U.S. nurse Dr. Sharon M. Kirkpatrick created a program that treats thousands of villagers in the Congo.

Dr. Kirkpatrick is with her friend Alicia Otupa of Kenya, right, and a guide on Luapula River.
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- Self- medication management among the elderly
- Coordination of care from hospital to home
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- Nutrition and weight maintenance for patients with cancer

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July 17-28, 2000

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May 24-26, 2000

For more information contact:
JoAnne M. Youngblut, PhD, FAAN
Director, Sarah Cole Hirsh Institute for Best Nursing Practices Based on Evidence
Frances Payne Bolton School of Nursing
Case Western Reserve University
11600 Euclid Avenue
Cleveland, OH 44106-4904
(216) 368-6303
schil@po.cwru.edu

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one years ago my son was hospitalized with an acute illness. Those of you who are parents can well imagine the physical and emotional toll that my husband and I were experiencing as our firstborn was tested, monitored, examined and diagnosed. As we sat forlornly in the waiting room, a miracle happened...Suzanne. She was our son's admitting nurse.

In a flurry of movement, Suzanne entered the room looking for us. She had momentarily left her son's side to find us, inform us, comfort us and guide us through the quagmire that was her familiar working environment. Suzanne became a constant for us through the week-long hospitalization, taking the lead in caring for our son and us.

She was the one who negotiated individualized care and treatment for our son. The one who would call us and report on his progress, when we couldn't be there. The one who helped us navigate the paper-work and payment system, and the one who monitored, evaluated and arranged follow-up. Suzanne was our advocate, and she led us—patient and family—to health.

This experience is what nursing is about and what nursing does best—leading people to health in compassion, intelligence and competence. This pivotal role that nursing holds in health care delivery is well documented through research, public opinion polls and testimonies. Nurses are what make or break the health systems and the health status of people. Every day a multitude of nurses leads a multitude of patients to well-being.

Every nurse is a leader. Regardless of title and position, every nurse exercises leading-edge authority to influence the health of those in his or her care. Every nurse uses knowledge and skills to make decisions with and about others. Every nurse accepts accountability to provide safe, competent care. The nursing profession assumes daunting responsibilities. Perhaps these become easier to take on because the prerequisites of nursing guide us: a sense of purpose, contribution, caring and a generosity of spirit.

As you read and enjoy the stories in this issue of Reflections on Nursing Leadership, you'll witness nurses taking the lead. Hopefully, you will also reflect on the value and uniqueness nursing brings to health care. Because of nursing's presence, patients and family are never alone, never left uncared for or uninformed, and never left without an advocate.

Nancy Dickenson-Hazard, RN, MSN, FAAN
Nurses, the patient advocates of caring

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Nancy Dickenson-Hazard, RN, MSN, FAAN
Suffering

NURSES HEEDING THE CALL

By Judy Sadler

In fact, this is the way many are socialized into the nursing profession: Stay objective; don't get too close to the patient; don't share yourself; be professional. Beginning with principles of therapeutic communication, students are taught appropriate methods to maintain a professional distance. Whether to insulate the nurse from the pain of the patient, or to keep professional distance, believing that objectivity is necessary, nurses are often encouraged not to enter the world of the one who is suffering.

Yet suffering is an individual, complex experience of a person that can only be explored one person at a time. Nurse-to-person (or nurse-to-patient) relationships are a major component of learning nursing. This relationship is a good position from which to begin to understand what suffering means to a person. It is an open and attentive stance to explore suffering. Yet are we willing to enter the world of suffering, to come close to the real or possible disintegration of the person?

Some nurses are willing to enter the world of suffering, and they lead the way. Whether in the midst of complex technological approaches or with the barest of equipment, these nurses have answered the call to care for those suffering. They have heard the cries of pain and acknowledged the person beyond the pain. They have used caring to enter the world of the patient, bringing their full selves into relationships with the ones suffering. Choosing to enter this world of suffering is not chosen lightly. Nurses, who are called and heed the call, respond to the person in need with an openness, an authenticity and a willingness to enter their world of suffering. They use caring to relieve suffering one person at a time.

Responding to suffering takes other forms as well. Working with suffering people day after day has the potential to open the eyes of the nurse to understand injustices. Being disengaged is no longer an option. These wrongs demand bold, brave responses, such as that of Massachusetts nurse Barry Adams, who blew the whistle on inadequate nurse staffing in his place of employment. There comes a time when just doing your best is not enough to correct the injustices of too few nurses to meet patient needs. Responses to suffering also include being willing to speak out against the travesties against the human spirit. It is leading the community response to violence, discrimination, homelessness, teen pregnancy, hunger and the loneliness of aging.

Suffering is not out there beyond our reach. It surrounds us; we can touch it. We can respond from a whole-person perspective, open to the possibilities. We can seek to understand what suffering is and what it means to the person. Meeting the sufferer with a genuine willingness to help, nurses can heed the call.

Judy Sadler, RN, PhD, is an assistant professor at Western Michigan University School of Nursing in Kalamazoo, Mich. She has a background in medical-surgical nursing in intensive care and rehabilitation, and has a career trajectory from charge nurse to vice president. She studies caring.
Suffering: Nurses Heeding the Call

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The Congo children’s weeping sores

By Sharon M. Kirkpatrick

Independence, Mo., Oct. 4, 1999—At the very core of nursing is the commitment to advocate for those who need assistance navigating the health care system. Sometimes this occurs in high-technology medical centers; other times, it occurs in remote villages in developing countries. Sometimes patients are passive; other times they reach out for help.

Nursing in the future will likely enjoy an unprecedented array of new high-technology devices designed to care for the privileged in wealthy nations. In numerous villages throughout the world, however, nursing in the new millennium will undoubtedly continue to depend heavily on ingenuity and the most basic of health care principles. Children in many developing countries silently suffer from painful, debilitating leg ulcers. One group of children in the Democratic Republic of Congo (formerly Zaire), however, proactively took the matter into their own hands. Knowing that the village health workers—lay volunteers trained in primary health care principles—routinely hold well-baby clinics, five school children in the village of Chiba waited patiently all day at the clinic to have their leg ulcers treated.

After all the babies were weighed, five children asked the volunteers to start a regimen of clinics to treat their leg ulcers. The initiative of five children ultimately became the catalyst for a treatment project that began in 1996 and has aided thousands of villagers ever since.
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After all the babies were weighed, the five children asked the volunteers to start a regimen of clinics to treat their leg ulcers. The initiative of five children ultimately became the catalyst for a treatment project that began in 1996 and has aided thousands of villagers ever since.
Primarily affecting school age children, these painful and often debilitating tropical leg ulcers most typically occur on the lower extremities. If left untreated, the ulcers become open, weeping sores two to three inches in diameter that attract flies and expose tendons and bones. The ulcers may remain for months or years. If they do heal on their own, a very thin skin is often formed which eventually breaks down, causing another ulcer (Schull, 1987).

Interestingly, the health workers themselves reintroduced nutritional issues alone, even if nutrition could not be improved. They were taught about the critical need for increased protein in their diets, many families responded by planting small crops of legumes and new crops planted. After being harvested and new crops planted. After being harvested and new crops planted. After being harvested and new crops planted. After being harvested and new crops planted.

Recent statistics indicate that infectious diseases and malnutrition continue to be major problems in the world. In 1997, 17.3 million deaths (of a global total of 52.2 million) were a result of infectious and parasitic diseases, while approximately half of all deaths of children under the age of 5 are associated with malnutrition (WHO, 1998). In response to the village children’s request, a treatment program combining traditional and Western medicine was ultimately implemented which successfully treated more than 1,000 cases of tropical leg ulcers in less than a year. Village health care—the vehicle we used for health delivery—is a primary care model supported by the World Health Organization for providing basic health education by lay volunteers in developing countries. The treatment project was divided into three components: development of an appropriate treatment plan, mobilization of supplies and treatment of the ulcers. As a consultant to the health workers, my primary consideration was to develop a sustainable prevention and treatment program that could be carried out by the local people.

A house-to-house survey was conducted by the volunteer health workers to discover the possible underlying causes of the ulcers. Open-ended questions regarding overall health concerns were included, as well as specific questions about the leg ulcers. The survey revealed an even higher incidence of leg ulcers than had initially been projected by either myself or the volunteer health workers. An important spin-off of the survey was the identification of another major health concern, schistosomiasis, which later became the target of a subsequent project.

Significant effort went into the planning phase of the project. Tissue biopsies were performed to diagnose the cause of the leg ulcers. When no specific causative organisms were revealed, the diagnosis of “tropical leg ulcers” was made. Major considerations in the design of the treatment plan were cost, availability of materials, and sustainability of project. Pictorial illustrations were developed to assist in teaching the treatment to the children and mothers. Captions were translated into Swahili.

Hundreds of hours went into the acquisition and preparation of materials. High schools in Georgia and church groups in Washington state prepared bandages. College students collected washcloths. Motels donated bars of soap. Charitable groups raised money for antibiotic ointments. Bandages and dressings were made from old sheets. Volunteers tore the sheets into 3-foot-by-4-inch strips and folded them into 4-inch squares, enabling both dressings and bandages to be made from the same item. Into one zippered plastic bag, volunteers assembled four folded strips of sheets, one washcloth and a bar of soap. They packed these supplies into crates that were flown to Africa.

**Treatment**

The first step in the treatment itself was to announce the initiation of the project in the village. This was accomplished expeditiously through the grapevine. Parents and children were invited to an educational session to learn about the causes of the ulcers and the ways in which they would be personally involved in the treatment. At the beginning of the treatment session, each child was given his plastic bag on which an identification number was inscribed. When treatment began, a volunteer health worker measured each leg ulcer with a plastic, see-through ruler and recorded the dimensions on an individual treatment card, bearing the patient’s identification number. We tracked the patient’s response to treatment and documented it.

The treatment itself consisted of antibiotic ointments, dressing, and bandages. Bandages and dressings were made from old sheets. Volunteers tore the sheets into 3-foot-by-4-inch strips and folded them into 4-inch squares, enabling both dressings and bandages to be made from the same item. Into one zippered plastic bag, volunteers assembled four folded strips of sheets, one washcloth and a bar of soap. They packed these supplies into crates that were flown to Africa.

**A CHIBA, Congo—**A boy displays his leg ulcer after his father walked more than 60 kilometers in one day to seek treatment for him at the village health care clinic.
Primarily affecting school age children, these painful and often debilitating tropical leg ulcers most typically occur on the lower extremities. If left untreated, the ulcers become open, weeping sores two to three inches in diameter that attract flies and expose tendons and bones. The ulcers may remain for months or years. If they do heal on their own, a very thin skin is often formed which eventually breaks down, causing another ulcer (Schull, 1987). Leading ultimately to septicemia, osteomyelitis or even death, ulcers create a serious presence of mind among children.

Unlike yaws, which presents a similar leg ulcer clinical picture, tropical leg ulcers do not have a causative organism; instead, they are caused by poor nutrition and lack of sanitation (Schull, 1987). Since tropical leg ulcers occur most frequently when food is scarce, improved nutrition is not always an option. In the initial plan designed to treat the children’s ulcers, dietary recommendations were planned as a primary component. Knowing that the villagers did not have a depth of understanding about nutrition, a simple plan was put into practice: a nutrition education project. Tissue biopsies were performed to diagnose the cause of the ulcers. As a consultant to the health workers, my primary consideration was to develop a sustainable prevention and treatment program that could be carried out by the local people.

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The treatment itself consisted of antibiotic ointments and dressings.
primarily of: 1) cleansing the ulcer with a traditional tea made from guava leaves; 2) applying topical antibiotic ointment for the most severe ulcers; 3) covering the ulcers with cloth bandages. Initially, severe cases were treated with amoxicillin, but this was discontinued when it became apparent that the ulcers responded well to less costly forms of treatment.

A traditional antiseptic solution made from guava leaves was chosen as the first line of defense for a number of reasons. It had been reported as effective in several different nations (United Nations, 1998). The leaves were readily available. There was no cost for the solution, which could easily be made by the villagers themselves. Mothers were taught to wash their hands, and the wound, with soap prior to applying the antiseptic solution. As soap was not always affordable, they were encouraged to use the guava leaf solution, even if they could not clean the wound with soap.

After cleansing, each wound was covered with a dressing and bandage. One strip was left folded as a 4-inch-by-4-inch dressing to cover the wound while the second cloth strip was unfolded and used as a bandage to keep the dressing in place. Two additional cloth strips were given to each child to be used as replacements while the first two...
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cloths were washed, dried in the sun for "sterilization," and stored in the bag until reused. In severe cases, the volunteer health workers placed a coating of triple-antibiotic ointment on the dressing prior to applying the dressing to the wound.

Named "uferi" after a local political party that bore the same characteristics of "emerging and flourishing overnight," the sores responded rapidly to treatment. Dramatic improvement was noted in many of the ulcers in one week's time. When records were reviewed after the first six months, volunteer health workers noted more than 600 uferi were treated and had successfully healed, although six or eight failed to respond. The volunteers believed the unsuccessful cases were due to the patients' lack of compliance. The news of the successful cases spread rapidly throughout the region. Within the first 48 hours, parents and children were walking more than 60 kilometers to obtain treatment. As treated children traveled back to their villages, the news spread even farther. Eventually the success story traveled several hundred miles up the Luapula River, as well as into the neighboring country of Zambia. The caregiver roles of the volunteer health workers gradually expanded to that of consultants in the development of similar projects in neighboring communities.

The development of self-esteem and leadership skills in the health workers was a significant result of the uferi project. Initially trained in 1990 as volunteer primary health care workers, they provided monthly growth-monitoring sessions for children under age 5, prenatal screening clinics for women, and a variety of educational sessions for community health issues—from sanitation to immunizations. With the uferi project, they became known as leaders who could mobilize communities and solve problems. Despite recent civil war and political struggles in The Congo, and the subsequent widespread suffering and deprivation, health workers have successfully continued efforts to improve village health care. Perhaps most importantly, because of the health workers' heightened roles, they are now successfully leading other efforts to improve their communities.

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cloths were washed, dried in the sun for “sterilization,” and stored in the bag until reused. In severe cases, the volunteer health workers placed a coating of triple-antibiotic ointment on the dressing prior to applying the dressing to the wound.

Named “ufeti” after a local political party that bore the same characteristics of “emerging and flourishing overnight,” the stores responded rapidly to treatment. Dramatic improvement was noted in many of the ulcers in one week’s time. When records were reviewed after the first six months, volunteer health workers noted more than 600 ufeti were treated and had successfully healed, although six or eight failed to respond. The volunteers believed the unsuccessful cases were due to the patients’ lack of compliance.

The news of the project spread rapidly throughout the region. Within the first 48 hours, parents and children were walking more than 60 kilometers to obtain treatment. As treated children traveled back to their villages, the news spread even farther. Eventually the success story traveled several hundred miles up the Luapula River, as well as into the neighboring country of Zambia. The caregiver roles of the volunteer health workers gradually expanded to that of consultants in the development of similar projects in neighboring communities.

The development of self-esteem and leadership skills in the health workers was a significant result of the ufeti project. Initially trained in 1990 as volunteer primary health care workers, they provided monthly growth-monitoring sessions for children under age 5, prenatal screening clinics for women, and a variety of educational sessions for community health issues—from sanitation to immunizations. With the ufeti project, they became known as leaders who could mobilize communities and solve problems. Despite recent civil war and political struggles in The Congo, and the subsequent widespread suffering and deprivation, health workers have successfully continued efforts to improve village health care. Perhaps most importantly, because of the health workers’ heightened roles, they are now successfully leading other efforts to improve their communities.

Sharon M. Kirkpatrick, RN, PhD, is vice president and dean of nursing at Graceland College in Independence, Mo.

**Women don't get heart attacks?**

By Margaret H. Kearney

Editor's Note: Dr. Kearney draws on qualitative data from a variety of sources and offers a theoretical model of women's adjustment to illness. Her model is used to counsel women who are facing or recovering from serious illness and other health crises.

Heart disease affects a smaller proportion of women than men in the United States, yet women are more likely to die after heart attacks (Lemke et al., 1993). Women's rate of heart disease is low in their premenopausal years, but after age 50, their risk rises steeply to equal men's by the age of 70. Women of color face a disproportionately higher risk of heart disease, as well as other chronic diseases, such as diabetes and hypertension, that can lead to heart problems. This risk has been tied to poverty; lower education levels; high-salt, high-fat diet; and stress.

White women with these risk factors also experience higher risk, yet discrimination in education, workplace, and health care settings and lack of health services in even well-to-do minority communities are added barriers to women of color. Lack of recognition and respect for culturally diverse value systems is a primary difficulty for black women, who are often treated as homogeneous, whether of African, Caribbean, South American, or other descent, and whether immigrant or native born (McBarnette, 1996). Systematic oppression and disregard can lead to fatalism and lack of confidence in both health care and self-care.

Women's numerous and unending role responsibilities also have been found to push them along a different path in recovering from heart disease. Women are less likely than men to take time off, be passive, or allow themselves to be taken care of during their convalescence at home. They are less likely than men to attend cardiac rehabilitation programs. As they are more likely to outlive their spouses, women may not have spouse caregivers or the financial means to procure help during recovery. They may have older husbands who require much care themselves (Rankin, 1992).

Women may not feel justified in refusing to perform household tasks or in seeking help for discomforting symptoms from physician authority figures (Hawthorne, 1993). For all these reasons, it is important to understand women's experiences of heart disease and their ways of coping with it, both to increase public attention to women's heart disease risk and to improve health professionals' response.

Struggling with symptoms for the sake of others

Many women disregarded their early heart attack symptoms. They didn't want to worry their loved ones, and they were uncomfortable relinquishing control of their bodies or their responsibilities to others. In interviews with a diverse group of women, Dempsey, Dracup, and Moser (1995) found that maintaining control was the women's chief objective in the period between noticing symptoms and coming in for treatment.

Based on their lack of knowledge of women's symptoms and risk of cardiac disease and their personal experiences of previous illnesses, women tried to manage their own symptoms and continue their accustomed roles until the severity of their distress and the lack of effect of their self-care made it impossible to continue. An 82-year-old woman told them:

I didn't really think anything about it because I have arthritis so bad; a lot of times I do have pain. I thought, it's a trivial thing. (p. 449)

Even when symptoms seemed serious, women considered their commitments to others and concerns for others' burdens. One remarked:

I didn't think it was anything serious. ... If I thought (my daughter) was out somewhere then I wouldn't want to interrupt her day. (p. 450-451)

Hawthorne (1993) interviewed women recovering from coronary artery bypass surgery. They had interpreted their symptoms as not serious and not heart related. Some reported that their physicians made the same judgments. A black woman had sought help from her physician for her angina for two years:

I would just have, you know, sharp pains ... through this left breast, and down into my arm. ... And he thought it was coming from a gas pocket that had developed in my gallbladder. ... I changed doctors and went to Dr. J. ... And when she examined me, she told...

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me that this was no gas bubble, this was my heart. (p. 231)

Cochrane (1992) also found that women were hampered in their early hours of symptoms by their own and others' lack of awareness of heart attack symptoms other than chest pain:

It was terrible, and it was all in my back ... It didn't go down my left arm. That would have alerted me, I think, but it didn't go down like that. (p. 85)

Only about half of women with heart attacks have chest pain or discomfort (Rankin, 1992). The range of women's symptoms can include nausea and vomiting, jaw pain, arm pain, back pain, diarrhea, and general weakness or dizziness. With such an array of symptoms, women logically used remedies that seemed to address the symptom based on their experience, rather than concluding they were having heart attacks:

I thought it was muscular. ... I'd stop (sweeping the driveway) after about 15 or 20 minutes, and go in the house, and sit down, and watch the boob tube or something, and put the heating pad on my back. And it seemed to help. (Cochrane, 1992, p. 86)

When their symptoms did not respond to usual self-care measures or resembled what they knew about heart attacks, women sought help. Their first action, however, was most often not to contact a health professional but to check out their perceptions with a "lay consultant" (Dempsey et al., 1995). This could be a spouse, adult child, coworker, or friend. The consultants generally responded with immediate concern and action. Unfortunately, however, some did not.

One woman was at work and was thought to be malingering to get out of working, and another's husband initially refused to respond to his wife's requests for help. Treatment was delayed, which increases the amount of heart damage and risk of death (Dempsey et al., 1995). References, page 45.

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**Toxic waste**

Deep in the roots of nursing comes a search for harmful sources

By Lillian Mood

COLUMBIA, S.C., November 1999—"I think we need a nurse." These were the words of the deputy commissioner for environmental quality control in 1993. He had come to ask if I would be interested in transferring to his area in the state agency that combines public health and environmental protection. He understood that I, as a public health nurse for more than 20 years, was most at home in places where his engineers and environmental scientists felt least comfortable—in communities, with groups of citizens who were upset and angry over environmental risks—both real and perceived.

What should we call my new role? I began as "director of risk communication," which has meaning for industries and environmental professionals but not for communities. Then we added "community liaison," a word preferred by our citizen board. My interpretation of the title occurs every time I introduce myself at a public forum and explain my function to people: "I am a public health nurse working in envi-
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University of Maryland School of Nursing

COLUMBIA, S.C. — Nearly 4,000 drums containing a variety of chemicals were found buried in a small rural neighborhood in Greenville County.

Toxic waste

Deep in the roots of nursing comes a search for harmful sources

By Lillian Mood

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COLUMBIA, S.C.—What now looks like a grassy field was the site of excavation of nearly 4,000 containers of buried chemical waste. Claude Martin points out the impact on his home to environmental nurse Lillian Mood, right, who worked with residents on their temporary relocation during the investigation and clean-up operations. Ms. Mood is a community liaison for the South Carolina Department of Health and Environmental Control.

The connection with environment is part of nursing’s heritage. Nursing heroes like Florence Nightingale and Lillian Wald made environmental conditions a central focus of practice. The Institute of Medicine’s report, released in 1995, makes a persuasive case that being faithful to the environmental heritage of nursing is only one reason for nurses to be involved in environmental health. Nurses outnumber every other health professional, and we are present in every health care setting. Nurses bring skills of listening, of accurate record keeping, of assessment, analysis, and problem solving, and of advocacy for individuals that can be expanded to group or class advocacy. And the people we serve and the public at large trust nurses.

Throughout the world—which in pulmonary care, oncology, pediatrics, public health or other specialties—nurses can do significant work in determining the causes of illnesses through inclusion of environmental exposures in their history taking. Nurses faced with presenting illness symptoms can probe potential sources of harm at home, at work and in communities. A caring nurse can elicit information that leads to the root of health problems, such as accurately assessing:

• A “failure to thrive” infant whose formula is mixed with well water contaminated with nitrates.
• A child with developmental delays whose father’s work clothes from his job in a battery plant or an automotive repair shop are worn home and washed with the family laundry, bringing lead contamination into his household.
• A family illness resulting from food preparation in the home, from undercooked hamburger containing E. coli to salmonella contamination from chicken on kitchen work surfaces.
• A relationship between asthma episodes and “ozone alert” days in congested urban neighborhoods.
• An outbreak of giardia among children in a day care center where careful hand washing is not practiced.

The public expects from nurses, and all health professionals assessing symptoms that may relate to environmental hazards, that we listen, understand the symptoms may have serious implications, offer direct...
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Environmental protection. My job is to connect you with the people, the information and the response needed to help with your concerns about the environment and its effect on your health.

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My recent participation with the South Carolina Department of Transportation Passenger Rail Advisory Committee illustrates how nurses can make a contribution outside our customary venues. Meeting new federal clean air standards for ground-level ozone and particulate matter would be a challenge for South Carolinians. Mass transit and the reduction of individual auto use, especially in congested urban areas, are part of the solution to air pollution. Other public health problems can also be impacted: motor vehicle injuries and deaths, driving after drinking, isolation of the elderly, greater access to health services, increased transportation to jobs for welfare-to-work moms, economic survival for minimum wage workers.

As I talked with civic organizations and individuals to promote mass transit, the list of benefits grew longer. A university would have land available for buildings rather than parking garages. The capital city could attract visitors to its revitalized downtown area. Smaller communities could promote their particular attractions, such as a refurbished opera house, antique shops, restaurants, art galleries, a retirement community or a recreational lake. Our committee recommendations are now in expert hands for implementation. They include a broad goal of clean air and water, short-range goals of commuter train projects, and a mid-range goal of connecting cities with a multi-modal transportation system. My membership on the committee gave me, as a nurse, legitimacy for entry to other groups to promote mass transit as a step toward improved public health.

My environmental health work is grounded not only in the fundamentals of environmental, public health and nursing science, but also in values that are a cross-section of my nursing discipline, my public health profession and my personal beliefs. Those values are prevention, social justice, building community and healing. Healing was my motivation for becoming a nurse and is still at the heart of my practice. Virginia Henderson's definition of nursing has served me well in a wide range of settings throughout my career. She speaks of nurses doing for people what they would do for themselves if they had the knowledge, the strength and the will, and a nurse's obligation to build self-sufficiency and independence from our help as rapidly as possible. Using Henderson's frame for practice, I believe that every encounter with a nurse should be a strengthening experience.

This is an unfailing guide for my actions and a powerful measure of outcome for my work. I keep a quote from Theodore Roszak posted on my doorway: "Healing people and healing the planet are part of the same enterprise."  

Lillian H. Mood, RN, MPH, FAAN, is the community liaison for the South Carolina Department of Health and Environmental Control. She is an adjunct faculty member at both the University of South Carolina College of Nursing and the School of Public Health. She received the 1999 American Public Health Association's Lillian Wald Service Award for exemplary public health nursing practice. In 1995, she was chair of the Institute of Medicine's Committee on Enhancing Environmental Health Content in Nursing, and is editor of Nursing, Health and the Environment with Andrew M. Pope and Meta A. Snyder.

World Health Organization, 1997

20% of global population lacks adequate drinking water

50% of global population lacks adequate sanitation

One billion people, mostly women and children in developing nations, are exposed to high levels of indoor air pollution

500 million people in more than 90 nations are affected by malaria due to agriculture, mining and urbanization.

40 million people have contracted symptomatic H1N1, schistosomiasis, leishmaniasis and Chagas' disease, particularly due to the influences of poor water, sanitation and housing.

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The Marie A. Duke Professorship in Nursing Science will support development of a program of research and education related to the care of individuals, families and communities at all stages of major health problems.

The Clinical care faculty (one position) and community health faculty (one position) are needed to become part of a dynamic group involved in teaching, research and clinical experiences in the School of Nursing. Qualifications include an earned doctorate in nursing or related field (M S, PhD, EdD), experience in education and a commitment to scholarship. A history of externally funded research and publications is desired.

Salary is competitive and commensurate with experience. Excellent benefits. Send a letter of application, curriculum vitae and contact information for three references to: L. Jon Williams, Ph.D., RN, FAAN, Dean and Professor, College of Nursing, 313 CON/HSLC Building University of Kentucky, Lexington, KY 40536-0212, (859)323-0015, Fax (859)323-1057, e-mail: coln-uk@uky.edu.

Auburn University School of Nursing invites applications for faculty positions in the areas of maternal/newborn, child health and community health and psychiatric/mental health nursing for fall semester. The school is seeking individuals with uncommon energy and creativity to help implement our new community-focused curriculum. Auburn University is a land-grant university with 22,000 students located in Auburn, Alabama, a family-oriented community with an excellent K-12 educational system. Auburn is two hours from Atlanta and three and a half hours from the Gulf coast.

Faculty responsibilities include teaching, scholarship and outreach activities. Candidates must have an MSN and doctoral degrees. Will consider candidates with substantial work toward the doctoral degree. Alabama RN license required. Send curriculum vitae, three letters of reference and transcript to Search Committee, School of Nursing, Miller Hall, Auburn University, Auburn, AL 36849.

Review of applications continue until positions are filled.

AUBURN UNIVERSITY OF ALABAMA

Faculty position

Auburn University College of Nursing (undergraduate, graduate and continuing education) is seeking a part-time, non-tenure track faculty member at the rank of Clinical Instructor to teach health assessment in the online MSN program. The successful applicant must have a minimum of three years of clinical experience as a professional nurse. The position is three hours per week and includes one course per semester. The application process is ongoing until an appropriate candidate is found. Interested individuals should complete an application form and submit a letter of interest, curriculum vitae, three letters of reference, and a current Alabama RN license to: Dr. E. Jennifer L. Brown, Chair, College of Nursing, Auburn University, Auburn, AL 36849

LINDA C. CALL CHAIR IN NURSING

Auburn University School of Nursing invites applications for a full-time, nine-month faculty position to implement the new community-focused curriculum for the Health Assessment course. This position will be three courses per semester. The successful applicant must have a minimum of three years of clinical experience as a professional nurse. An earned master's degree in nursing and a current Alabama RN license are required. Applications should be submitted online to: http://aupage.auburn.edu/coln/employment.html

African American, women and minorities are encouraged to apply.

UK College of Nursing UNIVERSITY OF KENTUCKY

Reflections on Nursing LEADERSHIP Second Quarter 2000 21
information in understandable words, and follow through on the indicated nursing actions.

My recent participation with the South Carolina Department of Transportation Passenger Rail Advisory Committee illustrates how nurses can make a contribution outside our customary venues. Meeting new federal clean air standards for ground-level ozone and particulate matter would be a challenge for South Carolinians. Mass transit and the reduction of individual auto use, especially in congested urban areas, are part of the solution to air pollution. Other public health problems can also be impacted: motor vehicle injuries and deaths, driving after drinking, isolation of the elderly, greater access to health services, increased transportation to jobs for welfare-to-work moms, economic survival for minimum wage workers.

As I talked with civic organizations and individuals to promote mass transit, the list of benefits grew longer. A university would have land available for buildings rather than parking garages. The capital city could attract visitors to its revitalized downtown area. Smaller communities could promote their particular attractions, such as a refurbished opera house, antique shops, restaurants, art galleries, a retirement community or a recreational lake.

Our committee recommendations are now in expert hands for implementation. They include a broad goal of clean air and water, short-range goals of commuter train projects, and a mid-range goal of connecting cities with a multi-modal transportation system. My membership on the committee gave me, as a nurse, legitimacy for entry to other groups to promote mass transit as a step toward improved public health.

My environmental health work is grounded not only in the fundamentals of environmental, public health and nursing science, but also in values that are a cross-section of my nursing discipline, public health profession and personal beliefs. Those values are prevention, social justice, building community and healing.

Healing was my motivation for becoming a nurse and is still at the heart of my practice. Virginia Henderson's definition of nursing has served me well in a wide range of settings throughout my career. She speaks of nurses doing for people what they would do for themselves if they had the knowledge, the strength and the will, and a nurse's obligation to build self-sufficiency and independence from our help as rapidly as possible. Using Henderson's frame for practice, I believe that every encounter with a nurse should be a strengthening experience. This is an unfailing guide for my actions and a powerful measure of outcome for my work.

I keep a quote from Theodore Roszak posted on my doorway: "Healing people and healing the planet are part of the same enterprise."

Lillian H. Mood, RN, MPH, FAAN, is the community liaison for the South Carolina Department of Health and Environmental Control. She is an adjunct faculty member at both the University of South Carolina College of Nursing and the School of Public Health. She received the 1999 American Public Health Association's Lillian Wald Service Award for exemplary public health nursing practice. In 1995, she was chair of the Institute of Medicine's Committee on Enhancing Environmental Health Content in Nursing, and is editor of Nursing, Health and the Environment with Andrew M. Pope and Meta A. Snyder.

World Health Organization, 1997

20% of global population lacks adequate drinking water

50% of global population lacks adequate sanitation

One billion people, mostly women and children in developing nations, are exposed to high levels of indoor air pollution

500 million people in more than 90 nations are affected by malaria due to agriculture, mining and urbanization.

48 million people have contracted symptomatic hiliaris, schistosomiasis, leishmaniasis and Chagas' disease, particularly due to the influences of poor water, sanitation and housing.

An important cause of cataracts and skin cancer comes from increased ultraviolet radiation from the sun reaching the globe's surface, due to damage to the stratospheric ozone layer.

FACULTY POSITION

Auburn University School of Nursing

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HANOI, WOMEN AND MINORITIES ARE ENCOURAGED TO APPLY.

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Four tenure-track positions available:

The Lin Col Clair Chair in Nursing was established to support leadership in education, implementation or rehabilitation of health care delivery and/or patient safety. Applications are invited for a successful track record of program development to the care of individuals, families, communities or populations in major health problems.

Clinical care track (one position) and Community Health Nursing (one position) faculty are needed to become part of a dynamic group involved in teaching, practice and research in academic health sciences centers and University qualifications include an earned doctorate in nursing (in the field of public health or related field); experience in education and a commitment to scholarship. A history of externally funded research (FRP) and publications is desired.

Success is competitive and commensurate with experience. Excellent benefits. Send a letter of application, curriculum vitae and contact information for three references to Dr. Jon Williams, Ph.D., RN, FAAN, Dean and Professor of College of Nursing, 313 CON/HSLC Building, University of Kentucky, Lexington, KY 40536-0221, (859) 257-0531, Fax (859) 257-1073, e-mail: chartwell@hslc.uky.edu.

UK College of Nursing
HOSPITAL CARE

Research shows erosion to advocacy role

By Bev O'Connell

Geelong, Victoria, Australia, Jan. 20—Advocacy is "an act of pleading for, supporting or recommending" (Macquarie University, 1991, 24). The nursing profession has embraced this concept as part of its caring ethos. It is common practice for nurses to compromise themselves as they advocate for patients. Although patient advocacy was not the objective of a recent grounded theory study, the data provide examples of advocacy (O'Connell, 1997; O'Connell, 1998). The study was conducted in acute care settings in major teaching hospitals in Western Australia.

Specifically, excerpts from the study offer explanations as to why nurses—who are predominantly baccalaureate educated—constantly check to see that the doctor has not forgotten a task related to patient care. Or a nurse performs tasks that are the doctor's responsibility in order to promote continuity of care: "So it's really the doctor's responsibility to make sure that all x-rays and tests and everything (is done). ... It's really their responsibility to make sure that they're there. It's not your job."

"We (nurses on a ward) were discussing why we thought that was our responsibility. I guess we feel responsible for the patient, and we sort of don't want to hold patient care up, although we know it's not our job. We don't really want to hinder the patient's progress through the system. Why should they suffer because of inefficiencies elsewhere in the system? I think we sort of have this maternal protective thing."

Other examples within the Australian context include nurses being uncomfortable writing emotional and/or psychosocial patient problems in the patient's notes, which is a professional requirement, as they felt it undermined the trusting nurse-patient relationship: "Although we know the person's anxious, we may deal with that from talking to the patient. Sometimes I think nurses might see that as a bit confidential. ... And they may not want to actually write that in (the notes)."

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It's mainly, as far as I can see, because there are too many patients and too few nurses (p. 76)."

Another patient wrote: "I believe that the nursing staff that attended me while I was in hospital were very caring and competent, but were in some cases extremely busy and thus were not able to be as attentive as perhaps they could've been."

Patients often empathized with nurses' working conditions: "I would not be a nurse for 'quids' (lots of money), because of the things they have to do and sometimes the abuse they receive."

The phenomenon of patients advocating for nurses should be reflected upon. Clearly, it is uncommon for consumers of any service to make excuses for staff who provide substandard services (patient care). One could argue that within this context, patients have observed and drawn conclusions that time constraints have impeded nurses from providing adequate care. This patient perspective needs to be considered.

Additionally, under these conditions nurses found it increasingly difficult to advocate for patients. The erosion of this important role is detrimental to the delivery of quality care and it is shortsighted to underestimate the value it adds to any health care facility. The growing trend of consumer interest in health care and the employment of independent patient advocates support the need for this type of service.

As nurses have sound knowledge of health care and work closely with patients over a 24-hour period, they remain the most suitable professionals to perform this role.

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Difficult to maintain this advocacy role:

"Once again the public health system is in disarray. Budgets are getting tighter, whilst the services provided are becoming broader and more expensive. . . . We are told that the hospital's restructuring is aimed at increasing efficiencies. . . . We tell Mr. Smith that we are sorry he has waited 30 minutes for pain relief, but due to management efficiencies his duty nurse, who called in sick, was not replaced. We are embarrassed when we explain to Mrs. Jones that—although she has been coming to our unit for a few years, and she knows all the staff and feels comfortable with our care—due to hospital restructuring, her next admission could be in one of four different wards. And we are sorry we do not know which nurses will be looking after her."

Nurses were compromised as their working conditions in acute care settings limited professional practice (O'Connell, 1998). This erosion of working conditions should be of great concern to the profession, as it has wide-range implications. In particular, time constraints within practice settings restrict a nurse from knowing the patient, which is an essential ingredient of individualized care (Radwin, 1995).

Interestingly, the busy pace and changing context of care have resulted in a role reversal where patients are advocating for nurses and support them as they work under difficult conditions. General comments from a patient satisfaction survey in an acute care setting illustrate this point (O'Connell, Young & Twigg, 1999):

"I found all the nurses who attended me knew their job well, cared effectively. But they were clearly always busy. I would not like to see their burdens increased without adequate support, since this would reduce capacity for caring as well as nursing per se. That would be a retrograde step in my opinion."

Some patients qualified their negative comments about nursing care, justifying why they marked some items low. One patient wrote:

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As nurses have sound knowledge of health care and work closely with patients over a 24-hour period, they remain the most suitable professionals to perform this role. It is necessary for hospital managers who are committed to delivering high standards of care to take cognizance of the current situation and to try to adequately resource the nursing service to maintain nursing's advocacy role.

References, page 45.

Bev O'Connell, RN, PhD, is an associate professor at Deakin University in Geelong, Australia. She was the nursing research director at Sir Charles Gairdner Hospital and director of the Centre for Nursing Research and Development at Curtin University of Technology in Perth. Her main research interests are patient care interventions and outcomes in acute care settings.
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Chronic anger robs our energy and creativity (Potter-Efron, 1994) and is contagious because it loves company. Sadly, chronic anger at work: 1) expects the best for our patients, 2) has a realistic expectation that is not met (Lyon, 1996), 3) will not meet its expectations and even celebrate if you were able to accomplish a little bit more (Lyon, 1991).

Choosing to let go doesn't mean that you no longer will have expectations and it is counterproductive to create negative thoughts like, "You mean you didn't get the baths done?"

Letting go

It is imperative to "let go" of an expectation when a person is incapable of or unwilling to meet it. The most challenging aspect of the current turmoil in the health care system is a lack of clear, simple solutions for delivering quality care at a substantially reduced cost. Everyone is searching. Lots of things don't make sense. It's a confusing time. In a very real sense this is an adventure—perhaps one we wouldn't choose to experience, but an adventure nonetheless. To expect that management should have the answers is unrealistic. Holding onto that expectation, rather than realizing that we are in the process of discovering what works and doesn't work, guarantees chronic anger.

Another way to guarantee chronic anger is to persist in holding onto an expectation that the other person is not willing to meet: "Carol never does her share of the work around here. I always end up picking up her slack!" If Carol really isn't willing to do something that you expect her to do, and you have no power to help her become willing (via consequences), then continuing to expect it only guarantees chronic anger for you.

The most dangerous emotion to experience in this circumstance is hope—hope that tomorrow will be the day that Carol will pull her weight. To stop chronic anger, you must let go of the expectation for that person at this point in time. Letting go doesn't mean that you wouldn't value something different; it just means that you realize that your expectation is not going to be met. I am frequently asked this question: "If I let go of the expectation, doesn't that mean she wins?"

First, you don't have to announce that you are letting go, and second, ask yourself this question: "Who is suffering?" Choosing to let go doesn't mean that you no longer will have to do something that Carol isn't doing, but it is choosing not to suffer with something that you can't change or control.

Reference, page 45

Look for Dr. Lyon's "Conquering chronic anger: Am I empowering myself?" in the next issue of Reflections on Nursing Leadership.

Brenda L. Lyon, RN, DNS, FAAN, is an associate professor in adult health at Indiana University School of Nursing and a nationally recognized expert on stress management.

Don't I have a right to expect the best for my patients?

Conquering chronic anger

By Brenda L. Lyon

INDIANAPOLIS, Jan. 9—Every organizational change that disrupts our role responsibilities, what we expect from—and how we interact with—each other becomes fertile territory for chronic anger. Chronic anger is a debilitating emotion that can cause uncomfortable physical symptoms including fatigue, depression, a decrease in productivity, burnout and interpersonal violence that is also called "horizontal" violence (Ellis, 1996; McCall, 1996; McKay, Rogers, McKay, 1989).

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Chronic anger robs our energy and creativity (Potter-Efron, 1994) and is contagious because it loves company. Sadly, when we experience chronic anger it deprives the discipline of its potential to make meaningful contributions to shaping a new reality for nursing.

As a nurse and stress counselor, I am especially concerned about the workplace stresses nurses experience. By developing effective self-care skills, you can harness your energy and prevent, or alleviate, chronic anger.

Anger is caused when you have an expectation that is not met (Lyon, 1991, 1995). Chronic anger is caused by holding onto an expectation that is not realistic. Current health care environments are stretched for material resources to meet the expectation; and 3) the person has the resources (e.g., capability, knowledge, time, material resources) to meet the expectation; and 3) the person is willing to do what is expected. (Lyon, 1991, 1995) A realistic expectation is one that has a reasonable chance of being met.

Why do you hold onto an unrealistic expectation? It's because you believe you have a "right" to expect it (Ellis, 1996). As a nurse you have rights—rights to be treated respectfully, rights to have grievances heard, and rights to advocate for patients. In fact, you not only have a right to question and to make informed decisions about nursing care, you are obligated to do so. However, having a "right" to expect something doesn't mean that the expectation will be met. When your rights are not honored, when your sense of "right" has been "wronged"—it's an emotionally charged situation.

There are three ways to alleviate chronic anger at work: 1) expect change; 2) communicate expectations clearly; and 3) "let go" of an expectation when it is clear that it is not going to be met.

Not too long ago I had the pleasure of meeting a young registered nurse who had been practicing as a staff nurse since 1994. I was conducting a workshop on conquering stress in the workplace, and she was on a panel of nurses who shared how they were coping with all of the turmoil in nursing practice. Her hospital was in the final phases of implementing the latest re-engineering of nursing care delivery. She was incredibly upbeat and positive. A nurse in the audience said, "Aren't you tired of all of the changes? Don't you get stressed out or angry?"

The nurse on the panel said, "Since I've been in practice (for five years), change is all I've known. This is my third redesign of how we deliver nursing care. I know the leadership at my hospital is doing the best they can to try to cope with the need to cut costs so that we can stay in the business of taking care of sick people. They frequently seek our input on how we can deliver the best care with fewer resources. We have great feedback systems, so when something isn't working we try to fix it. It's a challenge every day, but I don't experience anger about it. I think I'm advantaged, because all I've known is change. I expect it! I love what I do!"

Communicating expectations

As I talk with nurses about their particular stresses, they tell me that expectations are rarely discussed. As human beings we often participate in the phenomenon of automatic knowing or mind reading. That is, "I shouldn't have to tell you what I expect, you've worked here for five years." When expectations are not discussed, it is too easy to assume that what is expected is "the ideal."

I have had opportunities to help many staff nurses and managers in identifying and discussing the bare minimum expectations on "mash days" (named after the M*A*S*H television series about a mobile army surgical hospital in the Korean War). A mash day is the opposite of an ideal day. It is a difficult day when the nurse/patient ratio is stretched to the limit, and the bottom-line focus is simply on not harming patients. When everyone knows the mash day expectations, the changing level of expectations can easily be communicated.

You need to think about how incredible it is that you were able, in these difficult circumstances, to meet the minimum expectations and even celebrate if you were able to accomplish a little bit more (Lyon, 1991). "I was here for 8 or 12 hours, helped a few patients and didn't harm anybody!" It is counterproductive to create negative thoughts like, "You mean you didn't get the baths done?"

Letting go

It is imperative to "let go" of an expectation when a person is incapable of or unwilling to meet it. The most challenging aspect of the current turmoil in the health care system is a lack of clear, simple solutions for delivering quality care at a substantially reduced cost. Everyone is searching. Lots of things don't make sense. It's a confusing time. In a very real sense this is an adventure—perhaps one we wouldn't choose to experience, but an adventure nonetheless. To expect that management should have the answers is unrealistic. Holding onto that expectation, rather than realizing that we are in a process of discovering what works and doesn't work, guarantees chronic anger.

Another way to guarantee chronic anger is to persist in holding onto an expectation that the other person is not willing to meet: "Carol never does her share of the work around here, I always end up picking up her slack." If Carol really isn't willing to do something that you expect her to do, and you have no power to help her become willing (via consequences), then continuing to expect it only guarantees chronic anger.

The most dangerous emotion to experience in this circumstance is hope—hoping that tomorrow will be the day that Carol will pull her weight. To stop chronic anger, you must let go of the expectation for that person at this point in time. Letting go doesn't mean that you wouldn't value something different; it just means that you realize that your expectation is not going to be met. I am frequently asked this question: "If I let go of the expectation, doesn't that mean she wins?"

First, you don't have to announce that you are letting go, and second, ask yourself this question: "Who is suffering?" Choosing to let go doesn't mean that you no longer will have to do something that Carol isn't doing, but it is choosing not to suffer with something that you can't change or control.

References, page 45

Look for Dr. Lyon's "Conquering chronic anger: Am I empowering myself?" in the next issue of Reflections on Nursing Leadership. Brenda L. Lyon, RN, DNS, FAAN, is an associate professor in adult health at Indiana University School of Nursing and a nationally recognized expert on stress management.
Clinicians use group-wise effort for innovations

By Susan Diemert Moch, Julie Goldsmith

Eau Claire, Wis., Jan. 21—Clinical nurses at Sacred Heart Hospital needed to know if tympanic thermometers were the most accurate way to measure patient temperatures. And, if so, what research should they use as the basis for new practices?

The Professional Practice Committee met and discussed two articles on tympanic thermometers and two on integrating research into practice in 1996. The group decided tympanic thermometers were appropriate in many situations.

While discussing how to disseminate nursing research in practice, clinicians felt they would benefit by talking directly with author Dr. Sandra Funk at the University of North Carolina at Chapel Hill. She was contacted and her conversation, with questions and answers, was tape-recorded to share with larger numbers of clinicians. Staff nurses liked hearing this researcher's views.

For nearly a decade, six collaborative discussion groups have been designed and studied to effectively help clinicians determine the latest innovations for their patients in an enjoyable manner (Moch, Robie, Bauer, Pederson, Bowe & Shadick, 1997).

Convenience has been key to supporting staff nursing needs. A group of clinicians working on an acute care unit at Sacred Heart Hospital, for example, wanted to know the latest pain information. Clinicians met on a unit for one hour between shifts, allowing two shifts to fully participate. They attended three or four sessions, discussing four pain-related research articles. In small groups, they identified how the pain information could be used and possible hospital procedures that may need changing to implement the research completely.

Until recently, all of the collaborative groups conducted in Midwestern hospitals, clinics and community settings have involved the researcher by e-mail, telephone or direct conversation (Moch, Poirer, Dwyer, Nyseth, Rouse & Sommers, 1998).

However, nurses at the Mayo Clinic in Rochester, Minn., adapted the process to permit clinical nurse specialists to bridge the gap between research and practice. Nurses at Mayo Clinic serve a patient population that travels to the clinic from all parts of the state, nation and globe. Nurses were interested in a broad range of issues related to telephone interactions in caregiving, including licensure requirements for practicing outside state borders.

“Nurses throughout our whole institution provide information over the telephone,” said Christy Chua Patel, RN, MS, patient education specialist. “We are involved in telephone-triage and follow-up conversations after patients leave. There are questions from patients on wound dressing, tracheotomy care, ostomy care. What do we tell them? How do we document it?”
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Researchers invite clinicians to correspond by e-mail

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Bioethics, Nursing Ethics
Dr. Miriam E. Cameron
e-mail: mcameron@obhc.umn.edu

Research Dissemination
Dr. Sandra Funk
e-mail: sflex@umc.edu

Pain Assessment, Symptom Management
Dr. Fannee Gustaf-Johnsson
e-mail: fanee@sun.jhmi.edu

Young Caregivers of Adult Cancer Patients, Cancer Patient Needs
Dr. Marie F. Gates
e-mail: GatesM@umkc.edu

Postoperative Pain, Patient Satisfaction
Dr. Linda M. Herrick
e-mail: henn@mayo.edu

Cognitive Functioning in Elderly and Those with Chronic Illness
Dr. Debra A. Jensen
e-mail: jtraud@uwec.edu

Family Health/Practice Knowledge/Wisdom
Dr. Marius C. Litchfield
e-mail: Merian.Litchfield@clear.net.nz

Midlife Breast Cancer
Dr. Susan Diemert Moch
e-mail: smoch@uwec.edu

Cancer Patient Exercise to Manage Fatigue, Bone Marrow Transplant Patient Quality of Life
Dr. Victoria Mock
e-mail: vmock@sun.jhmi.edu

Articulating and Developing Nursing Practice, Enhancing and Describing
Dr. Christine Webb
e-mail: webb@webbc.u-net.com

Community Health, Hospice
Dr. Joyce Zarnecki
e-mail: jzavrecki@nara.edu

Domestic Violence, Homicide Risk Assessment
Dr. Jacquelyn C. Campbell
e-mail: jcampbel@sun.jhmi.edu

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By Joan M. Riley and Sara T. Fry

Advocacy is one of the fundamental moral concepts of nursing (Fry, 1994). Speaking up for the rights of a patient when he cannot speak due to illness; helping a patient to clarify his values and interests before making decisions; and protecting a patient's basic human values, such as privacy and human dignity, are all ways that a nurse fulfills the ethical obligation to be a patient advocate. However, increasing numbers of nurses are finding it hard to be an effective patient advocate in today's health care delivery system.

In a recent study conducted in collaboration with the Nursing Ethics Network, it was found that some of the most frequently
encountered ethical issues by registered nurses in New England involved patient advocacy (Fry and Riley, 1999). The survey of more than 8,000 practicing RNs living and working in six New England states indicated that protecting patients' rights and human dignity, respecting/ not respecting informed consent to treatment, and following/not following advance directives were among the most frequently encountered issues. Each of these issues affects the advocacy role of nurses.

RNs in the study also reported that they were most disturbed by issues that involved staffing patterns that limit patient access to nursing care, prolonging the dying process with inappropriate measures, not considering the quality of a patient's life, and caring for patients/families who are uninformed/misinformed about treatment. Being disturbed by these issues indicates that nurses are troubled by not being able to fulfill their advocacy roles.

If being a patient advocate means protecting the rights and values of patients during a vulnerable time of illness, these data show that nurses are currently experiencing many ethical issues in fulfilling this role. When nurses find that they cannot fulfill this obligation to respect, protect, and speak up for patients' rights, they may experience a conflict between their obligations and what actually occurs in patient care. As other studies have demonstrated, unresolved ethical conflicts can, over time, affect nurses' work satisfaction and have the potential to affect patient outcomes.

Supporting the advocacy role

What should be done to support the advocacy role of nurses and to enhance their abilities to handle ethical issues in patient care? One approach could be to offer content-specific ethics education to practicing nurses. The RN participants in this study indicated that they have, in general, a high-to-moderate need for ethics education in order to practice ethically.

The most frequently chosen ethics education topic, selected as other studies have demonstrated, unresolved ethical conflicts can, over time, affect nurses' work satisfaction and have the potential to affect patient outcomes.

As other studies have demonstrated, unresolved ethical conflicts can, over time, affect nurses' work satisfaction and have the potential to affect patient outcomes. The topic of patients' rights and autonomy, and informed consent, were also stated preferences for ethics education. Hence, not only did nurses clearly specify a need for ethics education, they also selected ethics education topics that express preference for support of their advocacy roles. These topics also link with the most frequently encountered and most disturbing ethical issues that RNs reported.

The results from this study heighten our understanding of the need for ongoing ethics education for practicing nurses. If it is to be responsive to this need, ethics education should:

- Address the ethical issues that nurses are currently experiencing embedded in the social, cultural and organizational structures where nurses practice.
- Encourage debate and rethinking about the traditional moral concepts of nurses, such as advocacy in a healthcare climate dominated by concerns of business and changing practice roles.

Practicing nurses have indicated a need for support to be effective patient advocates. That support should come in at least two forms: ongoing ethics education designed for practicing nurses, and from the workplace. The fundamental moral concept of advocacy should underpin all educational and workplace efforts. Nurses, as members of the healthcare team, are interdependent decision-makers who share clearly articulated obligations to protect the rights and human dignity of patients.

For more information, visit The Nursing Ethics Network via the Internet: www.bc.edu/nursing/ethics. References, page 45.

Joan M. Riley, RN, EdD, is an associate professor and chair of the Department of Nursing at Emmanuel College in Boston, Sara T. Fry, RN, PhD, FAAN, is Henry R. Luce Professor of Nursing Ethics at Boston College School of Nursing. They are members of the Nursing Ethics Network, which—through its Web site—connects nursing ethics experts with nurses searching for ways to address their own difficult concerns.

Private places

Patients teach spirit of nursing

By ReNel Davis

KANEHOE, Hawaii, Feb. 29—The history of Hansen's disease (leprosy) in Hawaii is the story of some 8,000 persons, young and old, taken from their families against their will and isolated on a remote peninsula on Molokai, beginning in 1865. The banishment and isolation continued until 1969. Today, around 50 patients choose to remain living in Kalapapa, Molokai, even though sulfone drugs were made available in the 1940s, and modern medicine keeps the disease in check.

Jeanine Tweedie, RN, MSN, assistant professor of nursing at Hawaii Pacific University, wanted her transcultural nursing students to learn about the people of Kalapapa because of their isolation and unique culture. The nursing group was privileged to be permitted onto the settlement. The area is under joint control of the National Park Service and Hawaii Department of Health, with a limited number of visits allowed. Permission was secured from the National Park Service to live there for four days, bringing an experience that helped provide deep insights about people whose lives have been affected by this disease and society's treatment of them.

The remote Kalapapa settlement on Molokai, Hawaii, may only be reached by foot, mule or small aircraft. Eight students and two professors—with all necessary food and supplies—launched their 40-minute flight in May 1999.

We had the opportunity to study the history of Kalapapa, venture through the community, perform community service such as beach cleanups and plant life maintenance, and talk with patients, nurses and community members. Transcultural nursing theory was utilized to help assess the community, identify health traditions and learn cultural phenomena that impact health needs. Time was spent with nurses who work at the small hospital and clinic to provide 24-hour spiritual and health care to the remaining patients who call Kalapapa home. We were also fortunate to be able to converse with several patients who have lived there for more than 50 years.

Patient advocacy was a major theme of this course, which helped students understand the need to combat fear, prejudice, rejection, segregation and the use of derogatory terminology associated with disease. At the same time, it was humbling to learn about the strength of the human spirit and the creation of a rewarding life of hope and dignity in the face of adversity.

This year another group of students will experience this important aspect of Hawaiian history. They too will see a place that exists in a time where life remains simple, and people are grounded in their choice to live close to the land and sea. There, among the unfortunates Kalapapa, sunsets are never lost, sands never leave, and a healing gentleness breathes on the winds of hope and human dignity.
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Reflections on Nursing Leadership Second Quarter 2000

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ReNel Davis, RN, PhD, assistant professor at Hawaii Pacific University in Kamehameha, traveled with the transcultural nursing group of Jeanine Tweedie, RN, MSN.
University of Minnesota creates leadership chair

MINNEAPOLIS, Feb. 22—The University of Minnesota School of Nursing is establishing an endowed chair to support a director for the Katharine J. Densford International Center for Nursing Leadership. The chair was made possible by a $3 million gift from Kaye Lillehei, a registered nurse at the university when Dr. Densford was dean.

The Densford International Center for Nursing Leadership provides a forum for addressing current issues in health care and nursing. Mrs. Lillehei's donation is the largest gift the school of nursing has ever received. Her niece, Angela Smith Lillehei, is a Sigma Theta Tau International member.

For information on the endowed chair, contact Dr. Marilee Miller at 612.624.7111, or by e-mail: milleo06@tc.umn.edu.

Heart association seeks council members

DALLAS, Jan. 10—The American Heart Association is accepting applications for charter membership in its Council on Nutrition, Physical Activity and Metabolism. The new council will bring cardiovascular disease risk factors not specifically represented by the current scientific councils, such as obesity and diabetes, to the forefront of the organization.

The group will promote lifestyle and dietary practices aimed at preventing heart disease and stroke, implement guidelines and serve as a forum for professional discussion and education. The association's 12 scientific councils represent areas of knowledge important to the mission of reducing death and disability from cardiovascular diseases and stroke.

More than 400 charter council members are needed. To apply for membership, contact Linda Johnson at 214.706.3777 or via e-mail at Lindaj@heart.org.

Teen smoking

PITTSBURGH, June 7, 1999—Using peer support to stop smoking may be particularly effective with pregnant teen-agers, according to University of Pittsburgh nursing researchers. Fifty-eight percent of pregnant teens quit smoking when they participated in Teen FreshStart Plus Buddy Program. The intervention may be successful because pregnant teens are concerned about the health of their unborn baby, said Susan Albrecht, RN, PhD. "It creates a window of opportunity for health care providers to offer advice." She and Maureen Reynolds, PhD, conducted the study.

Coronary risks for women

BALTIMORE, June 15, 1999—One year after coronary bypass surgery, a majority of women continue to have the same significant risk factors, according to a study at Johns Hopkins University. A year after bypass, 58 percent of the women are obese, 54 percent have high blood pressure and 92 percent have high cholesterol. Ten percent continue to smoke.

Some patients may consider themselves "fixed" after bypass surgery, while others are not properly informed about risk factors that may lead to secondary episodes of heart disease, said Jerilyn Allen, RN, ScD, principal investigator. The research included 130 women ages 55 to 75.

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Call for Nurse Experts for 2001 Media Directory

Submission Deadline: August 31, 2000

Sigma Theta Tau's "Media Guide to Health Care Experts" is disseminated annually to health care journalists, public relations executives and society members. The guide includes experts in a variety of health care areas who can speak to current nursing and health care trends.

If you are interested in being a media spokesperson, contact Andrea McDonald for a copy of the submission form at: 888.634.7575 (U.S. and Canada toll free); + 1.800.634.7575 (Global toll free) or e-mail: mcintosh@stti.iupui.edu.
University of Minnesota creates leadership chair

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Dr. Alan

Treatment incontinence in women

WASHINGTON, D.C., Feb. 21—Women who have had even one vaginal birth are two-and-a-half times more likely to report urinary incontinence than women who have not given birth vaginally. Women who have had a hysterectomy also have a greater risk of incontinence.

Incontinence can be successfully treated through pelvic floor training and bladder training, according to findings of a research project led by Carolyn Sampselle, RNC, PhD, FAAN, professor of nursing and women's studies at the University of Michigan. Women who used the Association of Women's Health, Obstetric and Neonatal Nurses' protocol for treating their own incontinence experienced reduced urine leakage. In addition, at the outset of the project, 14 percent of 132 women studied reported avoiding certain activities because of incontinence, but only 3.5 percent reported avoiding such activities at a four-month follow-up.

“The outcome very often enables women to avoid medication and surgery,” said Dr. Sampselle. "Not enough women know this, but nurses can inform and teach them." 8

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For more information or to receive an application please contact Sue Wheeler, RN, MN, EDC, by May 25th, at 608.654.7575 or e-mail: mcdonald@stti.iupui.edu.

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Call for Nurse Experts for 2001 Media Directory

Submission Deadline: August 31, 2000

Sigma Theta Tau's "Media Guide to Health Care Experts" is disseminated annually to health care journalists, public relations executives and society members. The guide includes experts in a variety of health care areas who can speak to current nursing and health care trends.

If you are interested in being a media spokesperson, contact Andrea McDonald for a copy of the submission form at: 888.634.7575(U.S. and Canada toll free); +1.651.634.7575(International toll free) or e-mail: mcdonald@stti.iupui.edu.

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Honor Society of Nursing

Honor Society of Nursing
**people**

**CLINICAL**

Hazel N. Brown, professor, and Rebecca B. Saunders, associate professor, both of the University of North Carolina Greensboro, have received grants totaling $37,652 from the North Carolina Department of Health and Human Services and the March of Dimes to support College Board Sisters, an adolescent pregnancy prevention program. The program, which focuses on girls whose sisters had a baby before age 18, encourages participants to graduate from high school and attend college.

Philip Esterhuizen, clinical nurse educator at Onze Lieve Vrouwe Gasthuis in Amsterdam, The Netherlands, has helped develop a program for hospital nurses on moral decision-making and has introduced portfolio use and reflection as instructional methods for student nurses. His research projects include the study of socialization of first-year student nurses.

Cheryl Gillis, Amy Harris, Mitzi Pepper and Virginia Singer, nursing students at Benning University in Gainesville, Ga., were inducted into Nu Gamma in November 1999 while traveling by boat on the Amazon River. The students were part of a medical missionary trip to Peru, treating patients under the supervision of Dr. Cathy Dyches.

Lillian Tom-Ozene, research assistant professor at the University of Utah in Salt Lake City, and Lorraine Valdez, nursing consultant for the Indian Health Service National Diabetes Program in Albuquerque, N.M., are volunteer co-chairs for a new American Diabetes Association program, "Awakening the Spine: Pathways to Diabetes Control and Prevention." Native Americans have a high incidence of type II diabetes. The outreach program brings culturally appropriate training to the community level for tribal employees, volunteers and leaders. Dr. Tom-Ozene is a member of the Navajo Tribe, and Ms. Valdez is a member of the Iñtepaluazo Pueblo Tribe.

**EDUCATION**

During a three-week trip to Southeast Asia, Constance M. Baker, professor of nursing administration at Indiana University School of Nursing in Indianapolis, presented a paper on problem-based learning at a Hong Kong conference; helped lead faculty workshops in the Philippines on writing for publication and on nursing curriculum; and presented a paper in Vietnam on curriculum development.

Karen Ball teaches undergraduate nursing students at Tarazani Polytechnic in New Plymouth, New Zealand, using games and physical interaction to enhance students' critical thinking. Ms. Ball is a home health nurse in Maryland.

Susan Chase, associate professor and chair of adult health nursing at Boston College School of Nursing in Massachusetts, has developed a joint master's degree program offered by the school of nursing and the Institute for Religious Education and Pastoral Ministry. Graduates of the program are prepared to work in a variety of clinical and pastoral settings. Jean O'Neill, Eileen Plunkett, Ellen Mahoney, Rachel Spector and Ronna Krozy served on the proposal task force.

John M. Clochesy, associate professor at Case Western Reserve University's Frances Payne Bolton School of Nursing in Cleveland, Ohio, has been named one of the most influential faculty in the nation by Black Issues in Higher Education magazine for her outstanding scholarship, service and integrity. The magazine also cited her role in renewing interest in research at the college.

**Reflections on Nursing LEADERSHIP**

**PEOPLE**

**CLINICAL**

Neville F. Strumpf, director of the Center for Gerontologic Science at the University of Pennsylvania School of Nursing in Philadelphia, has been named the Edith Clemensteinbright Chair in Gerontology, Dr. Strumpf and her colleague, Lois Evans, the Viola MacInnes/Independence Professor in Nursing, co-authored research on physical restraints that has led to significant reductions in the use of restraints at hospitals and nursing homes. Dr. Strumpf is currently studying palliative care and the use of interdisciplinary care teams to treat pain and manage symptoms.

**LEADERSHIP**

Lisa Marie Bernardo, assistant professor at the University of Pittsburgh School of Nursing in Pennsylvania, has received the 1999 Mildred K. Fincke Nursing Award from the Pennsylvania Emergency Health Services Council. Dr. Bernardo also received a $2,500 Special Project/Program Development Grant from the Emergency Nurses Association Foundation for "The Dog Bites Program: Documentation of Griefs and Bites in the Emergency Setting," an education program for emergency nurses, physicians and staff.

Patricia F. Brennan, Moehlman Bascom Professor at the University of Wisconsin-Madison School of Nursing and College of Engineering, has been elected president of the American Medical Informatics Association. She is the first nurse to hold that position.

Cynthia Flynn Capers, dean of the University of Akron College of Nursing in Ohio, has been named one of the most influential faculty in the nation by Black Issues in Higher Education magazine for her outstanding scholarship, service and integrity. The magazine also cited her role in renewing interest in research at the college.

Kimberly Howe, a PhD student at Case Western Reserve University's Frances Payne Bolton School of Nursing in Cleveland, Ohio, has been elected vice president of the Ohio Nurses Association.

Ellen Reynolds, a master's student in the pediatric nurse practitioner program at the University of Pittsburgh in Pennsylvania, has received a $2,000 advanced nursing scholarship as recipient of the 1999 Nightingale Award of Pennsylvania. She has written several articles on trauma, research and illness in children and is co-founder of Pittsburgh Safe Kids, an organization dedicated to the prevention of children's injuries.
Hazel N. Brown, professor, and Rebecca B. Saunders, associate professor, both of the University of North Carolina Greensboro, have received grants totaling $37,629 from the North Carolina Department of Health and Human Services and the March of Dimes to support College Bound Sisters, an adolescent pregnancy prevention program. The program, which focuses on girls whose sisters had a baby before age 18, encourages participants to graduate from high school and attend college.

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John M. Clochesy, associate professor at Case Western Reserve University's Frances Payne Bolton School of Nursing in Cleveland, Ohio, has been appointed to a three-year term as the Independence Foundation Professor of Nursing Education.

Patricia R. Cook, associate professor and assistant head of the University of South Carolina Aiken School of Nursing, has been appointed the Jane Wells Handly/Bank of America Chair in Nursing, which recognizes distinguished teaching, research and creative achievements.

Christina Hadak, assistant professor at Case Western Reserve University's Frances Payne Bolton School of Nursing in Cleveland, Ohio, was named Distinguished Nursing Educator of the Year by the Ohio Nursing Students Association.

Gladya Mahinda, assistant professor at Southern Illinois University Edwardsville, traveled to South Africa as part of an interdisciplinary team to explore the possibility of forming partnerships with South African universities. Through visits to medical facilities and conferences, the team learned about the country's health problems and the impact of apartheid and the new government on the lives of South Africans.

F. Patrick Robinson, doctoral candidate at the Marcella Niehoff School of Nursing, Loyola University Chicago, has received the 1999 Association of Nurses in AIDS Care/Glaxo Wellcome Doctoral Fellowship in HIV/AIDS nursing. His dissertation explores the psycho-endocrine-immune response to stress reduction in HIV-infected individuals.

Katryn G. Sapnas, assistant professor at the University of Miami School of Nursing in Coral Gables, Fla., has received a 1999-2000 Rotary International Ambassadorial Scholarship to continue her research as a visiting scholar at the University of Cape Town, South Africa. Dr. Sapnas studies motor vehicle crash prevention, focusing on at-risk driving behaviors and restraint use.

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Porcelain doll reflects art of nursing

Caroline Lachtara, RN, MS, created a porcelain nurse doll to complete a project requirement for an art in nursing course through Syracuse University. Her 30-inch nurse is a reproduction of an antique German 1900s nurse. Lachtara used an elaborate process that turns greenware into porcelain china by firing it at high temperatures in a kiln. She then spent nine hours painting the eyelashes and eyebrows. The doll's hand-sewn clothes include a blue silk dress, a white cotton apron, leather boots and a full set of undergarments, based on a nursing uniform from the early 1900s. Ms. Lachtara started making dolls in 1987 and has completed about 25 of assorted shapes and sizes. She spends two to three months creating each doll.

The doll required perseverance, the skillful use of her hands and attention to detail, says Ms. Lachtara. These are qualities she also uses when caring for patients and their families as staff nurse in labor, delivery, recovery and postpartum at Baystate Medical Center's Women and Infants Unit in Springfield, Mass. She is a part-time clinical faculty member in maternity at Springfield Technical Community College. — By Jane Palmer

Beverly Richards, associate professor at Indiana University School of Nursing in Indianapolis, has received the American Psychiatric Nurses Association's Award for Excellence in Practice for her work with Alzheimer's patients and their families. Annie Russell, department of medicine administrator for the Southern California Permanente Medical Group in San Diego, has received the 1999 Nursing Economic Leadership Excellence Award for her leadership in achieving quality health care while meeting financial objectives.

Ellen Sanders, president of Innovative Health Care Services Inc. in Boca Raton, Fla., has been elected president of the Board of Trustees of the Commission on Graduates of Foreign Nursing Schools in Philadelphia, Pa.

Gail Staats, associate director of the Center for Health Care Research at the Medical University of South Carolina in Charleston, has received the 1999 American Psychiatric Nurses Association's Psychiatric Nurse of the Year Award for her leadership in clinical, education and research areas of psychiatric nursing.

VNA Care Network, a visiting nurse agency in Massachusetts, has appointed Mary S. Farnsworth as executive liaison; Mary G. Whalen as director of hospice services; and Jane O. Woodbury as vice president of business and fund development.

Kenneth R. White, assistant professor and associate director of professional graduate programs in health administration at the Medical College of Virginia Campus of Virginia Commonwealth University in Richmond, has received the American College of Healthcare Executives Senior Level Healthcare Executive Regent's Award for the Commonwealth of Virginia for his contributions to the advancement of health care management.

Christine A. Wynd, professor of nursing at the University of Akron College of Nursing in Ohio and in the U.S. Army Reserve's Nurse Corps, has received the 1999 Federal Nursing Service Award from the Association of Military Surgeons of the United States. Dr. Wynd was honored for her paper about a method of evaluating the effectiveness of classroom training for critical care nursing in an Army Reserve environment.

PUBLICATIONS


Sue P. Heiney, Carole D. Howell and Elizabeth D. Viston are co-authors of Quest: A Journal for the Teenager Whose Parent Has Cancer, Palmetto Richland Center for Cancer Treatment and Research, Columbia, S.C., 1999. Dr. Heiney is manager of psychosocial oncology for the Center for Cancer Treatment and Research of Palmetto Richland Memorial Hospital in Columbia, S.C. Ms. Howell is patient and family counselor at the Center for Cancer Treatment and Research; and Ms. Viston is nurse manager at McDowell Hospital in Marion, N.C.

Claire Mailhot, Melinda Abis Brubaker and Linda Garratt Skeld are co-authors of Surgery: A Patient's Guide from Diagnosis to Recovery, UCSF Nursing Press, San Francisco, 1999. Dr. Mailhot is director of business development and planning at Lucille Packard Children's Hospital in Stanford, Calif.; Ms. Brubaker is coordinator of special projects at the University of Southern Main Edmund S. Muskie School of Public Service in Portland, Maine; and Ms. Skeld is a surgical services consultant in Redwood Shores, Calif.

Research

Anita J. Catlin, professor of nursing at Napa Valley College in Napa, Calif., has been awarded the Julia Hardy RN Scholar Award from the American Nurses Foundation to study end of life care for neonates who cannot benefit from neonatal intensive care.

Barbara Davies, assistant director of the graduate program at the University of Towers School of Nursing, has received the 1999 award for the best research paper from the Society of Obstetricians and Gynecologists of Canada. Her PhD research evaluated two strategies for the transfer of research results about fetal health surveillance guidelines into practice.

Carol Epstein, assistant professor at Case Western Reserve University's Frances Payne Bolton School of Nursing in Cleveland, Ohio, has been awarded $18,200 to study responses to weaning from mechanical ventilation among elderly patients who are critically ill. The Society of Critical Care Medicine will provide most of the funding. Dr. Epstein and John Clochesy, the Independence Foundation Professor of Nursing Education, have also received a $25,000 Case Western Reserve University President's Research Initiative Award to study the presence of biologic rhythms during and following critical illness.

Janice M. Johnson-Umezulike, professor of nursing at Lee College in Baytown, Texas, has studied pain perception in elderly African-Americans and Caucasians. Her research found that African-Americans have a lower pain tolerance than Caucasians, and the difference between the two groups was attributed to ethnic cultural factors.

Jeanie Kayser-Jones, professor in the Department of Physiological Nursing, School of Nursing and the Medical Anthropology Program, School of Medicine at the University of California, San Francisco, has received the 1999 Doris Schwartz Gerontological Nursing Research Award from the Gerontological Society of America for her research into the dietary needs of nursing home residents.

Norma A. Metheny, professor of nursing at the Saint Louis University School of Nursing in Missouri, has received a $230,000 grant from the National Institutes of Health/National Institute of Nursing Research for the study "Detecting Pulmonary Aspiration Associated with Tube Feedings."

Barbara Parker, professor of nursing at the University of Virginia in Charlottesville, has received the 2000 Distinguished Researcher Award from the Southern Nursing Research Society. Her most recent study, which tested the design of an intervention for abused pregnant women, found that women in the intervention program reported significantly less violence than women in the control group.

Carol Smith, professor of nursing at the University of Kansas School of Nursing in Kansas City, under a grant from the National Institute of Nursing Research, is studying the use of home-based technology to improve the quality of care for patients dependent on home health care. She has developed Internet education materials for patients and families.

Mail "People" items to Jane Palmer, Reflections on Nursing Leadership, 550 W. North St., Indianapolis, IN 46202. Send e-mail to jpalmer@xisi.org.

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Porcelain doll reflects art of nursing

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Moral Practice: Investing and Discounting Self

A poignant and readable quest for understanding ethical problems common in contemporary nursing practice. Of interest to clinicians, researchers, administrators and educators are conditions that influence moral action and ethical decision making—types—from boat rockers to bureaucrats. Other topics include investing and discounting of self and salient historical, social, cultural, political and economic factors that shape moral practice. (2000) $20 each- Item #ro72

The Roy Adaptation Model-Based Research:

25 Years of Contributions to Nursing Science

A critical analysis and synthesis of 167 studies based on the Roy Adaptation Model, this monograph should be a part of your personal library. (1999) $39.95 each- Item #1086

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LETTER FROM PRESIDENT PAT

Inside the Society

Sigma Theta Tau International Honor Society of Nursing

Learning & Leading Globally

Members & Chapters

Dear Sigma Theta Tau International members and colleagues,

It is with much excitement and hope for our society’s future that I write my first letter to you in Reflections on Nursing Leadership. On Feb. 4-6, I had the great honor of convening our 1999-2001 elected and appointed leadership team composed of the board of directors, committee chairs, editors and the regional coordinators.

Our agenda focused on articulating the presidential call to action into a program of work based on the strategic plan 2005. With an accepted board of directors’ biennial program of work, the committee chairs dialogued and planned with the board and staff, formulating actions that will meet our goals to develop members and build strong chapters. Two half-day retreats facilitated by Dr. Jane Root, a leadership and board development facilitator, enabled the board, the committee chairs, editors and staff to collaboratively create an action plan for the biennium.

Following the planning retreat, the leadership team addressed their business agenda items and I wanted to share with you information gleaned from reports and discussion. First, all of the standing committees, task forces and subsidiary boards have been appointed and given their biennial directions. Your response to our desire-to-serve call was overwhelming. These groups have been expanded to include as much expertise as possible with representation from both in and outside the United States. As the need for special work groups arises over the biennium, it is our intent to call on each of you for the vast international, regional and chapter work that lies ahead.

A review of the evaluation summary data for the 35th biennial convention revealed a positive education and networking experience (over 76 percent) for the 2,008 participants. Convention participants included 50.5 percent first-time attendees. Clinical and scientific sessions received 88.2 percent and 86.6 percent ratings of value and the leadership sessions received 87.8 percent.

The inaugural events of the Welcome Circle of Friends, conversations with candidates and the Heart of Nursing special display were rated favorably. Treasured events repeated from previous conventions—the leadership conversations, Audrey Hepburn Award Luncheon and Founders Awards—were highly regarded and attended. Due to feedback about scheduling, the board and program committee are examining alter-
Reflections on Nursing Leadership

Second Quarter 2000

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Clinical watch

By Jeanne Floyd

A member from Kansas wrote recently, "Consider the needs of the practicing nurse who wants to understand how to implement research findings in practice but who does not have the knowledge to critique research reports and generally understand research applications. This could be accomplished through clinical scholarship initiatives."

Over the past year, an overwhelming majority of members told the Sigma Theta Tau International Board of Directors that the current evidence-based practice movement is gathering speed in the health care industry.

In particular, baccalaureate-prepared nurses requested assistance with learning the nature of evidence-based practice. Included were the underlying philosophy of the process and its components. Members wanted to know, for example, how to (1) critique research reports, (2) select the findings that may be included in specific nursing care plans, (3) engage in discussions with multidisciplinary partners and patients about the applications, (4) address ethical issues that might surround applications, and (5) conduct outcomes evaluations and communicate findings.

As other nursing organizations are receiving similar requests from their members, the society has begun dialogues with Judith Oulton, executive director of the International Council of Nurses, and Diane Borden, president of the Midwest Nursing Research Society. Organizational leaders have finally found a way to work together to preserve the profession. Nurses want to examine ways to bring us together as a community and appointed leaders is at an all time high, proving once again that together we make the society succeed.

Pat E. Thompson, RN, EdD

FROM PRESIDENT PAT

In the final analysis, I believe the society is off to an energized, futuristic and cohesive biennal start. The collaboration among members, chapters, regions, staff, and elected and appointed leaders is at an all time high, proving once again that together we make the society succeed.

Jeanne M. Floyd, RN, PhD, CAE, is director of research and evaluation at Sigma Theta Tau International.
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As other nursing organizations are receiving similar requests from their members, the society has begun dialogues with Judith Oulton, executive director of the International Council of Nurses, and Diane Board, president of the Midwest Nursing Research Society. Organizational leaders have shared information about addressing this member need and exploring the potential for collaborative relationships. Proposed joint continuing education and professional presentations provide the basis for common understandings on behalf of the global nursing community.

The International Council of Nurses and the Midwest Nursing Research Society have agreed to invite their members to register their research abstracts with the Virginia Henderson International Nursing Library. A commitment to research has become the driver for nursing organizations to partner on behalf of the profession and improvement of health care.

"Nursing organizations have finally found a way to work together to preserve the profession. Nurses want to examine ways to bring us together as a whole," wrote Betsy Snook of Pennsylvania, capturing the spirit of this collaborative movement. A focus on issues of mutual concern, such as the examination of evidence-based practice, has been a driver for nursing organizations to partner on behalf of the profession and improvement of health care.

By Jeanne Floyd, RN, PhD, G, CAE, director of research and evaluation at Sigma Theta Tau International.
The future of research journals: a bite or a banquet?

By Jane A. Root

The British Medical Journal recently published an issue online in which it suggested a scenario for the “medical journal of the future” for its readers (see http://www.bmj.com/cgi/content/full/319/7220/a1). BMJ editors Abi Berger and Richard Smith predicted that “research studies will be published on a huge electronic database. The primary job of the surviving journals will not be to publish research studies, but rather to visit the database [and] scavenge the studies that are important for clinicians.” They predict that “knowledge will come not in distinct chunks (an issue of a journal) but rather as part of a rich web that will cater simultaneously for those who want a bite and those who want a full banquet.”

To paraphrase from the cartoon “Pogo,” we have seen the future and it is us. The Virginia Henderson International Nursing Library’s Registry of Nursing Research provides members with access to a database that makes the BMJ’s prediction a reality. Since the research knowledge indexes do access to the already published research in nursing, we have already begun reframing the Registry as the electronic publishing paradigm for otherwise unpublished clinical research. So, too late for predictions, BMJ ... we’re already doing it.

The Registry of Nursing Research is our electronic research resource, containing almost 12,000 studies submitted by more than 10,000 researchers. It continues to grow through the registration of new studies by members and nonmembers and through the automatic inclusion of researchers and abstracts from the nursing knowledge index. The Registry provides four types of searches: by specific researcher or other biographical data, by study details, directly by findings and by keywords named by the researcher for use in indexing. These unique features allow researchers to efficiently evaluate the usefulness of studies included in the Registry in their area of research interest.

Another offering in the library’s “menu” of knowledge resources is The Online Journal of Knowledge Synthesis for Nursing. The Online Journal provides full-text, integrative review of research pertinent to clinical practice. Now available is document delivery of any article from current or past volumes with online ordering capability. Ordering information is available online at the library’s Web site, www.nursingsociety.org/library. The Online Journal complements the Registry in providing a means for the nursing community to stay abreast of the vast amount of research published in nursing journals.

“We’re always looking toward what is our next step, building on what we have, based on our understanding of nursing’s knowledge needs and the technology we have available,” Betsy Weiner, RN, PhD, FAAN, chair of the Library Committee, has observed. “In this bennium we’ll continue to create knowledge resources that contribute toward the society’s vision of creating a global community of nurses who lead in using scholarship, technology and knowledge to improve the health of the world’s people—this truly describes the library’s mission in serving members.”

Visit the Virginia Henderson International Nursing Library, catering to those who want a “bite” or a “banquet” of research information and knowledge.

Jane A. Root, PhD, is director of the Virginia Henderson International Nursing Library.
The future of research journals: a bite or a banquet?

By Jane A. Root

The British Medical Journal recently published an issue online in which it suggested a scenario for the "medical journal of the future" for its readers (see http://www.bmj.com/content/full/319/7220/).

BMJ editors Abi Berger and Richard Smith predicted that "research studies will be published on a huge electronic database. The primary job of the surviving journals will not be to publish research studies, but rather to visit the database [and] scavenge the studies that are important for clinicians." They predict that "knowledge will come not in distinct chunks (an issue of a journal) but rather as part of a rich web that will cater simultaneously both for those who want a bite and those who want a full banquet."

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Career and leadership programs start
By Carol Paddock

'Becoming' series focuses on career goals
Sigma Theta Tau's International Leadership Institute is bringing high-quality, practical learning programs to achieve nursing career goals in the new millennium. The one-day, in-person workshops will offer tips on how to realize specific professional goals, or enhance a current career.

The series will be offered in six U.S. cities during 2000-2001. They will be held in Philadelphia, Pa., on June 1-2 and Atlanta, Ga., on June 16-17. Other cities will be Boston, Chicago, Denver and San Francisco.

Topics to be presented in Philadelphia and Atlanta include: "Becoming an Entrepreneur," "Becoming a Funded Researcher," and "CareerMap: Managing Your Career with Purpose." A preferred two-day registration fee allows selection of a different topic each day.

"Becoming an Entrepreneur" is presented in collaboration with the John Pappajohn Entrepreneurial Center, University of Iowa. Faculty from the university will explore the process of entrepreneurship. The second workshop will present the basic business skills needed to get started as an entrepreneur.

"CareerMap: Managing Your Career with Purpose" will be presented by Donna Wilke Cardillo, president, Cardillo Associates, New Jersey. She will focus on career alternatives for nurses and career management skills. She will guide nurses through interactive activities, help pinpoint career moves and offer useful career management skills. The CareerMap workshops are sponsored in part by an educational grant from nurses.com, a VerticalNet online professional community.

The 2000-2001 workshop series is presented in collaboration with two other United States nursing groups—the National Association of Hispanic Nurses and the National Black Nurses Association.

For more information on the upcoming workshops or to register online, go to www.nursingsociety.org/leadership, send e-mail to leadership@stti.iupui.edu, or call 317.634.8171.

Chiron Mentor-Fellows 2000 named
Six mentors and fellows have been named for the inaugural Chiron: The Mentor-Fellow Forum. Chiron Mentor-Fellows for the year 2000 are Fellow Kandy K. Smith, Mississippi, and Mentor Janis P. Bellack, South Carolina; Fellow Julie A. Olson, Wisconsin, and Mentor Melanie C. Dreher, Iowa; Fellow Monica L. Tenhunen, California, and Mentor Lois Evans, Pennsylvania.

Named for Chiron, the centaur in Western mythology who mentored Aesculapius, Achilles and Hercules, this new mentor-fellow forum from the International Leadership Institute offers members the opportunity to develop leadership skills according to individualized leadership plans. Participation can be through one of three channels: as a fellow, mentor or senior fellow.

Fellows are nurses early in their professional careers who wish to develop leadership skills through the guidance of an accomplished mentor. During a one-year program, fellows and mentors participate in group activities and carry out individualized leadership plans.

Mentors are a prestigious cadre of self-identified and/or invited leaders who are willing to guide the development of fellows. Interested mentors are encouraged to seek out potential fellows for a mentor-fellow pair.

Senior fellows are experienced professionals selected according to the strength of a well-developed plan focusing on leadership and scholarship. Senior fellow experiences are entirely individualized and do not include any planned activities. Examples of senior fellow plans might include a sabbatical for a faculty member, an agreement to work with an expert in his or her field, or a retired nurse interested in a new professional opportunity.

Andrea W. Koeppke, Indiana, completed her Chiron senior fellow experience in the fall of 1999. She took a sabbatical leave to teach classes at Seoul National University, South Korea. As part of her senior fellowship, she assisted the Lambda Alpha at a large chapter in South Korea as it dealt with loss of membership due to the financial crisis in the country.

"Through my experience in South Korea, I was exposed to nursing philosophies, curriculum and student relationships from an Eastern perspective," Ms. Koeppke said. "Also, my work with the Sigma Theta Tau chapter there allowed me to function in the role of a leader, reinforcing my skills in gaining trust in a group and negotiating solutions to problems."

For more information on Chiron: The Mentor-Fellow Forum, visit www.nursingsociety.org, or contact the International Leadership Institute at leadership@stti.iupui.edu, or phone 317.634.8171. Applications for Chiron-Mentor-Fellow 2001 are due June 30, 2000.

Carol Paddock is an International Leadership Institute specialist.
INTERNATIONAL LEADERSHIP INSTITUTE

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"Becoming an Entrepreneur" is presented in collaboration with the John Pappajohn Entrepreneurial Center, University of Iowa. Faculty from the university will explore the process of entrepreneurship. The second workshop will present the basic business skills needed to get started as an entrepreneur.

Anna C. Alt-White, associate chief of The Nursing Service for Research at the Veterans Affairs Medical Center in Washing­ton, D.C., will give aspiring researchers advice on how to become a funded researcher. The first day, Dr. Alt-White will present dozens of practical tips to expedite funding. The next day, she will tackle budgets, reviewer comments and hidden ethical issues.

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INTERNATIONAL LEADERSHIP INSTITUTE

Researchers receive grant

Researchers receive grant in which pharmaceuticals are prescribed is changing, including increased employment of advance practice nurses with prescription privileges and use of new models for pharmacy support. Their study participants will include interdisciplinary teams of 40 pharmacists and 210 advance practice nurses in 178 specialization groups that provide inpatient and ambulatory care.

Information on nursing research grants and application forms are available by contacting Sigma Theta Tau International's Professional Development Services toll free by phone: 888.634.5757 (U.S. and Canada), +800.634.5757 (global), or by visiting the Sigma Theta Tau International Web site: www.nursingsociety.org.

12th International Nursing Research Congress

Copenhagen, Denmark, June 8-9, 2001

CALL FOR ABSTRACTS DUE SEPT. 27, 2000

For more information, visit Sigma Theta Tau International's Web site: nursingsociety.org/research, or contact Sheri Thompson at: research@utn.iupui.edu, or fax to 317.634.8188.
Barbara Ann Schroeder leaves exceptional gift to nurses

By Anthony Mecca

Barbara Ann Schroeder, RN, MS, a member of Delta Gamma chapter and a nursing leader in Wisconsin, died an untimely death in 1999. She specialized in medical and surgical nursing with an emphasis on management, leadership and political involvement.

Ms. Schroeder generously gave approximately $200,000 to Sigma Theta Tau International to help advance its strategic programs, particularly those of the International Leadership Institute.

"Her strong professional commitment to nursing was reflected through her final bequest to Sigma Theta Tau. Her professional efforts will continue through the lives of many nursing graduates," said Grace Jokhemo, a cousin. "Her nursing colleagues, friends and relatives have long appreciated and benefited from her intellectual abilities and leadership qualities."

In addition to designating Sigma Theta Tau's gift, Ms. Schroeder included a number of other charitable organizations in her will. The exemplary contribution provided by this thoughtful member will be recognized appropriately by the society in the upcoming months.

Ms. Schroeder was active in the American Nurses Association and Wisconsin Nurses Association, chairing its Educational Administrators, Consultants, and Teachers Section. She also was president of the Milwaukee District Nurses Association.

She earned a bachelor of science in nursing with high distinction from the University of Minnesota, and a master of science in nursing from Marquette University. She was a faculty member, clinical instructor and senior level chairperson at the Milwaukee County Medical Complex School of Nursing.

New Virginia Henderson Fellows

Welcome to these philanthropists recently enrolling as Virginia Henderson Fellows: Anna C. Aik-White, RN, PhD; Dolores Bower, RN, PhD; Theresa L. Carroll, RN, PhD; Linda Q. Everett, RN, PhD, CNNA; Peg Gray-Vickrey, RN, DSN; Denise Heinenmann, RN, DrPH; Sue Kim, RN, MS; Alice M. Kuramoto, RN, PhD, C, FAAN; Mary A. Maher, RN, MS; Susan Morrison, RN, PhD; Alma Rambo, RN, PhD, and the late Barbara Ann Schroeder, RN, MS (posthumously).

Gifts of stock benefit donor and society

Many Sigma Theta Tau members contribute appreciated stock to fund their participation in the Virginia Henderson Fellow Legacy Program. This helps them to fulfill their philanthropic goals and also to avoid taxes on capital gains.

GIFTS TO THE LEGACY PROGRAM

Gifts to the Legacy Program range from $4,500 over 60 months for young members to a ceiling of $12,500 over 60 months for those 60 or more years of age. Providing the Legacy contribution in a lump sum—through stock or cash—can reduce the Virginia Henderson Fellow contribution as much as $2,500.

For more information, please contact Linda Brimmer toll free at 1-888-634-7575 (U.S. and Canada) or by e-mail: linda@stti.iupui.edu.

CORRECTIONS

The October 1999 Honor Roll of Philanthropists cited an incorrect professional affiliation for Virginia Henderson Fellow Johanna Winchester, RN, MSN. Ms. Winchester is vice president, Wesley Long Community Hospital of the Moses Cone Health System and a member of the adjunct faculty of the University of North Carolina at Greensboro. She is not associated with Georgia State University or Morehouse School of Medicine. We deeply regret this error.

APOLOGY TO MEMBERS: Due to unforeseeable mistakes in "unzipping" the computer file and reformatt ing the Feb ruary letter to many society members from Drs. Lucie Kelly and Suzanne Prevost, the production vendor created several typographical errors. We apologize for this highly unfortunate situation.

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Reflections on Nursing LEADERSHIP

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Indianapolis, IN 46202