‘Once a nurse, always a nurse’

U.S. Surgeon General
Richard H. Carmona, RN, MD, MPH, FACS
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“I hope that this book will be read by the leaders of our health professions and by policy makers whose decisions can enhance the quality of care for those who are vulnerable and in need. It challenges us to commit ourselves to compassion for the causes which Nightingale advocated so forcefully.”

— Baroness Caroline Cox of Queensbury International Human Rights activist
Vice President, Royal College of Nursing
President, Christian Solidarity Worldwide
Deputy Speaker of the House of Lords

“This special and timely work continues in the authors’ tradition of excellence and cutting-edge vision. It is both a summary of both the historical record and its relevance, and also references history within the most contemporary, even futuristic context for our own era.”

— Joan Watson, PhD, RN, FAAN
Prominent nurse scholar and author
Distinguished Professor of Nursing, University of Arizona
Chair of Nursing Science, University of Arizona Health Sciences Center
School of Nursing

This book makes an excellent text for course adoption as well as a personal reference book or gift for a colleague.

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Eighth grade, organizations and governments

I believe that wherever a health issue exists, there must be a nurse. Nurses have a responsibility to shape health care policy, whether that policy affects national systems, organizations, health care institutions, departments, units, corporations or communities (Foltz, 1996). To quote the International Council of Nurses: “Nurses closely interact with health care consumers in a variety of settings. This gives nurses a broad appreciation of health needs, how factors in the environment affect the health situation for clients and their families, and how people respond to different strategies and services” (ICN, 2001). Nurses must influence and shape health policies. To do this effectively, they should: 1) understand how policies and decisions are made; 2) keep abreast of developments in health and public issues; 3) communicate nursing knowledge, expertise and contributions to health, making that information visible and credible; 4) actively participate in structures congruent with their interests and positions; 5) engage with other key stakeholders and networks; 6) write, publish and speak on behalf of policies and accept positions on committees, task forces and boards; 7) build alliances and develop unified positions; and 8) develop and mentor the next generation for effective policy leadership (ICN, 2001; Foltz, 1996).

Shaping health policy, both individually and collectively, is mandated not only by the social responsibility of the nursing profession to act in the best interest of the public’s health needs, but also by constantly changing health systems in which nursing is the foundation for quality, safe and economically effective care. These contributions can be felt wherever patient care is delivered. It makes no difference whether it is in eighth grade, governments or institutions. Giving strategic voice and advocating for a common good make a difference.

References, page 36.

Nancy Dickinson-Hazard, RN, MSN, FAAN

Crossing the river

by Elaine McIntosh

The thing is—When the door closes and you sit down, it is only my listening nursing heart and your aching one. Even as you start from your body with the places reflecting that aching heart: Head, or back or hands or chest ... I am listening to your heart's search for the path. We have come to the spot in the river where the water is rough, and we have to find the stones that we can each step on to cross together to the other side.

Hard to do that sometimes: your fear of the falling, my fear of choosing the wrong stone for the step, and I have to assure that we are both looking for the same stepping stones. I reach for the stone, just above the water, hoping for the first step, and ask, if you could choose any stone, where would you go? You sometimes choose a stone on the far side of the river, telling me you feel trapped. Wishing to forage for another opening for the same stepping stones. And my nursing heart reaches to your heart and I have to assure that we are both looking for the same stepping stones. Where would you go? Elaine McIntosh, RNCS, FNP, is director, nurse managed centers, at the University of Michigan School of Nursing in Ann Arbor, Mich. "I have been working in nursing since 1966 and have been a nurse practitioner for 20 of those years," writes McIntosh. "No matter where I work with patients—at the bedside or in my current office—I believe that the work of finding each other's heartful communication is the core of what nursing really does."
EIGHTH GRADE was meant to be a year of privilege, tradition and celebration for my daughter and her classmates—a year of looking forward to high school and, finally, to be at the top of the pyramid. It was a time to leave the shelter and restrictions of elementary and junior high school for exciting, more independent lives.

Then the new principal arrived. Overnight, gone were the privileges and rites of passage that eighth-graders had come to expect: making the daily announcements, an extra study period for high-school entrance exams; the weekly dress-up, no-uniform days; and the monthly eighth-grade days when they ran school activities. Who was this monster who had come in, taken over and transformed their school? And what could they do about it?

After their initial outrage, depression and grief, they banded together to see how far they could get with the principal in reinstating these long-held, highly valued privileges. After all, they had class representatives whose job was to work with the teachers and principal to serve their best interests. Certainly, their needs were not being met. So they sprang into action. Amidst a flurry of phone calls and lunchtime meetings, and with the support of a few teachers who probably saw teachable moments, they listed facts, concerns and requests. Did they experience compr­

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Reflections on Nursing Leadership magazine communicates nurses’ contributions and relevance to the health of people worldwide. The magazine is published quarterly by the Honor Society of Nursing, Sigma Theta Tau International and distributed to the honor society’s active members, health care organization and supporters. It is issued in MEDLINE and CINAHL Information Systems in the scientific resources of libraries.
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Good morning, boys and girls; have you thought about becoming a nurse?

by Hila J. Spear

For the past few years, it's been my privilege to visit the fifth-graders my daughter teaches in an urban elementary school and talk with them about the profession of nursing. Not long ago, I had the opportunity to speak to another group of energetic and inquisitive boys and girls.

After a brief introduction, I asked, "When you think about nurses, what comes to your mind?" As the students shouted out responses, I quickly wrote them on the blackboard: "Nurses are girls"; "needles, giving shots"; "doctor"; "make pills"; "babies (as in newborns)"; "help the doctor"; and "they check your blood pressure."

One boy raised his hand and asked, "Can boys be nurses, too?" Most of his classmates giggled as they noted that girls make better nurses. I explained that boys and girls can become nurses, and they care for them when they are in the hospital. Getting stitches or having broken bones treated seemed to be common experiences for many. One girl stated, "Nurses make you feel better; they don't want you to hurt."

When my time with the students drew to a close, one asked if I would come back to tell them more about being a nurse. Sharing my experiences with the students provided them a glimpse of what a nursing career entails, and seeds of interest were planted.

It's not too early to inform young people in elementary and middle school about career opportunities in nursing (Haralow, 2000; Hough, 2003). Students need accurate information about potential careers before entering high school to help them make wise decisions about course work. According to a report from the American Association of Colleges of Nursing (2002), some school-aged young people view nursing as a substandard career that is technically oriented and unappealing to those seeking professional status.

Ferris noted, "Guidance counselors push bright students with an interest in health toward careers in medicine" (2001, p. 2). This is partly because nursing education is fragmented, with more than one pathway for entry into practice. Not requiring the baccalaureate degree as the minimum requirement for licensure creates confusion and fuels debate about whether nursing is a profession (Spear, 2003). Guidance counselors can be better advocates for nursing if they are educated about the various levels of academic preparation and the opportunities nurses have for upward mobility, professional growth, scholarship, leadership and advanced practice.

One boy raised his hand and asked, "Can boys be nurses, too?"

In print and film media, nursing is often either ignored or portrayed as subservient and inferior to the practice of medicine, rather than as an integral, equally important component of health care delivery. Those of us who are nurses need to be on the offensive about who we are and what we do. If we aren't, who will be? We need to spread the good word that nursing is a rewarding and meaningful profession (Goodrich & Rogers, 2001). With a serious nursing shortage and fewer college-bound students choosing to go into the profession, we need to make it a priority to publicly affirm and endorse nursing as an attractive and viable career choice.

As we grapple with issues related to nursing education and the sometimes overwhelming demands of our profession, we need to be united in our effort to communicate the many positive dimensions of nursing and its immeasurable contribution to the complex health care needs of individuals, families and communities across life spans and cultures. If we become involved in telling young people about the multifaceted and exciting careers they can experience as nurses, we can inspire a new generation of caring individuals to enter nursing. Share your stories of practice and emphasize the invaluable care nurses provide in promoting the health and well-being of society. Why not visit the future of nursing today by giving to elementary and middle school classrooms in your area? There you will find eager girls and boys who are interested in discovery and just beginning to chart their courses for tomorrow.

References, page 36.

Hila J. Spear, RN, PhD, is professor of nursing and director of graduate studies in the Nursing Department at Liberty University in Lynchburg, Va.
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One boy raised his hand and asked, "Can boys be nurses, too?" Most of his classmates giggled as they noted that girls make better nurses. I explained that both boys and girls can become nurses and provide the kind of care and support people need when they are sick. Shaming my experiences with the students provided them a glimpse of what a nursing career entails, and seeds of interest were planted.

"Nurses make you feel better; they don't want you to hurt." When my time with the students drew to a close, one asked if I would come back to tell them more about being a nurse. Shaming my experiences with the students provided them a glimpse of what a nursing career entails, and seeds of interest were planted.

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Quarter 2005
From Army medic to paramedic, from registered nurse to trauma surgeon, from sheriff's deputy to SWAT team leader, **U.S. Surgeon General Richard Carmona has**

**Been there, done that**

by James E. Mattson

**HAD IT NOT BEEN** for a chance meeting with a man called Sal, the Richard Carmona story would have turned out much differently.

"I didn't know the gentleman," Carmona told me in a recent phone interview. "I just happened to see him on the block at a candy store and struck up a conversation with him. Probably the thing that enamored me the most was his uniform and the green beret. I just spoke to him for a while, and he told me about all he did and [where he had] traveled.

"He encouraged me to go back to school. I said, 'Well, you know, I don't think I can. I am too old, I'm 17.'

"He's the one who encouraged me to go talk to an Army recruiter. He said, 'You need to do something with yourself, son. You're going to just languish here in the streets like your friends. If you don't get out of here, what will you have for your future?'

"He gave me my first reality check. So I went and spoke to the recruiter and the rest is history."
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F

For a U.S. surgeon general, the curriculum vitae of Richard H. Carmona, RN, MD, MPH, FACS, is definitely atypical.

In 1966, after years of chronic truancy and more than one request by administrators to end his academic career, he dropped out of New York City's Dewitt Clinton High School, located in the Bronx.

As an Army General Equivalency Diploma (GED), he began his career in health care as a combat medic with Special Forces—the Green Berets—in Vietnam. Wounded twice, he received two Purple Hearts, the Bronze Star and the Combat Medical Badge, the latter awarded only to medics exposed to direct enemy ground fire.

Upon leaving active duty, Carmona worked his way through college as a paramedic and registered nurse, eventually graduating with a Bachelor of Science degree from the University of California, San Francisco. In 1979, 13 years after dropping out of high school, he graduated No. 1 in his class from the University of California, San Francisco School of Medicine, the only person to graduate from that institution in three years instead of four.

In 1992, as a sheriff's deputy for Pima County, Ariz., Carmona inspired a made-for-TV movie by rapping from a helicopter to rescue the lone survivor of a medevac helicopter crash from his precarious perch on the side of a cliff. (Even today, Carmona works in White House ceremonies.

In 1999, while enroute to a University of Arizona football game to serve as the on-call medic, he came upon a Tucson accident scene where one driver had physically assaulted another and had just pulled a semiautomatic handgun from his vehicle. Retrieving his own gun, issued by the Pima County Sheriff's Department, Carmona ordered the man to drop his weapon.

Instead, the man fired at Carmona, grazing him in the temple, the same place he was wounded in Vietnam. Returning fire, Carmona, a trauma surgeon, shot the gunman and then tried—unsuccessfully—to save his life. Police later determined that the man had just stabbed his father to death and was apparently on his way to kill a former girlfriend when the incident occurred.

In 2000, Carmona was named a Top Cop by the National Association of Police Organizations and honored in White House ceremonies.

Richard Henry Carmona, the oldest of four children, was born Nov. 22, 1949, and grew up in the Harlem-Washington Heights area of Manhattan, where home was a small tenement. For his father, Racoul, the youngest of 27, and his mother, Lucy, the only child of a single mother, life was a daily socioeconomic struggle exacerbated by problems with alcohol.

Things could always be worse, they say, and for Carmona, they would have been, had it not been for his grandmother—his abuela—Martha.

“You can be poor, but she understood responsibility,” Carmona especially appreciates the woman in his life. “It’s the ladies in my life I most admire—those who perhaps gave up the most, who perhaps had the most to lose but never gave up anything, who never gave up the promise of the future,” says Carmona.

When my abuela used to talk to me, she always tried to make me understand I can be poor with dignity and still be a positive influence. I was 6 years old, we were homeless and on the street, and my grandmother—she had just lost her husband in Vietnam. She always tried to make sure we had clothes, that we wouldn’t let us be homeless. She would recruit my aunts and uncles to help us.

“In the 1960s, we never had a car, didn’t take expensive vacations or anything like that.”

“Actually, it was pretty good,” he told another interviewer. “I mean, we were all poor but, at the same time, none of us knew it. We all had the same problems. None of us had much money. We had camaraderie, a great friendship among all the kids who came from the same background. Most of us were either black or Hispanic, and most came from either broken families or very poor single-parent families. Even though we were tough, my recollections of that time are very fond and very positive.”

Vice Admiral Richard Carmona with the flag of the U.S. Public Health Service behind him. As surgeon general, Carmona oversees the 6,000 members of the Public Health Services Commissioned Corps, one of seven uniformed services of the United States.
F

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In 2000, Carmona was named a
Grand Knight of the Ku Klux Klan—
army around the whole world and save
everybody" (Rochlin, 2003, § 41).

The Carmonas have been married for
32 years. High school sweethearts,
they have been together for 38 years and
have four children.

"She was the uptown girl," said Car-
mona. "I was in Harlem and she was up
in a nice neighborhood. She went to
Catholic girls schools and had a nice
middle-class kind of life. I met her
because I was bused to schools in that
area. At the time, we lived in very differ-
ent worlds. I didn't even have the money
to ride the subway to go see her when I
wanted to. For some reason, she saw
something in me that I didn't see at the
time" (Rochlin, 2003, § 43).

Although Carmona ran with a street
gang during those years and saw many of
his friends turn to crime, he never did.

"I never, never did criminal things. I
never did drugs, yet everybody around
me did," he said. "When you are
surrounded, you can't help but tell
you. I can only attribute it to the fact
that my family grounded me very
strongly in quality characteristics—
right and wrong and truth and justice"
(Rochlin, 2003, § 10).

Looking back on that period, Car-
mona tends to focus on the positive.

"We were poor," he said, "but we
did OK. We never had a car, didn't
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Other highlights in a distinguished career

Completed surgical residency at the University of California San Francisco, and a
National Institutes of Health-sponsored fellowship in trauma, burns and critical care.

Awarded master's degree in public health policy and adminis-
tration in 1998—at age 49—from the University of Arizona.

Over the course of his career, has served as chief medical officer; hospital chief executive officer; public health
officer and chief executive officer of the Pima County health care system.

Founded and served as chairman of the first trauma care system in southern Arizona.

Served as medical director of the Arizona Department of Public Safety Air Rescue Unit and
department surgeon for the Pima County, Ariz., sheriff's department.

Has been named
National SWAT Officer of the Year.

Is a fully qualified police officer with expertise in
special operations and emergency response, including weapons of mass destruction.


Served as professor of surgery; public health; and family and community medicine at the University of Ar-
izona in Tucson and attending physician at the University of Arizona Campus Student Health Center.

As U.S. surgeon general, Carmona holds the rank of vice admiral in the U.S. Public Health Service and oversees the 6,000
members of the Corps, articulates health policy, analysis and advice to the president and the secretary of health and
human services; and protects and advances the health of the nation through educa-
tion and advocacy for effective disease prevention.

Carmona is the nation's second
Hispanic surgeon general. The first, Antonio C. Novello, served from 1990 to 1993
during the first Bush administration.
It was as a nurse that Carmona came to value some of the difficult lessons he had learned while growing up. Since his appointment as U.S. surgeon general, his appreciation for those lessons has only increased.

"I learned a lot in those times—learned a lot of what I needed to know to be a nurse—about the diversity of people, about having compassion and empathy for the less fortunate, under-served populations, what we call health disparities today. I mean, I got to experience all that as a child. It helps me a great deal in the position I am in now as U.S. surgeon general."

As far as Carmona is concerned, he's still a nurse. "You're never a former nurse," he said, "You're never a former nurse," he continued, "that nurse is the one who is going to cue you in when things are going on."

["Nurses] really are the true caregivers," he said. "That's the culture that is engendered in nursing, and it is a holistic culture as well, as you learn nursing and as you practice nursing. I mean, you have to get into all the holistic aspects where, very often, medicine gets fragmented. [Physicians] start to look at an organ or a disease. It's the nurses who provide that continuity, the holistic approach. Not to say that the docs don't. Docs are more focused on one part of that patient, but it is really the nurses who provide that continuity, the holistic approach. Not to say that the docs don't. Docs are more focused on one part of that patient, but it is really the nurses who are executing and coordinating all day. I think that we have to gain a greater understanding.

"That was one of the wonderful things I appreciated in Philadelphia [referring to his visit to the University of Pennsylvania's Schools of Nursing and Medicine on March 22, 2004.]"

The dean of the nursing school [Afaf Meleis] and the dean of the medical school [Arthur Rubenstein] came together and told the nursing students and the medical students that we are partners.

"This is not a competition; we work together. So they have combined grand rounds, combined continuing education seminars and such. I think that is wonderful. That is the kind of esprit de corps we need to engender, so that we are seen as a team. We work together. Our roles are complementary."

"Two of Carmona's goals as surgeon general are to promote further cultural understanding within the United States and to provide better international exchange of information by health care professionals."

"One of my primary goals," he said, "is to increase health literacy in the United States. We are largely a health illiterate society. Because nurses play a critical role in enhancing health literacy, cultural competence is important.

"If you are a nurse working in an underserved area in a county hospital in a poor section of town, the population you are seeing is probably going to be a lot different than if you are working in a high-end area of town with well-educated people. We have to really appreciate the culture these patients come from—Hispanic, black, Native American, Asian and so on—and we cannot be effective in our jobs as health professionals without understanding how patients understand their health and illness."

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EARLY 40 years have passed since he met Sal at the neighborhod candy store and had a conversation that changed the direction of his life. But Carmona hasn't forgotten where he came from.

"A day doesn't go by that I just don't still feel in awe," he told one writer. "I was at a meeting in Chile, reviewing documents with the health ministers from 14 or so other countries. We were forging agreements, and they passed me a document. I hadn't looked at it, but then I saw the signature page. It said, 'Vice Admiral Richard Carmona signing for the United States.' I got goose bumps. And I joked to my assistant, 'I wonder if these guys know I'm a high school dropout!'" (Billups, 2003, 3, 4.)
It was as a nurse that Carmona came to value some of the difficult lessons he had learned while growing up. Since his appointment as U.S. surgeon general, his appreciation for those lessons has only increased.

“I learned a lot in those times—learned a lot of what I needed to know to be a nurse—about the diversity of people, about having compassion and empathy for the less fortunate, under-served populations, what we call health disparities today. I mean, I got to experience all that as a child. It helps me a great deal in the position I am in now as U.S. surgeon general.”

As far as Carmona is concerned, he's still a nurse.

"You've never been a former nurse," he told a gathering of nursing and medical students at the University of Pennsylvania. "It's always part of your fabric." (Mennick, 2004, § 12).

I asked him to elaborate.

"I really feel, once a nurse, always a nurse," he responded, "because if you have come up in that culture and you've had the opportunity of belonging to that unique fraternity, there is a certain way you see patients and you see care and you see life. To me, it very much complements who I became as a physician, and certainly I draw upon those skills every day as a U.S. surgeon general."

"As you know," he continued, "the approach to nursing is a lot different than traditional medicine as a doctor. I always tell people, 'Nursing is the true caring profession.' That doesn't mean that doctors don't care, but doctors have multiple, rapid, episodic care throughout the day with their patients. That's the way it is.

"When I used to be a trauma surgeon and ran an ER and a trauma system and the ICU, I continued, 'I told my residents every day: 'We have the unique responsibility in society to probe the heart, the mind, the soul of these fellow citizens we call patients. But remember, you are here five or ten minutes, I would tell the medical students and the residents. 'It is the nurse who is here at the bedside 24 hours a day who is keeping this patient going—with your orders, without your orders—with good nursing care. That nurse is your eyes and ears. That nurse is the one who is going to cue you in as to what things are going on.'"

"[Nurses] really are the true caregivers," he said. "That's the culture that is engendered in nursing, and it is a holistic culture as well, as you learn nursing and as you practice nursing. I remember nurses asking me at the admission for the holistic aspects where, very often, medicine gets fragmented. [Physicians] start to look at an organ or a disease. It's the nurses who provide that continuity, the holistic approach. Not to say that the doctors don't. Docs are more focused on, what's your problem today? How do I fix that?"

How did Carmona's experience as a nurse influence him?

"It made medical school much easier," he replied. "[Medical] students are trying to figure out how to listen to heart sounds, how to do vital signs, what happens when you write an order. But how does it get executed, what does Q2 turning mean. All of that stuff was second nature to me. So I understood from the very first day what the impact of writing an order was going to be and who had to carry that out.

"I understood the nursing burden," he said. "I was much more prepared to deal with patient care issues than a physician might not even think about, because I had been on the other side. I know what it is to have to check the Foley [catheter], the chest tube, do the vital signs, turn the patient, check for bed sores, all this plus dealing with the patient's family, dealing with the social worker, coordinating all the care, preparing for rounds. All of those things were very second nature, and they would be to any nurse who has practiced clinically. It really very much complemented who I was as I learned to be a physician."

"I have often said," he continued, "that if there was no restraint on time or money, the ideal situation would be that all physicians should pass through nursing, because it just gives you a different dimension. It really makes a much broader defined, wholesome person."

I asked Carmona what would contribute to better understanding between nurses and physicians.

"There has to be more dialogue and there has to be an understanding," he responded. "I'll give you an example. When I was a nurse—it was a day that I had nurses in the room. Types of nurses were considered, according to how they were practicing. Typically physicians would come into nursing stations and nurses would get up, give them a seat, give them coffee and be in a very subservient position.

"I just see it more as a partnership. You know, the physicians take care of one part of that patient, but it is really the nurse who is executing and coordinating all day. I think that we have to gain a greater understanding.

"That was one of the wonderful things I appreciated in Philadelphia [referring to his visit to the University of Pennsylvania's Schools of Nursing and Medicine on March 22, 2004.]" (Phillips, 2003, § 12).

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Extending the Magnet concept to developing and transition countries

The standards used for Magnet recognition of hospitals in the United States also have been found to strengthen the profession of nursing and improve the quality of health care delivery elsewhere.

by Linda H. Aiken

When the Soviet Union dissolved in the early 1990s, hospital care in the new independent republics was of poor quality. Conventional approaches, such as reducing excess hospital capacity, improving health management training, strengthening medical education, and introducing less invasive diagnostic and surgical technologies, while important, did not result in care quality that met international standards. Nurses were numerous but their roles were underdeveloped, and they had been isolated from advances in nursing elsewhere in the world.

International transfer of nursing models

The International Hospital Outcomes Study, led by nurse researchers at the University of Pennsylvania School of Nursing, has recently documented that poor work environments for nurses were associated with poor quality of care and adverse patient outcomes in eight developed countries with differently organized and financed health systems. The similarities in nursing across these countries led us to infer that innovations found to improve nurse work environments in one country would likely be successful in others.

Magnet recognition, a process that involves implementation of 14 evidence-based standards of nursing excellence, has been shown to transform nurse work environments in U.S. and U.K. hospitals while improving quality and patient outcomes. Hospitals outside the United States, predominantly in countries with well-resourced health care systems, are applying for Magnet recognition in record numbers. I wondered if it would be feasible to implement Magnet standards in countries with fewer resources. If so, would those standards serve as a catalyst for improving patient satisfaction and quality of care?

In 1992, American International Health Alliance (AIHA), funded by the United States Agency for International Development (USAID), began establishing partnerships between U.S. institutions and their counterparts in countries of the former Soviet Union. The first partnerships involved hospitals.

When visiting completed AIHA hospital partnerships as part of an evaluation team, I found it intriguing to observe examples of nursing practices that tend to characterize U.S. Magnet hospitals. I sought out American nurses who had been leaders in the early AIHA partnerships to validate my impressions: Sharon Weinstein, who had served as a major consultant on nursing for AIHA; Jane Younger, previously chief nurse and chief operating officer of Jewish Hospital in Louisville, Ky. (now a Magnet hospital); and Salpy Akaragian from UCLA Medical Center, who has had a sus-
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tained nursing presence in Armenia for more than a decade.

We quickly reached a consensus that, as a result of their partnership with U.S. hospitals, four hospitals in Russia and Armenia, known very well to these nurse leaders, had been moving slowly toward developing professional nursing roles. We soon became enthusiastic advocates for a demonstration program to systematically test the effects of introducing Magnet standards into these hospitals through a targeted program of technical assistance and partnerships with U.S. Magnet hospitals. Could Magnet standards applied to developing professional nursing in a developing country improve quality of hospital care? AIHA agreed to sponsor our experiment.

International volunteerism

Upon hearing of our goal to implement Magnet standards in the context of a developing country, many of our American colleagues, who know first-hand how difficult it is to achieve Magnet recognition, were incredulous. Our first step was to enlist the help of the American Nurses Credentialing Center (ANCC), since the introduction of its Magnet standards was central to our initiative. We’re grateful that leaders of ANCC, particularly Executive Director Jeanne Floyd and President Cecilia Mulvey, were willing to take a big risk on our idea.

It was a risk because some thought that translating the Magnet concept to a non-English speaking developing country could undermine the high standards set for U.S. Magnet hospitals. Having the ANCC as a strategic partner was critical to recruiting the volunteer experts we needed to partner with the Russian and Armenian hospitals. In addition, the prospect of receiving an ANCC award for excellence upon successful implementation was a key motivator for everyone involved.

The demonstration had two central design elements: voluntarism and twinning. We asked for U.S. hospitals that had achieved Magnet status to volunteer as institutional partners. Four responded and agreed to bear all the costs of their partnerships, including sending staff to work in their partner hospital and host their partners in the United States.

North Shore University Hospital in Manhasset, N.Y., was twinned with Erebouni Medical Center in Yerevan, Armenia; Wake Forest University Baptist Medical Center in Winston-Salem, N.C., with St. Grigor Lusavorich Medical Center in Yerevan; Robert Wood Johnson University Hospital in New Brunswick, N.J., with Sokolov Medical Center in St. Petersburg, Russia; and Aurora Health in Milwaukee, Wis., with Central Clinical Hospital in Moscow.

No salaries were paid. The original group of four nurses who designed the program was joined by Eleanor Howell of Creighton University, an experienced management consultant in Armenia, and three ANCC-trained and -certified consultants: Peggy Jones, chair of ANCC’s International Advisory Committee; Vicki George of Catholic Health University of the Americas; and Anita Lymburner, a full-time consultant.

Building professional nursing roles

The partnerships began, at a very basic level, to develop infrastructure to support professional nursing. Roles of the chief nurse officer, nurse managers and staff nurses were established through the creation of job descriptions, responsibilities and qualifications. The institutions’ mission statements were modified to explicitly identify high-quality, patient-centered care and the centrality of professional nursing roles as priorities.

Patient-rights policies were adopted, and institutional committees were established that required nurse involvement in setting and maintaining clinical standards and in achieving continuing quality improvement. Though tedious, the process of putting in writing the requirements of an organizational infrastructure to support professional roles and qualifications for nurses was educational for everyone, and it set the stage for sought-after changes in care processes that initially had seemed abstract and unattainable.

Physicians gained a greater understanding of the role of professional nurses, and they developed appreciation for their qualifications that, for the first time, included certification of clinical competencies. Quickly, changes in physicians’ working relationships with nurses were observed. Nurses became the primary providers in intensive care units previously staffed by physicians. Nurses’ range of expertise moved from custodial activities to therapeutic care, including management of intravenous lines and medications, caring for patients on respirators, and responsibility for patient and family teaching.

Some commonly observed practices conflicted directly with recommended evidence-based care and current research findings. For example, because of lack of supplies, plastic drink bottles were routinely used for Foley catheter drainage. The problem was not the type of container but lack of a closed sterile system. Physical restraint of disoriented patients was frequent and without appropriate observation.

Exploration of the science base regarding these practices was the beginning of the hospitals’ development of evidence-based nursing practice. Over the course of the program, both of these practices were successfully modified. For the U.S. Magnet partners, the project was a rediscovery of the power of the art and science of nursing, often overshadowed in the high-tech care environment of U.S. hospitals.

The concept of patient-centeredness was not familiar to health care workers in the former Soviet republics. Since we in the United States are working to have more patient-centered care, this was a common area of discussion between the dyads. The demonstration hospitals included patients’ families in care to a much greater extent than U.S. hospitals. In addition to providing excellent results in terms of allaying patient and family anxieties, this family orientation facilitated discharge planning at an early stage of hospitalization, a benefit that has resulted in a rethinking of practices in U.S. partner hospitals.

Demonstration hospital nurses, on the other hand, saw in visits to their U.S. partners the use of privacy curtains in emergency rooms, surgical recovery areas and ICUs. The chief nurse in one demonstration hospital took a sample privacy curtain home and created similar curtains in her hospital in Armenia.

Evaluating progress

Two forms of evaluation were built into the program. One form was peer review, following the general guide-lines for Magnet hospital appraisal in the United States. We modified the process, recognizing the absence of computerized information, shortage of paper and copying machines, and language differences between appraisers and demonstration hospital staff.

An independent outcomes evaluation was also instituted in collaboration with the School of Public Health at American University of Armenia. Research techniques developed at the University of Pennsylvania for studying U.S. Magnet hospitals were replicated in both Russia and Armenia.

Staff nurses in the demonstration hospitals were surveyed at the beginning and end of the pilot period. Patient satisfaction surveys also were conducted. The resulting data show substantial expansion in the professional roles of nurses, improved institutional infrastructure that supports nursing and better doctor-nurse relationships. Patient satisfaction was significantly higher on units that had implemented Magnet standards, and markers for quality of care showed improvement.

Journey to Nursing Excellence Awards

In recognition of the substantial progress achieved, the ANCC presented each hospital a Journey to Nursing Excellence Award. The ceremonies, which took place in Armenia and Russia, heralded a new era for professional nursing. Covered by the press, including television, the events were attended by top management, senior physicians and high-ranking public officials. Nursing was no longer invisible, and the pride of the nurses was electric.

For their contributions to global health, the four U.S. Magnet hospitals also received Journey to Nursing Excellence Awards from the ANCC at the national Magnet meeting in October 2004.

Magnet standards for hospitals have been shown to have the same transformative effect in resource-poor health systems as in resource-rich ones. The initiative was successful beyond our wildest imaginatons, because nurses share the same commitments globally and because people in leadership positions in a number of organizations were willing to lead.

To strengthen professional nursing around the world and globally position nurses to be more influential in quality improvement, we are pursuing additional opportunities to replicate the concept of twinning Magnet hospitals in well-resourced countries with hospitals in developing ones.

Linda H. Aiken, PhD, FAAN, FRGN, is professor and director, Center for Health Outcomes and Policy Research, University of Pennsylvania in Philadelphia.
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Nurses migrating to Western nations, where nursing advocacy is a central tenet of practice and where malpractice actions are on the increase, may find themselves in a legal and cultural dilemma.

by Chad Priest

The word "advocacy" comes from the Latin advocatus, meaning "one who is summoned to give evidence" (Hewitt, 2002, p. 439). The need for advocacy in the medical setting arises from a patient's vulnerability during illness and the stifling impact of the medical establishment on patient autonomy (Hewitt, 2002).

Concepts of nursing advocacy—and patient advocacy in general—have developed differently from country to country. While the concept of nursing advocacy is now a central tenet of nursing practice in the Western Hemisphere, vigorous patient advocacy is not an expected—or even accepted—nursing function in many cultures. For nurses trained in these cultures, practicing assertive advocacy may be a significant challenge.

To improve the overall care of patients and avoid costly litigation, nurses across the globe must understand the centrality of the advocacy role in nursing care and how this role varies from country to country. Where the advocacy role is legally or normatively expected, as is the case in the United States and other Western nations, nurses and health care providers must ensure that proper education and training are provided to immigrant nurses before they begin caring for patients.

In some situations, nurses are required to independently analyze every order from a physician and compare it against data collected from their own nursing assessment and through the filter of their own nursing judgment (Cavico, 1995). Specifically, nurses who blindly follow physicians' orders that, on their face, are dangerous or inappropriate may be held liable.

There are no nursing advocacy negligence regimes outside the United States. As a result, nurses educated elsewhere may frame the issue of advocacy differently than their U.S. colleagues. While these nurses surely advocate for patients, they may not do so with the professional intentions required by a growing number of U.S. courts. Because the major importers of nursing labor—United States, Australia, Canada, Ireland and United Kingdom—have well-developed concepts of patient rights and a normative, if not legal, expectation of nurses serving as advocates, it is important for them to support the development of advocacy as a value ethic among nurses recruited from other countries.

Foreign-trained nurses and advocacy in U.S. hospitals

Several studies have documented cultural differences among countries in the way nurses perceive their roles and ex-
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Nursing malpractice and advocacy

Nurses are much more likely to be sued individually in the United States for malpractice than in any other country. The number of malpractice actions against nurses has steadily increased over the last several years (Cavico, 1995). In a comprehensive review of several hundred nursing malpractice actions, one author found six primary categories of nursing negligence: 1) failure to follow the nursing standard of care, 2) failure to use equipment in a responsible manner, 3) failure to communicate, 4) failure to document, 5) failure to assess and monitor, and 6) failure to act as a patient advocate (Croke, 2003).

Although nurses are generally expected to execute physician orders, they are increasingly being held liable for failure to properly advocate for patients in the face of improper or questionable orders (Cavico, 1995). Specifically, nurses who blindly follow physicians' orders that, on their face, are dangerous or inappropriate may be held liable.

In some situations, nurses are required to independently analyze every order from a physician and compare it against data collected from their own nursing assessment and through the filter of their own nursing judgment (Cavico, 1995). In the United States, assertive advocacy is explicitly mandated in a growing number of state nurse practice acts, solidifying advocacy as a basic element of the nursing standard of care.

There are no nursing advocacy negligence regimes outside the United States. As a result, nurses educated elsewhere may frame the issue of advocacy differently than their U.S. colleagues. While these nurses surely advocate for patients, they may not do so with the professional intentions required by a growing number of U.S. courts. Because the major importers of nursing labor—United States, Australia, Canada, Ireland and United Kingdom—have well-developed concepts of patient rights and a normative, if not legal, expectation of nurses serving as advocates, it is important for them to support the development of advocacy as a value ethic among nurses recruited from other countries.

Foreign-trained nurses and advocacy in U.S. hospitals

Several studies have documented cultural differences among countries in the way nurses perceive their roles and exa-
pointed out that nurse managers in that concepts (Pilette, 1989). In discussing command, while individualistic cultures generally thought to be less assertive in health care settings, where directly confronting physicians and other care providers to ensure safety is now part of the basic standard of nursing care, hesitancy to question orders or challenge authority figures may have a detrimental effect on patient safety and outcomes. 

In a study of Asian nursing students in the United States, one author pointed out that concepts such as “independence, autonomy, individuality, creativity and venturesomeness” are often at odds with prevailing collectivist sentiments of Asian nurses and created emotional conflict. Nurses trained in collectivist countries such as Philippines and India are often at the mercy of the employing agency. (Spangler, 1991, p. 11). Most important in this analysis, the Asian students had difficulty adopting direct and open communication styles and tended to be nonassertive (Abu-Saad et al., 1982).

Finally, nurses working outside their home country on a temporary visa are often at the mercy of the employing hospital, which usually arranges for the nurses’ migration. Nurses trained in collectivist cultures are generally thought to be less assertive in nurse-physician relationships than their colleagues in individualistic cultures. The majority of non-U.S. nurses working in the United States were trained in collectivist countries such as Nigeria, India and the Philippines (Flynn & Aiken, 2002). For Asian nurses working in the United States, the courts and legislatures may do the job for us.

Spangler noted that, despite assimilation of many Western values, Philippine nurses place a high value on respect for elders and authority (Spangler, 1991). A byproduct of this culture of respect is hesitation to engage in confrontation or to question the orders of superiors, and to refrain from “answering back when admonished by a person in authority” (Spangler, 1991, p. 29). For non-U.S.-trained nurses working in U.S. hospitals, where directly confronting physicians and other care providers to ensure safety is now part of the basic standard of nursing care, hesitancy to question orders or challenge authority figures may have a detrimental effect on patient safety and outcomes. (Spangler, 1991, p. 11). Most important in this analysis, the Asian students had difficulty adopting direct and open communication styles and tended to be nonassertive (Abu-Saad et al., 1982).

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cute their duties. The dominant culture in which the nurse is trained is likely to impact the type of nursing care provided patients.

Globally, nurses do not all share the same job description. Many adopt different attitudes toward patient care and have different expectations of what it means to nurse. Although nurses must be clinically competent to be licensed, there is no single measure available to determine a nurse's professional judgment with regard to patient advocacy.

One study utilized cultural variability theory to divide nurses, internationally, into two major culture groups: collectivist and individualist (Flynn & Aiken, 2002). Collectivist cultures generally value teamwork over individualism and have a greater respect for chains of command, whereas individualistic cultures place less importance on teamwork and place high value on egalitarianism. Nurses trained in collectivist cultures are generally thought to be less assertive in nurse-physician relationships than their colleagues in individualistic cultures.

The majority of non-U.S. nurses working in the United States, one author pointed out that concepts such as "independence, autonomy, individuality, creativity and venturesomeness" are often at odds with prevailing collectivist sentiments of Asian nurses and created emotional conflict. Another study in the United States (Abu-Saad, Kayser-Jones, & Tien, 1982, p. 11) noted that the majority of Asian nursing students in the United States, one author pointed out that concepts such as "independence, autonomy, individuality, creativity and venturesomeness" are often at odds with prevailing collectivist sentiments of Asian nurses and created emotional conflict. Another study in the United States (Abu-Saad, Kayser-Jones, & Tien, 1982, p. 11) noted that the majority of Asian nursing students in the United States challenges (Abu-Saad, Kayser-Jones, & Tien, 1982, p. 11). It is important in this analysis, the Asian students had difficulty adopting direct and open communication styles and tended to be nonassertive (Abu-Saad et al., 1982).

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Challenges of advocacy for the global nursing community

One author has pointed out that when cultures mix in a work environment, the resultant mix creates a new dominant cultural paradigm (Pacquiao, 2002). While multiculturalism, as a term of art, has become almost clichéd, there is no denying the powerful results of intercultural collaboration. For example, nurses from collectivist countries may be able to help U.S.-trained nurses better appreciate the interplay between a patient's rights and the community's needs, and U.S.-trained nurses may be in a position to influence and coach nurses educated elsewhere about the values and ethics of advocacy within an individualistic cultural framework.

To what degree does cultural learning influence or inhibit the development of skills necessary to properly advocate on behalf of patients? Repeated references in the nursing literature to assertiveness and advocacy reflect a uniquely American vision of nursing, one that requires nurses to go "head-to-head" with physicians or hospital administrators when decisions or plans of care run afoul of a patient's interests or desires.

Such a vision may not be culturally appropriate in some countries. How do consumers of non-U.S. nursing labor embrace cultural differences while ensuring that immigrant nurses are properly trained to guard important patient rights? Here are some issues to consider:

Nurses working outside their home country ... may be reluctant to advocate for patients if they perceive that such advocacy could put them at odds with their employing agency.

1. Research about advocacy is sparse, and the correlation between nursing advocacy and improved patient outcomes has not been conclusively demonstrated. The nursing academy must pursue vigorous inquiry into this central tenet of nursing practice, so that it can be properly defined and understood. If nurses fail to outline the contours of the nursing advocacy role in the United States, the courts and legislatures may do the job for us.

(Continued on page 36)
Elder care in Saudi Arabia
by Faisal Aboul-Enein

SAUDI ARABIA is an Islamic kingdom whose population is comprised mainly of urban Muslims and a small nomadic group of Bedouins. Since 1970, there has been a major shift from rural to urban living—from 49 percent urban in 1970 to 78 percent in 1991 (Tumulty, 2001). This growing localization of the populace has created an increased demand for elder care in acute-care hospitals, and this pressure continues to strain a health care system already facing the demands of a growing, young population.

At present, the concept of long-term care facilities does not exist in Saudi Arabia, and health care providers have taken few initiatives to develop such facilities. A study by Mufti (2002) revealed that, given the complexity of older patients' illnesses, Saudi Arabia's health care system, provided free to all citizens, contributes to the problem of long stays in acute-care hospitals.

In March 2001, the health minister, Dr. Osama Shobokshi, announced a novel plan for introducing a trial health insurance scheme directed at 4 million expatriates residing in the kingdom. The Saudi population was not included in this trial, because the government wants to implement steps in gradual phases. The program is intended, however, to eventually cover all citizens and expatriates residing in the kingdom.

Policy discussion
Studies on issues and problems of long-term care reveal that elder Saudis generally prefer home care to hospital care or care in long-term facilities, such as nursing homes (Mufti, 2002). Al-Shammari (1991) found that a high percentage of older patients did not require inpatient care and that 70 percent of patients' homes were suitable for their care.

The general cultural perception of most Saudis is that residential facilities such as nursing homes are found only in Western societies and that these are religiously/culturally unacceptable to them (Al-Shammari, 1991). The policy crisis is grounded, therefore, on the conjunction of several sociocultural forces: 1) improved economic/health conditions, 2) rapid urbanization of the traditional multigenerational family and 3) the increase of women joining the work force. These forces combine with the deeply held traditional beliefs of the majority of older citizens about care at the end of life. Key to the policy vacuum, however, is the lack of health care planning by administrators and clinicians for the needs of older people.

The shortage of acceptable care for older citizens cannot be alleviated without dealing with structural problems in the health care system. Policy planners who attempt to address these needs must look at the macro-level structure of the country. At present, duplication of services and frivolous demands are identified sources of waste. Addressing the needs of the people while raising cost consciousness will require coordination of government agencies, as well as closer consultation with and integration of ideas by planners and consumers (Umeh, 1995).

Cultural constraints
There are few cultures in which relatives do not agonize over the prospect of having to send a loved one to a nursing home. Saudis, however, have an intensely negative concept regarding institutionalization of their elders. This notion lies in the deeply held religious tenet that one should be kind to one's parents and care for them in old age. From personal observations, I see a clash pending between the cultural/religious attitudes of the people and the practical/economic pressures faced by the country.

One element contributing to the country's increased demands on health care began around 1991, about the time of the first Gulf War. At that time, estab-
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From personal observations, I see a clash pending between the cultural/religious attitudes of the people and the practical/economic pressures faced by the country.

One element contributing to the country's increased demands on health care began around 1991, about the time of the first Gulf War. At that time, estab-
lishing more hospitals and clinics to service the population was an imperative. The focus, understandably, has been on the young and those between 15 and 44 years of age. Little or no attention has been paid to specifically addressing the needs of the older population, the care of whom currently involves long stays in acute-care hospitals.

The country has now come to a point where it must deal with the cost of care for this subsection of the population, a group that, like its counterpart in most Western industrialized nations, consumes most of the health care services. At the same time, it must continue to deal with the health care demands of the burgeoning young population that represents 42.8 percent of the total (Central Intelligence Agency, 2002).

Saudis are aware of the need for such specialized care for their older people. However, as long as the government continues to bear the cost of health care, most citizens will resist development of long-term care alternatives.

Recommendations
Pressure to implement policy changes in long-term elder care will eventually come from change of attitudes within the kingdom. It is essential, however, that Saudi Arabia address sooner, rather than later, the economics of this problem. Before establishing long-term care facilities for older Saudis, some immediate steps should be considered.

Several medical centers offer limited home-health services maintained largely by nurses. The administrators should strengthen this branch of nursing operations to benefit older Saudis who wish to remain at home.

Furthermore, health care administrators should educate expatriate nurses on the importance of long-term elder care in the Saudi health care system. Even with hospital-based long-term care, which is preferred by the younger population, most older citizens prefer receiving nursing care at home. The economics of this approach must be assessed by appropriate cost-benefit studies. It must be remembered, however, that home care is more suited to the Saudi culture and therefore probably worth the cost of immediately establishing long-term care facilities, including home nursing care (Mufti, 2002).

Alternatives to care of older people in long-stay, acute-care hospitals exist and are not limited to care at home, even though this may prove to be the most viable alternative. Depending on the wishes of older Saudis, other programs to consider include social meal provision, transportation services and hospice services for the terminally ill. The challenge is to continue building on the tremendous growth in health services that the country has already witnessed and, at the same time, to delay or prevent institutionalization by providing other options.

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Faisal Aboul-Enein, RN, MSN, MPH, NP, is clinical instructor and family nurse practitioner at Texas Woman’s University College of Nursing in Houston.
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Fatima-Abd-Eman, RN, MSN, MPH, NP, is a clinical instructor and family nurse practitioner at Texas Woman’s University College of Nursing in Houston.

I was somewhat disturbed to read the article titled “Bridging the Strains” in the Fourth Quarter 2004 issue of Reflections on Nursing Leadership. As the son of a Cuban immigrant, I felt the piece highlighted Cuba and its health care system the wrong way. The authors give a one-sided view of what appears to be a great system, without even mentioning the more than 40 years of human rights violations Castro and his regime have inflicted on the Cuban people.

Additionally, the health care system is not that good. I have visited family in Cuba and took advantage of having a cousin who was a physician in Cuba to tour some hospitals. All I saw were deplorable conditions, lack of supplies and extremely poor morale from the obviously overworked nursing staff. Although I was excited to see an article published on Cuba, I was disappointed it did not give the whole picture. Que pena (Spanish for what a shame).

Charles P. Buscemi, ARNP, BC
Coral Gables, Fla., USA

I always enjoy the stories in Reflections on Nursing Leadership, and the Third Quarter 2004 was no exception. I especially enjoyed “On the Road Again,” about Susan Sewart Gooch and her rescue efforts from a fractured leg. Several weeks after reading the article, I was involved in a head-on collision while on the way to defend my dissertation and was airlifted by helicopter to the trauma center with a compound tibia and fibula fracture. Now I have a similar device but on the lower leg. This experience has been a complete turnaround for me as a former flight nurse and ER nurse. It was rewarding to be the patient of several former students of the nursing program where I teach. Thanks for the article. Dr. Gunby’s progress is an encouragement and inspiration to me.

Belinda Doyal, RN, MSN, CEN
Tyler, Texas, USA

To the editor:

Letters to the editor should be submitted via fax or e-mail to James Mattison, Editor, Reflections on Nursing Leadership, Fax 713.921.3146. E-mail: jmmattison@iuipui.edu. Please allow 4 to 6 weeks. We reserve the right to edit submissions.

Just wanted to drop a quick note to say how much I have enjoyed the last few Reflections on Nursing Leadership magazines. I have especially enjoyed Nancy Dickenson-Hazard’s “Notes” and the articles about holistic leadership like “A Time to Heal” by Peter Block and “Servant Leadership” by Larry Spencer. After 14 years as a nurse practitioner, many of my duties have a managerial aspect, and I am finding more and more the need to see the forest as well as the trees. Systems management, proactive change, quality assurance—these things are the challenge we face every day as we endeavor to provide high-quality, cost-effective health care. More and more, I think the truth is emerging that leadership must be compassionate, holistic and respectful, and that it must recognize, as Peter Block said, “the primacy of relationship.”

Thank you. Keep up the good work. We are all out here trying to do our work. Articles like these are enormously helpful. Take the magazine to work and share it with my non-nurse clinic manager. We are both trying our best to make things work in increasingly lean times.

Deborah St. Julien, MSN, RNC, WHNP, FNP
San Jose, Calif.

I was somewhat disturbed to read the article titled “Bridging the Strains” in the Fourth Quarter 2004 issue of Reflections on Nursing Leadership.
We need ALL of our nurses

by Khurshid Khawaja

NURSES are a precious resource in every corner of the world, and hospitals face serious challenges in providing high quality care. While the nursing shortage is worldwide, it takes its greatest toll on developing countries. Not much literature is available, however, on this aspect of the shortage. Meanwhile, many nursing opportunities—advertised daily—attract nurses from Asian countries to the Western world, resulting in major nursing migration.

Nursing migration is largely responsible for the high average annual turnover rate of nurses—23 percent—currently experienced by Aga Khan University Hospital (AKUH) in Karachi, Pakistan. Sixty-six percent of this turnover is caused by migration to countries such as the United States, United Kingdom and Canada, where wages offered to nurses are high compared to Pakistan. Seventy percent of these nurses migrate to the United Kingdom, where nurses are not required to pass any type of entry level examination.

Nursing turnover and patient safety

The Institute of Medicine (2000) stated that nurses are the largest component of the health care workforce, and a high rate of turnover can have adverse consequences for patient safety. It further stated that lesser nurse staffing is associated with increased length of stay, nosocomial infection (antimicrobial-resistant infection, postoperative infection and pneumonia) and pressure ulcers (2001). These studies provide substantial evidence that more nurses equal to better patient outcomes.

Subsequent studies further substantiate that inadequate nurse staffing levels result in increased patient deaths (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002), and that less nursing time per patient is associated with higher rates of infection, gastroesophageal bleeding, pneumonia and cardio-are stroke, as well as deaths from these and other causes (Needleman, Burhans, Manthe, Stewart, & Zelevinsky, 2002).

Sufficient nurse staffing is indispensable to patient safety. A headline in the Chicago Tribune declared, “Nursing mistakes kill, ineptitude harms” (Beren, 2000). The article went on to report that over a five-year period, 1,720 deaths and 9,584 injuries among hospital patients resulted from action or inaction of registered nurses.

In other causes (Needleman, Buerhaus, Mattke, Stewart, Zelevinsky, Aiken, Clarke, Sloane, Sochalski, & Silber, 2002), and that less nursing time per patient is associated with increased length of stay, nosocomial infection (antimicrobial-resistant infection, postoperative infection and pneumonia) and pressure ulcers (2001). These studies provide substantial evidence that more nurses equal to better patient outcomes.

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Peterson (2001) stated that numerous factors influence the nursing shortage, including retention, recruitment, increase in age of working nurses and core compensation. In developing countries such as Pakistan, however, these factors are exacerbated by high turnover rates caused by nursing migration.

The nursing shortage is a most critical problem, as it increases the cost of care and may compromise the quality of care. In Pakistan, for instance, insurance for health coverage is not available. Patients require health services in private health care institutions must pay the cost of care from their own pockets. Pakistani nurses, recognizing that hospitals in Pakistan cannot increase wages without seriously impacting the level of patient care, see migration to other countries as an obvious route to improving their financial status.

The AKUH and nursing retention

To ease the nursing migration problem, an AKUH management task force recommended 37 strategies in 1998 for improving nursing recruitment and retention. Of these strategies, approximately 84 percent were implemented between 1999 and 2000, with no observable impact on turnover. In early 2002, the same AKUH task force again assessed the issue of nursing shortages and implemented 27 recruitment and retention strategies.

Aiken and Campbell (2001) and Aiken (2001) reported that improvement in job satisfaction results in higher nurse retention and decreased staff turnover. However, the AKUH nursing task force found that, in spite of the many interventions implemented, the impact on the turnover rate has not been achieved. In fact, the turnover rate related to migration has increased from 45 percent in 2002 to 66 percent in 2004.

In implementing its strategies to reduce turnover, the AKUH task force has raised many questions, including:

1) Will the AKUH ever be successful in retaining nurses and providing quality care to its customers, as long as nursing recruiters from the United Kingdom and the United States continue to attract the migration of nurses to those countries?
2) Recognizing the reduction in standards of practice that occurs in hospitals affected by nursing migration, what role should world health organizations play in

As a pictograph, this 2002 photo of BScN graduates of Aga Khan University School of Nursing in Karachi, Pakistan dramatically communicates the impact of nursing migration. In 2004, the turnover rate of Aga Khan University Hospital was 23 percent, represented by all 96 students in the picture. Of those who left the hospital, 96 percent migrated to other countries, represented by the 37 graduates faded back in this photo. (NOTE: This is for illustration purposes only and is not intended to communicate that these particular nurses have migrated.) The three men standing in the center front row are Dr. Shameem Khanzad-Lakhani, president of Aga Khan University; Ambassador Sadiqullah Khan Daniel, chairman of the AKU Board of Trustees; and Robert Baker, provost of Aga Khan University.

Khurshid Khawaja, RN, BM, BScN, PhD, is assistant professor and director, nursing services, at Aga Khan University Hospital in Karachi, Pakistan.
We need ALL of our nurses

by Khurshid Khowarda

NURSES are a precious resource in every corner of the world, and hospitals face serious challenges in providing high quality care. While the nursing shortage is worldwide, it takes its greatest toll on developing countries. Not much literature is available, however, on this aspect of the shortage. Meanwhile, many nursing opportunities—bestowed daily—are faced by nurses in Asian countries in the Western world, resulting in major nursing migration.

Nursing migration is largely responsible for the high average annual turnover rate of nurses—23 percent—currently experienced by Aga Khan University Hospital (AKUH) in Karachi, Pakistan. Sixty-six percent of this turnover is caused by migration to countries such as the United States, United Kingdom and Canada, where wages offered to nurses are high compared to Pakistan. Seventy percent of these nurses migrate to the United Kingdom, where nurses are not required to pass any type of entry level examination.

Nursing turnover and patient safety

The Institute of Medicine (2001) stated that nurses are the largest component of the health care work force, and a high rate of turnover can have adverse consequences for patient safety. It further stated that leaner nurse staffing is associated with increased length of stay, nosocomial infection (urinary tract infection, postoperative infection and pneumonia) and pressure ulcers (2001). These studies provide substantial evidence that more nurses equate to better patient outcomes.

Subsequent studies further substantiate that inadequate nurse staffing levels result in increased patient deaths (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002), and that less nursing time per patient is associated with higher rates of infection, gastrointestinal bleeding, pneumonia and cardiac arrest, as well as deaths from these and other causes (Neddleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002).

Sufficient nurse staffing is indispensable to patient safety. A headline in the Chicago Tribune declared, "Nursing mistakes kill, medical "laws"." (Benn, 2000). The article went on to report that over a five-year period, 1,720 deaths and 9,584 injuries among hospital patients resulted from action or inaction of registered nurses.

Peterson (2001) stated that numerous factors influence the nursing shortage, including retention, recruitment, increase in age of working nurses and core compensation. In developing countries such as Pakistan, however, these factors are exacerbated by high turnover rates caused by nursing migration.

The nursing shortage is a most critical problem, as it increases the cost of care and may compromise the quality of care. In Pakistan, insurance for health coverage is not available. Patients requiring health services in private health care institutions must pay the cost of care from their own pockets. Pakistani nurses, recognizing that hospitals in Pakistan cannot increase wages without seriously impacting the level of patient care, see migration to other countries as an obvious route to improving their financial status.

The AKUH and nursing retention

To ease the nursing migration problem, an AKUH management task force recommended 37 strategies in 1998 for improving nursing recruitment and retention. Of these strategies, approximately 84 percent were implemented between 1999 and 2000, with no observable impact on turnover. In early 2002, the same AKUH task force again assessed the issue of nursing shortages and implemented 27 recruitment and retention strategies.

Mathews and Campbell (2001) and Aiken (2001) reported that improvement in job satisfaction results in higher nurse retention and decreased staff turnover. However, the AKUH nursing task force found that, in spite of the many interventions implemented, the impact on the turnover rate has not been achieved. In fact, the turnover rate related to migration has increased from 45 percent in 2002 to 66 percent in 2004.

In implementing its strategies to reduce turnover, the AKUH task force has raised many questions, including:

1) Will the AKUH ever be successful in retaining nurses and providing quality care to its customers, as long as nursing recruiters from the United Kingdom and the United States continue to recruit the migration of nurses to those countries?
2) Recognizing the reduction in standards of practice that occurs in hospitals affected by nursing migration, what role should world health organizations play in

As a pithy photograph, the 2002 graduates of Aga Khan University School of Nursing in Karachi, Pakistan dramatically communicate the impact of nursing migration. In 2004, the turnover rate of Aga Khan University Hospital was 33 percent, represented by all 56 students in the picture. Of those who left the hospital, 36 percent migrated to other countries, represented by the 37 graduates found back in this photo. (NOTE: This is for illustration purposes only and is not intended to communicate that these particular nurses have migrated.) The three men standing in the center front row are Dr. Shaminur Khan-Lakhk, president of Aga Khan University, Ambassador Ansaf Khan-Delitsch, chairman of the AKU Board of Trustees, and Robert Baker, provost of Aga Khan University.

Khurshid Khowarda, RN, BM, BSN, is assistant professor and director, nursing services, at Aga Khan University Hospital in Karachi, Pakistan.
Michelle August-Grady has received the Nursing Education Award from the PA State Nurses Association. Beth S. Barth,* associate professor at the University of North Carolina at Greensboro School of Nursing, has received the 2004 Outstanding Faculty Mentor in Gerontological Nursing Education Award from the John A. Hartford Foundation for Geriatric Nursing and the American Association of Colleges of Nursing. Tori Boree, assistant professor at the University of Iowa College of Nursing, is a co-recipient of the Excellence in the Academic Setting Award from the International Nursing Simulation Organization for Clinical Simulation and Learning.

Ann Bargnes, former chair of the Government Community College ADN program, and S. Marlene Ritz,* director of education at San Diego Kaiser Permanente, are co-directors for "Credible Student Clinical Placement through a Nursing Service Education Collaborative," a project of the San Diego Service-San Diego Education Consortium. The project received the 2004 Linkages Award from the Council on Linkages Between Academia and Public Health Practice.

Julian Chamber-Eissors,* instructor at Florida Public Information System Center in Tampa, Fla., has been elected chair of the American Association of Poison Control Centers' national educators group.

Liemee Edwards,* associate professor at the University of North Carolina at Charlotte, has been elected president for the National Student Nurses Association for Teaching Excellence at the university.

Louise Fitzpatrick,* The Connally endowed dean at Villanova University College of Nursing, has received the National League for Nursing Award for Outstanding Leadership in Nursing Education.

May Futrell,* professor and chair of the Department of Nursing at the University of Massachusetts Lowell, received the university's 2004 Frances Lowell Faculty Award for Distiguished Service.

Doreliss M. Gibb, program director and assistant professor of obstetrics at Barry University in Miami, Fla., has been named the 2004 Orlando Deaconess of the Year by the American Association of Nurse Anesthetists.

Pat Gorzola,* associate professor and manager of the Nursing Continuing Education Program at the University of South Florida, has received the Florida Hospital Care Education of the Year Award from the Tampa Bay Chamber of Commerce.

Katherine Johns,* a student at Maryville University-St. Louis, has received the Wesley School of Nursing Alumni Association Endorsed Scholarship from the Wesley School of Nursing.

Gloria J. McVicar,* associate professor and assistant dean at the University of Medicine and Dentistry of New Jersey School of Nursing, has been named a fellow of the American College of Medical Assistants.

Susan Petro,* director of Education for the Northeastern Iowa Health Care Rights Organization, has received the NICN-HIHOC Community Health Educator of the Year award.

Karen Anzalone,* assistant professor at the University of North Dakota School of Nursing, has received the 2002 Outstanding Faculty Mentor in Gerontological Nursing Education Award from the John A. Hartford Foundation for Geriatric Nursing and the American Association of Colleges of Nursing.

The University of Texas Medical Branch School of Nursing in Galveston, has been named a fellow of the American Academy of Nurse Practitioners.

Charles Burton,* a doctoral candidate at the University of California at San Francisco School of Nursing and a nurse practitioner for the University of California at San Francisco School of Medicine, has been chosen as a 2004 Faminkawork Award in Aging Fellow.

Michèle P. Campbell of Hamburg, N.Y., has received the Kathleen J. Divine Advocacy Award from the PA State Nurses Association.

Karen Clark has been named dean of the Indiana University East School of Nursing in Richmond.

Leslie Coleman, assistant professor of nursing and director of the adult nurse practitioner specialty program at Vanderbilt University School of Nursing, has joined the board of directors for Partners in Nursing, a non-profit internal medicine clinic in Nashville, Tenn.

Jo Ann Dalton, chair of the Department of Adult and Elder Health Nursing at the University of Cincinnati College of Nursing, has been elected to the board of directors for the Geriatric Oncology Annual Conference. She has also been appointed to the board of directors for the National Nursing Staff Development Organization's Excellence in Professional Development Leadership Award.

Brenda Euclide, project director at the University of Maryland School of Nursing, has been elected to a two-year term as second vice president of the Maryland Nurses Association.

Janet Allen, dean of the University of Maryland School of Nursing, is one of four recipients of the 2004 Grass Roots Star Award from the American Association of Colleges of Nursing's Government Affairs Committee.

Barbara E. Allen, Corinne M. Anderson, Dianne L. Josephson, Ferne C. Kyba and Linda L. Schickendantz are among recipients of the 2004 Champion Award from the Texas Partnership for End of Life Care.

Barbara L. A. Arendt,* has been named 2004 Alumnus of Distinction by the University of Miami School of Nursing.

Diane Billings, professor and associate dean for teaching, learning and information resources at Indiana University School of Nursing at Indiana University-Purdue University Indianapolis, has received the Emily Henshaw Lifetime Achievement in Nursing Award.

Sara Phillips,* associate professor at the University of Iowa College of Nursing, has received the first 3M Littmann Stethoscope Scholarship Award.

Elizabeth Amsden, director of Education in Gerontological Nursing, education and research at University of North Carolina Hospitals, has received the North Carolina Nurses Association's Nurse Educator of the Year Award and the National Nursing Staff Development Organization's Excellence in Professional Development Leadership Award.

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Richard Whippersnapper

Heather Bradford is relatively new to the midwife profession, having received her master's in nurse-midwifery in 2001 from the University of Pennsylvania. She was shocked to learn she had won the 2004 Kit Carson Award from the American College of Nurse-Midwives (ACNM).

"I had no idea I was nominated for it," Bradford said. "It is quite an honor to be given an award in Kit's name. She is a wonderful mentor and leader in our profession."

Established in 1998, the Kit Carson Award, also known as the "Young Whippersnapper Award," is named after a living legend—the ACNM's fourth and youngest president. The award honors a nurse-midwife who has been certified for less than 10 years and has demonstrated innovative, creative endeavors in clinical practice, education, administration or research in midwifery and/or women's health.

Bradford has been working since April 2002 as a certified nurse-midwife at the Center for Women's Health at Evergreen in Kirkland, Wash.

"I love teaching women about their bodies and how to better care for themselves," Bradford said. "I have always connected with the philosophy of midwifery care and feel a professional calling to be 'with women,' which is the literal translation of the word midwife."

The award has empowered Bradford to contribute even more to midwifery. She plans to continue advocating for women and the midwifery profession through clinical practice and legislative action and by encouraging student participation. She also intends to pursue a PhD, with the goal of teaching nurse-midwifery in an academic setting.

—Jennifer Armstrong

To promote a healthy lifestyle, health initiatives often focus on creating a supportive environment that empowers individuals to make healthy choices. This might include promoting physical activity, offering nutritional guidance, and encouraging regular check-ups. By creating a supportive environment, societies can help individuals lead healthier lives and reduce the prevalence of chronic diseases. Health initiatives can also work to promote mental health by reducing stress and promoting well-being. This might involve providing stress management resources, counseling services, or other support. By promoting mental health, societies can help individuals lead happier and more fulfilling lives. In addition to promoting physical and mental health, health initiatives can also work to promote social and economic well-being. This might involve advocating for policies that improve access to healthcare, ensure fair wages and working conditions, and promote education and training opportunities. By promoting social and economic well-being, societies can help individuals achieve a sense of fulfillment and purpose in their lives. These efforts can lead to a healthier and happier population, which can contribute to a stronger and more resilient society.
Christine Kuhn was the winner of the Vivian F. Harlow Award, sponsored by the American Academy of Nurse Practitioners in Women's Health for the Mark Haigler Award in 2004. She has also been appointed to the University of Texas Health Science Center at Houston, School of Nursing, as an assistant professor.

Nancy Langton, president of the National League for Nursing, has been named the 2004 advocate of the American Association of Collegiate Nursing Schools. She has also been appointed to the University of Hawaii at Manoa, as a consultant.

Kathleen Connolly has been named the 2004 recipient of the Distinguished Alumna Award from the University of New Mexico, as a consultant. She has also been appointed to the University of Arizona, as an assistant professor.

Suzanne Mitchell has been named the 2004 recipient of the Distinguished Alumna Award from the University of Nebraska, as a consultant. She has also been appointed to the University of Kansas Medical Center, as a consultant.

Julia O'Malley Stinson has been named the 2004 recipient of the Distinguished Alumna Award from the University of North Carolina, as a consultant. She has also been appointed to the University of Wisconsin-Madison, as a consultant.

Suzanne Smith has been named the recipient of the 2004 Distinguished Alumna Award from the University of South Carolina, as a consultant. She has also been appointed to the University of Kentucky, as a consultant.

Kimberly VanRoozen, a nurse in the Ambulatory Care Unit at Children's Hospital Medical Center, has been named the 2004 recipient of the Distinguished Alumna Award from the University of Colorado, as a consultant.

Kathleen Driscoll, assistant dean for academic affairs at the University of Texas at Austin, has been named the 2004 recipient of the Distinguished Alumna Award from the University of Iowa, as a consultant. She has also been appointed to the University of Georgia, as a consultant.

Mary M. Aruda has been named the recipient of the 2004 Distinguished Alumna Award from the University of Pennsylvania, as a consultant. She has also been appointed to the University of California, San Francisco, as a consultant.

Karen Seuser, associate professor and director of the University of California, San Francisco, has been named the recipient of the 2004 Distinguished Alumna Award from the University of Southern California, as a consultant. She has also been appointed to the University of California, Los Angeles, as a consultant.

Barbara Mitchell, executive director of Nursing 2000, has been named the recipient of the 2004 Distinguished Alumna Award from the University of North Carolina at Chapel Hill, as a consultant. She has also been appointed to the University of California, Davis, as a consultant.
Christine Kuhle won the Innovations in Women's Health Contestsponsored by the National Association of Nurse Practitioners in Women's Health and 3R Practitionerof the Year—an award she has previously been nominated for. Kuhle worked in theBehavioral Health Resource Library in Mt. Pleasant, Maine.

Nancy Langston, chairperson and trustee of the Greensboro School of Nursing Foundation for Nursing Education, has received the Outstanding Leadership Award from the National League for Nursing for 2005.

Mary M. Martin has been appointed director of nursing consultancy and assistant professor at the Medical University of South Carolina College of Nursing. She recently retired as a colonel in the Air Force.

Gloria McGurk, clinical assistant professor at the University of Florida College of Nursing, has been named the 2004-05 chair of the University’s Minority Mentor Program. Berenice Mazurek Menytko has been appointed senior vice chair of the University of Pennsylvania School of Nursing, and a senior vice chair of the University of Pennsylvania School of Nursing, and a senior vice chair of the University of Pennsylvania School of Nursing.

Judith Menzies recently received a grant from the American Cancer Society for her “Preparing the Next Generation of Nurses”-funded by the Health Resources and Services Administration of the Department of Health and Human Services.

Marguerite L. Zein, PhD, RN, FAAN, has received the 2004 Distinguished Alumni Award from Simmons College for Nursing. She has served as chair of the Simmons College School of Nursing and has held several key positions in the public health field.

Julia O’Malley Spivakos, a nurse in the Ambulatory Surgery Unit at Children’s Memorial Hospital in Chicago, Illinois, has been named to the 2004-05 Distinguished Alumni Award from Simmons College for Nursing.

Suzanne Smith, assistant professor at Florida International University, has been named the 2004 Red Ribbon Award from the Center for Health Education Research at the University of Miami. She has been appointed to the board of the Air Force Association.

Marilyn Rock, a registered nurse specializing in occupational health and nutrition, is a co-principal investigator for a $2 million grant from the National Institute for Occupational Safety and Health that “identifies occupational and other stressors and the use of Safe Needle Devices Among Home Health Care Workers.”

Laurie Kennedy-Malone,* associate dean and director of the School of Nursing at the University of Miami, has been named the 2004-05 chair of the University of Pennsylvania School of Nursing Foundation for Nursing Education, has received the Outstanding Leadership Award from the National League for Nursing for 2005.

Louanne Lawson, assistant professor at the University of Arkansas for Medical Sciences and forensic nurse practitioner, has been appointed editor of Journal of Forensic Nursing. She received her master’s degree from the University of Texas and BSN from the University of Arkansas at Little Rock. She is also a Certified Forensic Nurse, a licensed practical nurse, and a registered nurse in the State of Arizona.

Charlotte M. Sherr, associate professor at the University of Arizona School of Nursing, has been named the 2004-05 chair of the University of Pennsylvania School of Nursing Foundation for Nursing Education, has received the Outstanding Leadership Award from the National League for Nursing for 2005.

Jeneine Smith, director of nursing research at Vanderbilt University School of Nursing, has been named the 2004-05 chair of the University of Pennsylvania School of Nursing Foundation for Nursing Education, has received the Outstanding Leadership Award from the National League for Nursing for 2005.

Dorothy T. Stout, a professor at the University of Illinois at Chicago, has been named a Fellow of the American Academy of Nursing. Stout is a co-principal investigator for a $2 million grant from the National Institute for Occupational Safety and Health that “identifies occupational and other stressors and the use of Safe Needle Devices Among Home Health Care Workers.”

Lois V. Tjaden, PhD, RN, FAAN, has been appointed to the board of the Air Force Association.

Patsy V. Williams, an associate professor at the University of Kentucky, has been named the 2004-05 chair of the University of Pennsylvania School of Nursing Foundation for Nursing Education, has received the Outstanding Leadership Award from the National League for Nursing for 2005. She is also a Certified Forensic Nurse, a licensed practical nurse, and a registered nurse in the State of Arizona.
Held liable (Continued from page 32)

2. In the United States, the Commission on Foreign Graduate Nursing Students (CFGNS) should develop specific measures to assess the ability of nurses from other countries to advocate for patients. If such a measurement is not feasible, the CFGNS might work with state boards of nursing and nursing school credentialing bodies to approve select schools of nursing in other countries for fast-track certification. These schools could be closely monitored for many different aspects of training, including critical value-ethics training relating to advocacy.

3. To encourage advancement of nurses from other countries must develop programs to ensure that they understand the hospital's jurisdiction, including the need for assertive and thoughtful advocacy for patients. It has been suggested that advocacy, like other nursing care skills, can be learned through instruction and exposure to those already in the necessary streams and coalitions, so as to understand the unique advocacy role of the U.S. nurse.

Globally, nurses have different views and values about the concept of patient advocacy. To maintain a safe environment of care, health care institutions and schools of nursing should consider how foreign-educated nurses are socialized and educated to ensure that all nurses are properly trained to speak up for their patients. Failure to do so may result in poor patient outcomes and an inconsequence that contributes to patient safety. We need to mention a noted opportunity for cultural learning.
Students (CFGNS) should develop specific measures to assess the ability of nurses to provide patient care, including critical value-assessment. This will ensure to other nurse-advocates (Foley, et al., 2003) as to understand the unique opportunity to observe routine nurse training, including critical value-assessment. The George Washington University Law School, D.C.

3. Americans from other countries must develop programs to ensure that they understand the basic requirements for practicing in the hospital's jurisdiction, including the need for assertive and thoughtful advocacy for patients. It has been suggested that advocacy, like other nursing care skills, can be learned through instruction and exposure (Zinn, 1997). Chad Minick, & Kee, 2002. Hospitals should take steps to provide non-U.S. nurses with specific advocacy training and ample opportunity to observe routine interactions between nurses and physicians, so as to understand the unique advocacy role of the U.S. nurse.

Globally, nurses have different views and values about the concept of patient advocacy. To maintain a safe environment of care, health care institutions and schools of nursing should consider how foreign-educated nurses are socialized and taught the necessary steps to ensure that all nurses are properly trained to speak up for their patients. Failure to do so may result in poor patient outcomes and a concomitant increase in the risk of legal and financial liability, not to mention a missed opportunity for cultural learning. 

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FACING THE FUTURES


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Frey, B.J., Micksch, M., & Kuo, C.C. (2002). How nurses' responses to the Critical Incident were analyzed. Journal of Nursing Scholarship, 34, 67-75.


Make a difference in your chapter by making a difference in your community

by Beth Anderson

ONE OF my favorite movies is "Field of Dreams." In this story, Ray Kinsella, an Iowa farmer played by Kevin Costner, follows the instructions of an inner voice and converts part of his cornfield into a baseball diamond. Throughout the film, the phrase "If you build it, they will come" is repeated whenever Kinsella begins dreaming, Kinsella makes a decision to do something, and, like Costner's character in the movie, the voice telling me to "Go ahead. Take the leap and build your own "Field of Dreams.""

In 2003, an article in our local newspaper reported that the state of women's health and their access to health care were not at an acceptable level in the United States. On my way to work, I heard the same news item cited by a local radio station. At first, I didn't know what I was going to do with this information. Shortly afterward, however, upon learning that I had been elected president of Zeta Phi Chapter, I began to hear, like Costner's character in the movie, the voice telling me, "If you build it, they will come."

What was the voice telling me to build? As I met with the executive committee and realized we were doing business as usual, it dawned on me, Zeta Phi could make a difference in the community by facilitating collaboration with other nursing organizations to focus on women's health issues. But how? What would be the focus? Where to start? Is this an opportunity to get the chapter involved in legislation? What about education on women's health issues? Which health issues?

I shared my idea with members of the committee. They were interested but had the same questions I did—and more. Who had time to take this on? Not to be discouraged, I tried to find information on the subject. It was as broad and wide as the cornfields in the movie.

On May 6, 2004, I learned that all 50 states had received failing marks in a report card on women's health issued by the National Women's Law Center (NWLC) and the Oregon Health and Science University. When I signed on the Internet that evening, I found a link on the NWLC Web site (www.nwlc.org/details.cfm?id=1861&section=health) that led to a report card on women's health. It was as broad and wide as the cornfields in the movie.

The next step was to focus on registered nurses in the community. What are RNs? 1) RNs are not always the best role models for healthy behaviors. Many, for example, are obese or addicted to smoking. 2) In our community, the RN population is older (average age 44) and, due to the nursing shortage, most will be working longer. Reducing chronic health conditions for these women will help improve their retention as nurses.

This baseball field in Iowa, used as the setting for the movie "Field of Dreams," is now a tourist attraction.
Build it and they will come

Make a difference in your chapter by making a difference in your community

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ONE OF my favorite movies is "Field of Dreams." In this story, Ray Kinsella, an Iowa farmer played by Kevin Costner, follows the instructions of an inner voice and converts part of his cornfield into a baseball diamond. Throughout the film, the phrase "If you build it, they will come" is repeated whenever Kinsella begins to question why he continues with his dream despite intense societal, financial and family pressures.

At the end of the story, it becomes evident that the reason people come to Kinsella's ball field is their desire to return to the values and comfort of an earlier, less confusing time. By building his dream, Kinsella makes a difference in people's lives. What does this have to do with the Honor Society of Nursing, Sigma Theta Tau International? After being elected for the second time in eight years as president of Zeta Phi Chapter [Dayton, Ohio], I realized that the chapter had a problem not unlike that of other chapters—the cycling of the same people through its leadership roles. To increase member involvement and to make Zeta Phi the health care force it was intended to be in our community, we needed to develop our own field of dreams. For nearly two years, that's what we've been doing and, like Kinsella, we too believe "they will come."

In EARLY 2003, an article in our local newspaper reported that the state of women's health and their access to health care were not at an acceptable level in the United States. On my way to work, I heard the same news item cited by a local radio station. At first, I didn't know what I was going to do with this information. Shortly afterward, however, upon learning I had been elected president of Zeta Phi Chapter, I began to hear, like Costner's character in "Field of Dreams," an inner voice telling me, "If you build it, they will come."

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On May 6, 2004, I learned that all 50 states had received failing marks in a report card on women's health issued by the National Women's Law Center (NWLC) and the Oregon Health and Science University. When I signed on the Internet that evening, I found a link on the NWLC Web site (www.nwlc.org) to a community group and performing screening exams. Ten highly motivated and creative members attended the kickoff meeting. They were excited about the opportunity to make a difference in the health of women in our community. During a group analysis of the Ohio data, we discussed the importance of prevention in reducing future chronic health problems.

The next step was to focus on registered nurses in the community. Why RNs?

1) RNs are not always the best role models for healthy behaviors. Many, for example, are obese or addicted to smoking.

2) In our community, the RN population is older (average age 44) and, due to the nursing shortage, most will be working longer. Reducing chronic health conditions for these women will help improve their retention as nurses. More nurses in the community will have access to health care through community health care organizations as well as acute, long-term care and outpatient settings was possible.

3) Access to the RN population through community health care organizations was as well as acute, long-term care and outpatient settings was possible.

4) Three members of our group are participants in the National Women's Health Study. Consequently, we could access that data and use some of the study's tools to complete an assessment of our community's nurses.

5) Opportunity for education and interventions by chapter members was more likely to occur.

6) The number of RNs in the community could make a powerful force for working with governmental agencies to support health care initiatives that focus on smoking and obesity.

7) Improved prevention practices of community RNs combined with positive role modeling would result in improved health for their patients and the community.

T H E N A M E we chose for our project is Nursing RENEWAL: Improving Our Health. The word RENEWAL is also an acronym that stands for Reflecting on Enthusiastic Nurses through Education, Wellness, Attitude and Leadership.

The tie-in of our project's name with "Create the Future Through Renewal," the call to action made by President Daniel Petat at the honor society's biennial convention in 2003, was purposeful. This will be a renewal for our chapter.

I don't know the eventual impact of our project. With the assistance of one or two graduate students from Wright State University College of Nursing and Health, our initial plan is to conduct and analyze the results of a community-wide survey of RNs. After that, we'll determine which interventions make the most difference.

RENEWAL is a work in progress that I would compare to "Field of Dreams" at the point where Ray Kinsella had finished the field and was not quite sure what would happen next. I'm a little anxious that, in our enthusiasm for the project and study, we might lose sight of the initial reason we embarked on this journey—to increase member involvement and leadership development. I see maintaining that focus as my job. The RENEWAL team, however, is not concerned. "We will build it and they will come."

I would be thrilled if part of the outcome of this project is that other chapters recognize its potential for making a difference and bring together the leaders of various nursing, community health care and social service agencies to improve health in their communities.

Go ahead. Take the leap and build your own "Field of Dreams."
2004 Chapter Leader Academy: Simply a-mazing
by Nicole Thompson

ON E MOUSE with big blue ears and a small black nose, 48 slices of yellow cheese, and one maze: What do these things have in common? On Nov. 6 at the Omni Severin Hotel in Indianapolis, Ind., they were all part of a Chapter Leader Academy (CLA) graduation celebration inspired by the book Who Moved My Cheese? (Johnson, 1998).

The celebration culminated three full days of learning, sharing and networking for the 475 chapter leaders in attendance. They represented 210 chapters, four countries, all 50 U.S. states and all 15 honor society regions.

"Graduation was a fun time," said Larry Plant, president of Kappa Zeta-at-Large Chapter. "[I] was pleased that the speaker had such a wonderful story to share at the end of a well-planned conference.

In the two days prior to the ceremony, chapter leaders learned about the Honor Society of Nursing, Sigma Theta Tau International, chapter operations and leadership skills. The breakout sessions also provided opportunity to interact with regional coordinators and committee members, headquarters staff and chapter leader panels.

"I found the most beneficial [part of CLA] was the breakout sessions that I attended, because we had a lot of choices," Plant said.

"I learned a lot," said Karen Gorton, Rho Sigma Chapter president and 1998), "for Karen, giving is a heartfelt honor. "It was something I could do in honor and memory of my grandmother, who was a nurse. Gram taught me that giving is an honor, and that I would get much more from my gifts if they were given from the heart."

Another journey included a special thank you to all for contributions of $20,000. Two other attendees became Virginia Henderson Fellows during the event: Cherie Rowder and Vicki Nikou. Karen Morin, a member of the honor society's board of directors, committed to becoming a Sigma Theta Tau Fellow, the recognition established for contributions of $20,000.

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"The main reason I decided to become a fellow," said Holsinger, "is the opportunities it provides for nurses in need of research funding and leadership training. It has taken me a very long time to get my MSN, due to lack of funding. If my contribution helps one good nurse just make it over that edge, it will all be worthwhile."

Also at Chapter Leader Academy
Philanthropy: Power for nursing innovation
by Laura Klaum

IN ADDITION to learning about chapter operations, leadership and the honor society at Chapter Leader Academy (CLA), chapter leaders educated one another about the value of philanthropy to nursing. Attendees participated in an educational session, hosted a fundraising dinner and invited fellow members to help nurses heal, lead and learn by contributing to nursing scholarship, leadership and the honor society's future.

Nurse philanthropist Nancy Ridenour noted: "Philanthropy provides the power for innovation in our profession. For nursing to continue to lead the way in meeting the needs of people around the globe, we must attract others to share our vision and ensure our sustainability. It is imperative that nursing's good works thrive into the future, and philanthropy is the key to our success."

During CLA, 25 chapters and members purchased pavers to benefit the good works of nurses, raising more than $14,000 toward the goal of $2 million established for the program.

Philanthropist Karen Gorton bought a paver at the foundation booth, engraved in memory of Dorothy Lains Gorton. For Karen, giving is a heartfelt honor. "It was something I could do in honor and memory of my grandmother, who was a nurse. Gram taught me that giving is an honor, and that I would get much more from my gifts if they were given from the heart."

President Dan Pesut, fourth from left, poses with Virginia Henderson Fellows from left Terri Mathew, Larry Plant, Darlene Lessard, Jane Kirschling and Beth Holsinger, all members of Kappa Zeta-at-Large.
2004 Chapter Leader Academy: Simply a-mazing
by Nicole Thompson

O NE MOUSE with big blue ears and a small black nose, 48 slices of yellow cheese, and one maze: What do these things have in common? On Nov. 6 at the Omni Severin Hotel in Indianapolis, Ind., they were all part of a Chapter Leader Academy (CLA) graduation celebration inspired by the book Who Moved My Cheese? (Johnson, 1998).

The celebration culminated three full days of learning, sharing and networking for the 475 chapter leaders in attendance. They represented 210 chapters, four countries, all 50 U.S. states and all 15 honor society regions.

"Graduation was a fun time," said Larry Plant, president of Kappa Zeta-at-Large Chapter. "[I] was pleased that the speaker had such a wonderful story to share at the end of a well-planned conference.

In the two days prior to the ceremony, chapter leaders learned about the Honor Society of Nursing, Sigma Theta Tau International, chapter operations and leadership skills. The breakout sessions also provided opportunity to interact with regional coordinators and committe members, headquarters staff and chapter leader panelists.

"I found the most beneficial [part of CLA] was the breakout sessions that I attended, because we had a lot of choices," Plant said.

"I learned a lot," said Karen Gorton, Rho Sigma Chapter president. "The opportunity to learn from others firsthand is invaluable."

Several chapter leaders shared their time and expertise during CLA, assisting with breakout sessions, registration and at the Volunteer Interest Profile (VIPProfile) kiosk.

"For me personally, the highlight of CLA this year was being able to volunteer at many of the sessions," said Louise Baca, Theta Sigma Chapter president-elect. "To be a part of something that I feel is so beneficial to chapters and chapter leaders is very rewarding for me."

Like the mice in Who Moved My Cheese?, during Chapter Leader Academy graduation ceremonies.

Aboard member Karen Carlson hands out cheese as she plays the role of Scurry, the mouse in Who Moved My Cheese?, during Chapter Leader Academy graduation ceremonies.

Reference, page 54.

Nicole Thompson is constituent communications and training specialist at the Honor Society of Nursing.

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Periodicals evolve to meet changing needs

FROM THE scholarly tone of a journal to the visual appeal of a magazine to the warp-speed immediacy of nursing’s hottest topics online, Honor Society of Nursing periodicals have won awards and critical acclaim for their professional relevance, depth of coverage and attractive design.

“I am pleased and proud to offer this family of products to our members,” says Linda Finke, RN, PhD, director of the Professional Development Center. “Each has its own history and evolution, and I believe that each serves our membership in a particularly connected way.” Honor society periodicals include:

- *Excellence in Nursing Knowledge (ENK)* — The honor society's newest publication, available online, ENK covers cutting-edge nursing topics and is guest edited by nursing leaders and world-recognized authorities in their field who work on the frontlines in a variety of health care institutions. Published monthly, ENK is available to honor society members for the special yearly subscription rate of only $9.95.
- *Journal of Nursing Scholarship (JNS)* — This scholarly journal, published quarterly, provides peer-reviewed research by the world's foremost nursing scholars. Ranked high among nursing journals, JNS is available in both print and full-text online format. Active members of the honor society receive a subscription to JNS as a benefit of membership.
- *Reflections on Nursing Leadership (RNK)* — In addition to honor society news, this award-winning, full-color magazine provides informative articles, biographic profiles and personal narratives that communicate the vitally important contributions that nurses make toward improving world health. The recipient of two prestigious APEX awards in 2004—one for magazine design and layout, the other for magazine writing—RNK also is provided as a member benefit.
- *Worldviews on Evidence-Based Nursing* — This new, peer-reviewed scholarly journal provides best evidence and best practice content for nurses around the world involved in clinical practice, education, administration, research and policy making. Worldviews is available in both print and full-text online formats on a subscription basis. Active honor society members are eligible for a special reduced subscription rate.

"We are constantly evaluating our publishing program, refining existing publications and planning new publications that will best meet the changing knowledge needs of our members and other nurses around the world," says Jeff Burnham, editor in chief.

Academy recognizes honor society book

OrDinary PeopLe, Extraordinary Lives, published by the Honor Society of Nursing, Sigma Theta Tau International, recently received a Media Honorable Mention Award from the American Academy of Nursing. It is the first of the honor society's books to receive the AAN honor.

"We are pleased to accept this award on behalf of all nurses who lead their professional lives in an often-silent but extraordinary manner," said co-author Carolyn Snelzter. "Fran Vlasses and I are delighted to be recognized in the company of individuals and groups that have contributed so much to the nursing profession." Snelzter and co-author Vlasses accepted the award at the AAN annual convention in Washington, D.C., in October.

Winners of the Media Award included: The Campaign for Nursing's Future, by Johnson & Johnson; Campaign to Improve the Portrayal of Nurses on "ER," by The Center for Nursing Advocacy; The Working Hours of Hospital Staff Nurses & Patient Safety, a study by Rogers, Hwang, Scott, Aiken and Dinges (July 2004); and RN Past, Present and Future, an exhibit by the Barbara Bates Center for the Study of Extraordinary People, Extraordinary Lives was the only book thus recognized. It is available at www.nursingknowledge.org.

Explore Indy at biennial convention

Make plans now to attend the honor society's 38th Biennial Convention, Nov. 12-16, 2005, at the Indiana Convention Center. In addition to the innovative, cutting-edge educational sessions and luncheons, make time in your schedule to explore Indianapolis, where it's so easy to do so much. Museums, shopping and dining are just steps from the convention center. Use your free time to explore the Indiana State Museum, where you can learn about Indiana's history and experience exhibits relating to art, science and culture. Or visit the unique Eiteljorg Museum of American Indians & Western Art, where you'll find paintings, pottery and sculpture.

Chiron pairs named

Increasing nursing retention and job satisfaction, helping nurses reconnect their nursing spirit through reflection in art, creating formal and informal structures for support and participation in research, increasing scholarship and developing a faculty practice—each of the foregoing are among the innovative projects that will be the focus of participants in the 2005 Chiron Mentoring Program.

During the one-year program, mentees are paired with nurse-mentors, experienced professionals who can assist mentees in achieving professional goals that are centered on leadership, scholarship and evidence-based nursing. Four mentee-mentor teams have been selected for the Chiron program that began in January. They are: Mentee Judith E. Betha, RN, MSN, Xi Theta, and mentor Christine L. Latham, RN, DNSc, Nu Mu; mentee Rosalind Gail Jones, APRN-BC, MSN, Beta Omicron, and mentor E. Gerald Bennett, APRN, PhD, FAAN, Beta Omicron; mentee Julie Ann Kubiak, RN, Nu Mu; and mentor Janet B. Younger, RN, BSN, Med, MS, PhD, CPNP, Gamma Omega; and mentee Amy Lynne Spurlock, RN, PhD, Iota Theta, and mentee Bernita K. Hamilton, RN, PhD, Iota Theta.

Applications for a second 2005 Chiron program, beginning July 1, are due March 31. Projects can be in a variety of areas including practice, scholarship and health policy. For more information, visit www.nursingsociety.org/convention for more information.

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Redesigned library to open soon

E ARLY in 2005, the Honor Society of Nursing, Sigma Theta Tau International will launch its redesigned electronic library, powered by a more efficient data management system and search engine. The Virginia Henderson International Nursing Library, at www.nursinglibrary.org, is the realization of the honor society’s mission to provide nurses, in all roles around the globe, online access to reliable nursing information that can be easily used and shared. The ultimate goal is to make the library one of the most comprehensive resources for nursing information.

More powerful, easier to use

Technological improvements, design enhancements and other changes have been made, based on feedback from users who were sometimes confused and frustrated when trying to navigate the former site. The new site makes it much easier for users to obtain evidence and scientific findings from the more than 22,000 research studies and conference abstracts collected. The site also provides tools for researchers and a clinical lab, and it facilitates networking by providing researcher profiles and contact information.

Through its complementary database, the Registry of Nursing Research, individuals will have free access to nursing research data and conference abstracts, as well as information and data collected from nursing groups that include the Eastern Nursing Research Society, Midwest Nursing Research Society, Southern Nursing Research Society, Western Institute of Nursing, Oncology Nursing Society and the Africa Honor Society.

The library’s databases will be searchable via many fields including authors’ names, keywords, publishing source and abstracts. Wherever possible, demographic information about researchers is included to help facilitate networking. Nurse investigators will be able to enter information about their current work and completed work online via a revised form that has been streamlined to enable registration within minutes.

The honor society is committed to providing knowledge resources to help advance nurses and patient care. The Virginia Henderson International Nursing Library, dedicated to improving the health of people through knowledge development, dissemination and utilization, provides the latest research important to all nurses and nursing students.

Built-in benefits for you

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Content development team: Virginia Henderson International Nursing Library

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Developing clinical leadership in Australia

by Elizabeth Percival

LIKE MANY professionals who work in large organizations with complex systems, senior clinical nurses in public health units in Adelaide, South Australia, are faced with clinical problems that seem to require a management solution. In a culture where a management solution is the only response to a clinical challenge, the end result is often less than optimal, leaving managers frustrated and clinical nurses feeling disempowered. Outcomes include below-standard care delivery, reduced patient supervision during staff meal breaks, nurses and allied health care employees working in isolation and not as a team, and inadequate access by patients to call bells.

Leysie Long, director of nursing and patient services at the Royal Adelaide Hospital (RAH), saw this as an opportunity to improve patient care, staff satisfaction and morale. The RAH already had a commitment to improving safety and quality in health care, which coincides with government health policy. Strengthening clinical leadership would augment this goal.

The Royal College of Nursing in the United Kingdom (RCN, UK) had successfully developed a clinical leadership program for England, Wales, Scotland, Switzerland and Belgium. This program appeared highly suitable as it differed from other leadership programs in the following ways: 1) A two-tiered professional development program, it met the needs of both senior clinical nurses and local facilitators (experienced senior nurses holding managerial positions); 2) it focused on the person receiving care; 3) it concentrated on leadership qualities with the purpose of improving practice; 4) it was designed to provide substantial and ongoing professional support for course participants; 5) it was structured to work proactively with participating organizations to positively impact individuals, the health care team, the organization and health care policy agendas.

In cooperation with the RCN, UK and the Department of Health in South Australia, this Clinical Leadership Program (CLP) was conducted for nurses in public health units across South Australia. Susan Mann was appointed director and state lead facilitator.

The central focus was to enhance patient care, with the nurse or midwife as the agent of change. The objectives were to: 1) develop individuals professionally and personally to enhance quality of patient care, 2) develop quality of care by enabling clinical leaders to implement and sustain targeted practice improvements, 3) adopt patient-centered leadership strategies to deal with the realities of day-to-day practice, 4) develop an organizational culture that enables patient-centered leadership to be established, and 5) influence health policy to advance patient-centered leadership in the future.

The South Australia CLP specifically adapted to the South Australian and Australian context, commenced in February 2003 and ended in May 2004. Ten local facilitators (operational level) received intensive preparation for the inaugural program, and 60 senior clinical nurses (implementation and delivery level) participated in the course.

All participants were employed in acute care clinical settings in state government health units. The length of the program for senior clinical nurses and local facilitators was 12 months and 15 months, respectively. Participants were released from their duties one day per week and three days per month.

Susan Mann (2004) reports that all core components of the CLP were implemented, and the evaluation demonstrated tangible benefits for the majority of local facilitators and clinical leaders.

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Professor Emeritus of Professional Development Center, Sigma Theta Tau International

Marcelline R. Harris, RN, PhD

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Cheryl B. Thompson, RN, PhD

Deputy Dean of Graduate Medical College of Nursing, consultant for the Virginia Henderson International Nursing Library

Sarah Jones, RN, PhD, DC

Assistant Professor, School of Nursing, School of Informatics, Indiana University, consultant for the Virginia Henderson International Nursing Library

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All participants were employed in acute clinical care settings in state government health units. The length of the program for senior clinical nurses and local facilitators was 12 months and 15 months, respectively. Participants were released from their duties for one day per week. By the end of the course, 57 completed it. Mann (2004) reports that all core components of the CLP were implemented, and the evaluation demonstrated tangible benefits for the majority of local facilitators and clinical leaders.
Pave the way to a brighter future for nursing

With the help of many friends, Sigma Theta Tau International Foundation for Nursing is accelerating toward its goal of $2 million in its Brick Paver Campaign. This exciting project is raising funds to advance nursing scholarship through research, to provide more nurses with leadership development opportunities through programs such as Chiiton Mentoring and Omada Board Mentoring, and to strengthen and ensure the honor society’s future.

Thus far, 60 chapters have raised nearly $40,000 toward helping nurses achieve their quest for knowledge. Historically, chapters have supported the honor society’s fundraising initiatives. During the Knowledge Building Campaign in the late 1980s, every chapter participated, and numerous chapters contributed to the 75th Anniversary campaign in 1997. Complete chapter participation will raise more than $200,000. It is wonderful when nurses help nurses heal, lead and learn!

Responsible for generating another $123,000 are 197 individual friends, organizations and supportive groups. Many are nurses, but local vendors and companies are contributing as well. Companies are embracing sponsorship opportunities of $2,500, $5,000, $10,000 and $20,000 to help offset the costs of site construction and installation, as well as the brick paver celebration to be held during the honor society’s 38th Biennial Convention.

Four-inch by four-inch pavers are available for $500, and eight-inch by eight-inch for $1,000. Pavers are personalized, and many are engraved with the names of inspiring individuals who are no longer with us, but whose enduring spirits remain an integral part of us. Others are inscribed with names honoring those who are guiding and mentoring nurses, encouraging them, comforting them and reminding them not to give up.

What would the world be like without nurses? The brick paver celebration, scheduled for Nov. 13, in Indianapolis, Ind., will be a fitting tribute. Please plan on attending this special event designed to honor nurses and those who have encouraged nurses in their journey and quest for knowledge.

Donors may have pavers inscribed with their own names; the names of organizations, companies, friends and mentors; or in memory of a deceased loved one. Ordering pavers is easy, with flexible payment options.

To order a paver or for information about the campaign, call Sigma Theta Tau International Foundation for Nursing toll-free at 1.888.634.7575, or order online by going to the Sigma Theta Tau International secure Web site, www.nursingsociety.org/giving/gift.html, and clicking on “Give online.” To obtain a downloadable, mail-in order form, go to the same Web address and click on “Giving Form.”

Chapters, organizations, groups and individual friends are leading the way to help nurses heal, lead and learn. Thank you for your generous, philanthropic spirit in support of nurses everywhere!
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Chapters, organizations, groups and individual friends are leading the way to help nurses heal, lead and learn. Thank you for your generous, philanthropic spirit in support of nurses everywhere!
Research grants awarded

THE HONOR Society of Nursing, Sigma Theta Tau International, is committed to improving the health of people worldwide through increasing the scientific base of nursing practice. In support of this mission, the honor society advances nursing leadership and scholarship, and furthers the utilization of nursing research in health care delivery as well as public policy.

Funding research is a historical imperative and major tenet of the honor society's current long-range plan—the advancement of nursing research through research. In 1934, the honor society established the first fund for nursing research in the United States, now known as the Research Fund. From a modest initial award of $600 in 1936, the program has matured into a sophisticated and integral part of the organization's scholarly activities. Sigma Theta Tau International is pleased to announce the following research grant recipients.

Sponsored research awards

Doris Bloch Research Award
Brenda Skaggs, RN, MS, recipient of the 2003 Doris Bloch Research Award, will research "Psychometric Testing of the Meaning in Heart Disease Instrument." The purpose of this study is to examine the reliability and validity of a new measure, the Meaning in Heart Disease Instrument (MHD), developed to measure meaning-based coping activities and coping outcomes in cardiac patients.

Marylou Yam, RN, PhD, C, recipient of the 2003 Rosemary Berkel Crip Research Award, will study "An Intervention to Increase Self-Efficacy and the Implementation of Health Promotion Behaviors and Decrease Depression Among Women Who Have Experienced Intimate Partner Abuse." The purpose of this study is to examine the effect of a self-efficacy enhancement intervention on the perception of self-efficacy, symptoms of depression and perceived ability to implement health promotion behaviors among battered women.

Sigma Theta Tau International Research Grants

Gerene Baudoff, RN, PhD, FCCP, recipient of the 2003 Sigma Theta Tau International Small Research Grant, will study "Effect of Pulmonary Rehabilitation Exercise on Biobehavioral Outcomes in Chronic Obstructive Pulmonary Disease." The aim of this study is to describe changes in biobehavioral outcomes related to stress and mucosal immunity during a single exercise session of pulmonary rehabilitation in patients with moderate to severe COPD.

Robin Newhouse, PhD, a recipient of the 2003 Sigma Theta Tau International Small Research Grant, will study "Developing a Survey of the Effect of Environmental and Organizational Changes on Nursing in Rural Hospitals." The aim is to develop an instrument to identify how environmental and organizational changes have affected nursing in rural hospitals and explore issues surrounding implementation of evidence-based practice in rural hospitals.

Melissa Scollan-Koliopoulos, MSN, RNCS, CDE, a recipient of the 2003 Virginia Henderson/Sigma Theta Tau International Small Research Grant, will research "Measuring Multigenerational Legacies of Diabetes." The purpose of this study is to fill the gap in the literature with reference to the impact of a multigenerational occurrence of type 2 diabetes on an individual's adaptation to diabetes self-management.

For information about research grants offered through Sigma Theta Tau International, please go to www.nursingsociety.org.
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Sigma Theta Tau International Research Grants

Sigma Theta Tau International Small Research Grant

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Diane Berry, PhD, CANP, recipient of the 2003 Sigma Theta Tau International Small Research Grant, will research "A Nutrition and Exercise Education Program with Coping Skills Training for Overweight or Obese Parents of Obese Children." The main aim is to compare physiological body mass index measures, health promoting behaviors, and eating self-efficacy of experimental parents to control parents at baseline, three and six months. The secondary aim is to compare physiological measures of experimental parents' obese children to control parents' obese children at three and six months.

Kara Clapp, RN, MS, recipient of the 2003 Sigma Theta Tau International Small Research Grant, will study "The Process of Young Caregiving from the Perspectives of Young Caregivers and Their Chronically Ill/Disabled Parent(s): A Grounded Theory Approach." The purpose of the study is to identify a substantive theory of the young caregiving process from the perspectives of adolescent caregivers and the chronically ill/disabled parents receiving care from these adolescents.

Susan Fetzer, RN, PhD, recipient of the 2003 Sigma Theta Tau International Small Research Grant, will research "Evaluation of a Faces Rating Scale for Assessing Pain Among Hospitalized Chinese-Speaking Adults." The purpose of this descriptive, correlational, multisite study is to determine if the Faces Rating Scale, adapted for use with non-English speaking Chinese adults, is a reliable and clinically applicable measure for pain assessment among hospitalized patients.

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Mo-Kyung Sin, RN, DSN, recipient of the 2003 Sigma Theta Tau International Small Research Grant, will study "Cross-cultural Comparison of Biopsychosocial Factors Related to Physical Activity." The purpose of this study will compare biopsychosocial factors related to physical activity of older Korean Americans and older people residing in Korea and look at relationships among the biopsychosocial factors and physical activity.

Ying-Hea Su, RN, BSN, MS, recipient of the 2003 Sigma Theta Tau International Small Research Grant, will research "Biopsychosocial Impact of Parental Cancer on Schoolagers." This study aims to integrate Lazarus's Cognitive Appraisal Theory of Stress and Coping, cognitive developmental theory, social/emotional developmental theory and physiologic stress response theory to characterize the stress-coping process of children who have a parent with cancer and to help determine the point at which interventions might be most effective.

Danuta Wojnar, RN, MN, MEd, recipient of the 2003 Sigma Theta Tau International Small Research Grant, will study "Lesbian Women Miscarriage Experiences." The purpose of this study is to explore what is like to miscarry from the perspective of lesbian women.

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"I chose to purchase a paver as a way to say thank you to my grandmother for all that she did for me, my family and those she cared for as a nurse. She died before knowing I became a nurse. Gram was someone who gave to all around her, not only of herself, but of her means, time and wisdom — what we as nurses should all do. She taught me that giving is an honor and that you will get much more from it when it comes from the heart. It is because of her and what she stood for that I am doing this in memory of Dorothy Lains Gorton, RN."

Contributions are tax-deductible and may be made in installments or in a lump sum. Pavers paid in full by October 1, 2005, will be dedicated on November 13, 2005, during the 38th Biennial Convention in Indianapolis, Indiana.

For more information, visit us online at www.nursingsociety.org/giving, or contact the foundation staff at foundation@stti.iupui.edu; +1.317.634.8171; 1.888.634.7575.
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Sigma Theta Tau International Honor Society of Nursing
Call for Volunteers
Contribute your talents while meeting and interacting with nurse leaders. Volunteers are needed for the exhibit hall, hospitality, House of Delegates, registration and more. Volunteer information is available on the honor society's Web site.

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