates in biology or
chemistry, or economics at the undergraduate level could also apply to graduate nursing
programs. This is not to say undergraduate programs would not have sciences that may
be pre-requisite for graduate level nursing courses. Any four-year course of study has
room for electives, and students can take more or less of them, depending on career
intentions. Time, nursing input, and demand will ultimately determine what the “best” baccalaureate preparation will be for admission to graduate nursing programs, as they do now.

The goal of the differentiation in nursing practice is two-fold: 1) Provide a clear distinction for the public through educational and licensing requirements between RNs and Advanced Practice Nurses (APNs); and 2) Provide a clear distinction in health service settings. The APN will be positioned to manage clinical and/or administrative services of a hospital, long term care, or other facility. As clinical service providers, services would include clinical practice and/or oversight of two-year RNs in complex patient care issues. As administrators or managers of facilities, APNs will be prepared to participate in the management of patient to staff ratios, care teams, budget decisions, and so forth. Part of the re-positioning of nursing in the marketplace, for example, as leaders in managing managed care and/or as cost effective substitutes for physicians, is to encourage students to have this as a professional goal because these jobs will be in demand in the marketplace.

6) National organizations that represent nursing will be expected to cross party lines, and to cultivate relationships with Republican and Democratic leadership. Access to the White House is important, and must be an option for nursing regardless of which party is in power. Nursing influence is severely diminished in overall health policy by practicing partisan politics, and prevents influence on a broader level. Democratic insider motivations and attachment to the labor movement cloud the ANA's judgment about policy issues that should receive bipartisan attention. Democrats typically represent the
labor movement, and are more sympathetic to women, to the poor, and to the middle class. A partisan orientation does not speak well to competing viewpoints about the benefits nursing can bring to health care. It also does not recognize the potential influence of nursing if it embraced both parties in a bipartisan fashion.

7) **Nursing needs to embrace and actively participate in the managed care movement.**

Managed care does have problems. Profit-orientation and greed seem to drive managed care more than any real desire to improve cost-effectiveness. In an era when cutting costs is popular, nursing is vulnerable. However, using patient care as a vehicle to save nursing jobs is irresponsible and unjustified. As one respondent said, “...they [nursing] argue from a very emotional, non-data driven basis, such as ANA stating that every patient needs a nurse. That’s nonsense. Every patient needs care. And a whole variety of people may give care.” The possibilities for nursing in managed care are far-reaching—-not just in the advanced practice realm, but also in case management. If nurses would embrace the opportunities available, and market themselves to insurance companies, or to families who need help navigating the managed health care system, they would be providing a greatly needed service. Preventive services are another area that will be burgeoning in the coming years. Nurses who are educated in business and health care finance could open independent practices under contract with managed care companies. The opportunities are endless. The managed care environment would provide an excellent source of employment for the baccalaureate prepared nurse, or the new health services administrator who comes from a reformed baccalaureate program, as described above.
FUTURE NURSING MODELS

The new baccalaureate prepared health services professional in nursing will be provided with a solid liberal arts education, with emphasis in health policy, an economic perspective, health care systems, and financing. Detailed traditional nursing theory would not be required, but could be taken in elective courses. Students would be provided with an understanding and appreciation for the roots of nursing, but with a much broader conceptualization of health care as a system. The skill of the graduate of this curriculum will encompass an understanding of the politics of health care, and cost containment. At the same time, it will teach ethics and elements of business. The graduate will emerge with an understanding of the patient within a broad context of the health continuum, and an appreciation for the complexities facing society and health care professionals to use the system wisely, and to the maximum benefit. The undergraduate work will provide the basis for graduate education in clinical advanced practice, or health services administration.

Advanced practice nursing will start at the master’s level, and split into two types, administrative and clinical. This would no longer allow the title or term advance practice nurse to be given without formal education at the master’s level. Existing APNs who received specialized training or experience in the pre-existing APN model could be grandfathered in, however in the new model all APNs would be master’s prepared (minimum). While the focus of each type of APN coursework is individual (clinical and administrative), core courses about business and health policy could be taken together, so each graduate will appreciate the other’s role and sphere of expertise. To accomplish this,
most traditional nursing schools will need to undergo a radical change of both content and faculty. Deans should have previous health service administration or business administration background, in addition to nursing. Employment would be based primarily on teaching merit as opposed to publications and grant writing. Publishing and grants for innovative programs are still important, indeed a critical feature for higher education, but a teacher’s recognition must be based on ability to teach and exchange ideas as the first priority. These days the emphasis on teaching, particularly in larger universities, has fallen close to being unimportant, with the real teaching often taking place by others than the professors. In the new vision, this will need to change. It is also important to consider the need for future teachers within master’s level education. University programs will still require doctorates for professors, but course offerings about education and how to teach would need to be included in master’s curricula, perhaps even through a joint degree.

**IMPlications for Nursing**

An important consideration in the issues of education and curriculum are the environments that faculty and graduate level students are exposed to. An interesting study would be a description of the management and clinical practice experience of deans and senior faculty. A research question could ask if having more clinical or managerial experience make a better dean, or does it depend on the individual? The academic environment in which faculty may have studied and now teach, deserves mention here. In an environment that seems to value research dollars and tenure as much or more than innovation and relevance in the marketplace, the stage is set for creation of a stagnant leadership. Such an
environment becomes the completion of a vicious cycle, by the re-creation of new faculty using the existing faculty as molds. Notwithstanding, many excellent faculty exist whose molds should be cast in bronze. But the point is, many faculty are not so good, and too often they are allowed to re-create students who have to jump through the same irrelevant hoops that their teachers did, and that their teachers did before them, and so on. Some schools are embracing concepts of practice and academic partnerships. Another topic for future research is to what extent the partnerships are really partnerships, and how much do moneys spent for nursing research count in relation to real or potential impact on the problems (or solutions) noted above.

A further study could be to follow a cohort of nurse graduates from “traditional” nursing education, and from a “reformed” education. Graduates from the reformed programs would have received preparation in health policy, business, economics, and communication. They would have been exposed to the type of faculty described above, who have a passion for excellence, and the willingness to make rapid changes within the changing environment. It would be interesting is to see what, if any, difference the reformed program made in the course of careers.

With all of the attention this study has paid to the Associate Degree nurses, the potential impact on Licensed Practical Nurses (LPNs) must also be recognized. LPNs receive one year of training, and presently practice at a technical level. It is possible that LPNs could be eliminated by the changes that have been proposed, and they are an important group of
practitioners to consider. This study chose to focus on the dilemmas facing RNs; the implications on LPNs deserve further study.

The need for more nursing research is well documented and there is some outstanding research that has made difference in health care. Much, if not most, of the research is for academic purposes and of little value, but that is true in any field. The value of the nursing diagnosis taxonomy in research will undoubtedly continue as a matter of debate among nurses, and studies will have to be evaluated on their own merits.

A interesting study to consider is a survey of nurses in practice, education, and in national organizations, about what they may be thinking needs to change in nursing, but are afraid to say. The literature speaks about what needs to be done in nursing (e.g., more influence, more nurse-driven policy, more leadership) but little to nothing is said directly about how nursing leadership, national organizations, and nursing education need to change radically and dramatically to move forward. One respondent said nurses often will not speak in courageous terms publicly, but will offer support for those that do behind the scenes. Is this due to fear of being blackballed by nurses “in power” that do not agree with them? A contributing nurse noted in Kelley’s (1996) study on nursing leadership, “My master’s thesis, which was seen as critical of the ANA, was sharply criticized by nursing leaders. Disclaimers to my book give some indication of the bureaucratic reaction” (p. 78). Will a similar reaction take place to this study?
The courage to speak the truth starts with each individual and one person’s voice may give rise to other voices. There will always be a leadership group in nursing, as well as nurses who do not really care about any issues at all, regardless. The average person in any field or profession probably just tends to her/his job. In general, it is unwise to expect more from any group. Some leaders will rise from the ranks, others emerge as a result of education or circumstances. This is the group that will change education and produce and influence health policy. It is hoped that nursing could increase its opportunities to influence health care systems, and improve professional opportunities by implementing the recommendations provided in this study. The use of nursing doctorates in education, practice, health policy and administration is beyond the scope of this study, but extremely relevant to the recommendations proposed. In addition, there will always be those nurses who rise to powerful and/or lucrative positions but consider themselves ex-nurses, or for some reason believe they are merely former nurses, and have no interest in pursuing any nursing-related activities.

The results of this study do not paint nursing in an upbeat picture. Leadership, education, and policy-making skills have been examined by a group of influential nurses and others who have had exceptional careers. However, the purpose is not to admonish any nurse or nursing group. The data presented is not particularly surprising, or even that different from what has been said by some nurses before. At the same time, the capability and talent within nursing yield much hope. The purpose of this information is to provide additional data to make positive changes in curricula, attitudes, and influence in nursing, and to improve the effects of nursing in policy-making processes.
APPENDIX A

Core Interview Questions

1. What is your definition of health policy?
   Do you think nursing understands health policy?

2. What has nursing accomplished in the last 20 years in terms of health policy?
   In terms of making clear to the public what nursing is and can be?

3. How would you describe your contributions to policy changes in nursing and/or health policy in the last 20 years?

4. What is your definition of nursing? Of the health care system?

5. What is your vision (paradigm, construct or model) for nursing?
   For the health care system?

6. What do you think will really happen?

7. What is it that nursing does not understand about health policy?
   What is it that health policy does not understand about nursing?

8. What could change in our educational process?
   What is good about it? What is bad? What could change?

9. How could education produce the type of nurse you want?

10. What is it that nurses can offer the public that other health professionals cannot?
APPENDIX B

Respondent
Address
Town, State, Zip

Dear Dr. or Ms. Respondent,

You may have received a phone call from ___________ that I would be trying to contact you about a potential interview. I'm in the process of setting up interviews for my research in nursing and health policy, and I'd like to include your perspective. I'd like to know more about your vision for the health care system and nursing. I'm interested in how we can elevate the "products" of nursing education to improve the position of nursing within the larger health policy arena.

I have a unique opportunity at the Union Institute Graduate School, to explore the relationship between nursing education, leadership, and health policy. My dissertation is an examination of current health policy issues and the effectiveness of nursing at the policy table. Many believe that it is not so much an issue of nursing getting a seat at the policy table, but the effectiveness the seat yields. I am interviewing the nurses that I think have the most savvy and experience in leadership and policy.

While it would be much easier to conduct the interviews over the phone, I think you might agree that we would lose a lot, and it would simply not provide the same level of quality for my work. I'll include a CV so you have some information about my background. Please drop a line, or let me know a convenient time when I can call to discuss my request (my home # is: ____________). I would like to meet you sometime between _________ and _________ either in _________, or perhaps someplace else convenient to you. I will appreciate it very much if you can find the time to meet me.

Sincerely Yours,

Alexis Wilson
APPENDIX C
SAMPLE CONSENT FORM

Alexis A. Wilson

I am in the process of researching the relationship between policy formation and administrative implementation, specifically in relation to the profession of nursing. My goal is to combine this work with my own professional experience, and yours. I would like to include your experiences to validate, contradict, and/or to enrich my own findings and opinions. I would appreciate your participation, and request your permission to use the content of our personal interview for inclusion in my dissertation writing and research.

The data will be used as part of my Ph.D. dissertation, and ongoing professional work. As a participant in the interview, you have the right to read any information that pertains to you and to our interview and can, if you like, receive a copy of the final printed dissertation. After reading the writing generated from the interview, you may withdraw your participation, and any information generated from that participation, for any reason, prior to any publication.

Your cooperation is greatly appreciated.

Alexis A. Wilson

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I, ______________________________ hereby consent to the use of relevant information from my personal interview with for educational and research purposes. I understand and concur that the transcript of my taped interview will be used as part of the investigator's Ph.D. dissertation, and may be used in the writing and speaking derived from it. I further understand that the investigator will allow me to read the writing generated from the interview, and that I may withdraw my participation, and any information generated from that participation, for any reason, prior to any publication outside of the dissertation.

Date: _______________ Signature: ________________________________

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154
APPENDIX D

**Evolved Interview Questions**

1. What effects do you feel nursing has had on health policy?

2. Could you comment on our current educational process?

3. How do you think nursing will factor into the future economics of health care?

4. What roles do you think the national nursing associations have had in general, and in health policy making in particular?

5. What is nursing's biggest asset and biggest liability?
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156


161

