Advocate for the dying

Florence Wald, RN, MN, MS, FAAN
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Already, in this issue, many of the columns and features you've enjoyed, such as Noteworthy, RNews Capsules and Honor Society Book Review, are now exclusively online. To access them, go to www.nursingsociety.org/RNL.

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Did we really learn it all in kindergarten?

Robert Fulghum’s book, *All I Really Need to Know I Learned in Kindergarten*, contains a great many lessons on ethics and morality. This has certainly been true for my family.

I remember my 6-year-old daughter collapsing in a heap and sobbing one day after school because a classmate had broken all her new crayons. “It’s just not right,” she wailed. “She shouldn’t have done that!” I also remember the time my 8-year-old son had his TV and video-game privileges revoked for his part in trash and then refusing to help clean up the playroom at his friend’s house. Stomping all the way home and to his room, he muttered, “It’s just not fair; it’s just not fair!”

Then there was violation of House Rule No. 3: No playing basketball in the house. Of course they did this, at ages 5 and 12, resulting in two broken dishes that they repaired with Scotch tape solution (Fulghum, 2001). To do the right thing by doing things right, nurses: [list of practices]

- Provide unrestricted care (play fair)
- Stimulate inquiry about people’s health and welfare (look and wonder)
- Maintain standards of personal health and professional conduct (live a balanced life)
- Share responsibility for sustaining the natural, dignity and environment (clean up your own mess)
- Provide care compatible with people’s safety, dignity and right (don’t hit [hurt] people)

So, maybe we all really do need to know about righteousness did come from kindergarten.

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Nancy Dickinson-Hazard, RN, MSN, FAAN

Notes from the Chief Executive Officer

Reflections on Nursing Leadership

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To find out, turn to page 18.
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Sigma Theta Tau International Honor Society of Nursing

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I've been an RN for three years and continue to marvel at the fact that I'm truly living a dream. I wanted to be a nurse for as long as I can remember. My mother recorded in my childhood journal that, at age 3, I announced, "I'm going to be a nurse when I grow up." When I was 7 and Mom was recuperating after surgery, she wrote, "Chrissie has been taking such good care of me, even helping me out of bed. She still says she wants to be a nurse some day."

Well, 33 years after high school, I made it. In May 2002, I graduated from Baker University School of Nursing with a BSN. The icing on the cake was my induction into the Honor Society of Nursing, Sigma Theta Tau International and receipt of the student recognition scholarship. I knew the honor society existed but didn't dare to think I'd be included in this group. I attended the 37th Biennial Convention in Toronto and was amazed at the company I was in—nursing leaders from all over the world.

After one year of nursing practice, I was asked to share my thoughts and experiences with new graduates and their families at our chapter's induction ceremony. Here are some of my thoughts on "my first year as an RN":

After surveying many nurses, I have discovered that most of them do remember embarrassing and poignant events that took place in their first year of practice, no matter how long ago it was.

There are the things that a new nurse is most afraid of: Your first "Code Blue," the first time a patient falls out of bed and you hear that "klunk" and just know it is a head hitting the tile floor, the dreaded medication error that we all make at some time, deciding whether or not to call a physician at 3 o'clock in the morning, a patient dying.

The first time a patient became unresponsive was during my first week on the night shift. Just as I made my way around the end of the bed to stand next to this swaying man, he keeled over, head first. I swear I heard the voice of a former clinical instructor say, "Don't let his head hit the floor!" So I slipped under him, scooping his very large body up in my arms as we both slowly slid to the floor. We landed with his head in my lap and me sitting in a pool of his urine, and I had my answer to "What will I do if ... ?"
You’ll know you’re a nurse when...

by Chris G. Alumbaugh

I’ve been an RN for three years and continue to marvel at the fact that I’m truly living a dream. I wanted to be a nurse for as long as I can remember. My mother recorded in my childhood journal that, at age 3, I announced, “I’m going to be a nurse when I grow up!” When I was 7 and Mom was recuperating after surgery, she wrote, “Chrissie has been taking such good care of me, even helping me out of bed. She still says she wants to be a nurse some day.”

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You'll know you're a nurse when...

Step out onto the unit as a "real" RN. Equipment is either being improved or breaking down. Policies and procedures are continually being revised, just when you become comfortable with "the way we always do it." We may imagine that we are emotionally prepared for anything, but just wait for the first Code you experience, or the first time you have to put that lady with dementia into soft restraints to keep her from pulling out her IV and taking off her oxygen mask.

Finding humor in otherwise sad, scary, or embarrassing situations is sometimes a must, such as when your patient receives one soft-diet tray too many and the food becomes an abstract painting on the way to the room where you find your patient confusing a confused patient in her gibberish just to soothe her, and you fear the non-sense you've spoken came far too easily; that's when you feel you've walked into a bad joke, or in the isolation of those who are all alone in life—or in a world of their own because of dementia or schizophrenia.

But when such a patient suddenly looks you in the eye and you know he understands you for a brief moment, or when she reaches for or actually kisses your hand and says, "Thank you for my kindness" or "I love you, doc," that's when you find yourself filled with wonder at the path you have chosen.

In my opinion, those Johnson & Johnson TV and print ads hit the nail on the head. Nurses dare to care. We can care for all people—the lovable and the unlovable alike; those who appreciate our help and those who don't, or can't; those whose disease or physical condition would cause the average person to turn his eyes away. But nurses don't look away. Why? It's what nurses do.

I appreciated Jo Rycefield-Malone's article, "The case of the singing man," in the most recent issue. Beyond good nursing care, there may have been—and probably were—other forces at work in the singing man's healing. Music (including singing and chanting) has been documented to increase endorphin, regulate stress-related hormones (such as ACTH), increase circulation and boost immune function. And it sounds as if there was a mind shift, also. Don Campbell's The Mozart Effect is an excellent introduction to the power of music on our patients. Introducing effective music at the bedside is a nursing intervention with many benefits.

I was so drawn to your cover photo of Sue Thomas Hegyvary—that absolutely can-do attitude tempered by the hint of a smile. I could not wait to read the article about her, and I wasn't disappointed in the least. What an encouraging, uplifting and fascinating story.

To the editor:

Letters to the editor should be submitted via fax or email to James Mattson, Editor, Reflections on Nursing Leadership. Fax: +1.715.925.2146. E-mail: jm@stti.iupui.edu. Please include your name, address, and phone number. We reserve the right to edit submissions.

I enjoyed Dr. Meehan's recent article, "In the shadows of nursing history," it is extremely helpful and know your profession if you do not understand where its roots lie. I started out my nursing career under the tutelage of the Sisters of Charity. The nurses were often asked to perform for the patient who always remained at the center of our education. In addition, we learned every aspect of hospital care. This included not only nursing classes, but also using our biochemistry knowledge during rotations to plan dietary meals for our patients. While I do not wish to be seen as pining for the days of diploma schools, this exposure to all aspects of hospital management created a core sense of what we were about. At the time, we had no clue as to why we had to rotate through dietary. After 25 years as a nurse, I must say that past experience makes me a better nurse.

As Meehan so aptly points out, nurses have a diverse and proud history that sometimes is overshadowed by Florence Nightingale. Nursing can claim leaders such as Mary Breckenridge and Virginia Henderson, truly two giants among many, who should be treasured for their abilities to make us better nurses. I do not wish to be seen as pining for the days of diploma schools, this exposure to all aspects of hospital management created a core sense of what we were about. At the time, we had no clue as to why we had to rotate through dietary. After 25 years as a nurse, I must say that past experience makes me a better nurse.
Some things will surprise you in that first year. The high patient-to-nurse ratio, the vast amount of documentation required to cover your shift adequately, and how hard it is to master the skill of time management. You'll be amazed at how much you learn in one year—and how fast that year passes.

My fellow graduates and I were told it could take a year to feel comfortable and confident working independently. We thought, "A year? That sounds like an eternity!" But here it is, a year later, and by most accounts, we do face each shift with the confidence that a) we know how to care for each patient, and b) we know whom to ask for help or advice when needed.

Still, there's the discrepancy between "knowledge" and "application" of information and the isolation double-check that clamp on the nozzle to a Foley catheter bag, right? Well, one sure knew the patient was on a nitroglycerin drip that year, and the other knew their patient's slippers! You know, you learn in one year—and how hard it is to master the skill of putting on a negative pressure bag in less than 30 seconds.

But when such a patient suddenly looks in the eye and you know he understood you for a brief moment, or when your patient receives one soft-diet tray too many and the food becomes an abstract painting on the wall, or when your eyes fill with wonder at the path you have chosen.

In my opinion, those Johnson & Johnson TV and print ads hit the nail on the head. Nurses dare to care. We care about people—their lives. We care about helping them to repay a debt to the nurse who had been alone, that he had died peacefully, and that he had even smiled twice as I assured him that, if he was ready, it was going to be okay.

I was so moved by your cover photo of Sue Thomas Hegvy that absolutely can't move past the tears in my eyes. I could not wait to read the article about her, and I wasn't disappointed in the least. What an encouraging, uplifting and fascinating story. It's the kind of story you can share with to get through a nursing course. Although I was not a nurse myself, it was the kind of story I found myself sharing with others. I was moved to tears by Sue Thomas Hegvy's story.

I enjoyed Dr. Meenan's recent article, "In the shadows of nursing history," It is extremely interesting and I know your profession if you do not understand where its roots lie. I started out my nursing career under the tutelage of the Sisters of Charity. The teaching style was very different. We were taught by the patient who always remained at the center of our education. In addition, we learned every aspect of hospital care. This included not only nutrition classes, but also using our biochemistry knowledge to corner patients to make sure they were eating healthy meals. One of the things I remember most is listening to stories from nurses who had been there for decades. They shared their experiences with us, and we learned from them.

I also enjoyed reading the article by Colleen Stainton. I can't help but feel a sense of what we were about. At the time, we had no clue as to why we were studying nursing, but we knew that we were learning to be nurses and that we were making a difference.

As Meenan so aptly points out, nurses have a diverse and proud history that is often overlooked by those who have never worked in a hospital setting. Nurses have been at the forefront of medical care for centuries, and they continue to play an important role in our society today. The power of nursing is still being explored and understood, and I believe that nurses have a unique role to play in the future of medicine.

Thank you so much for continuing the excellent work of Reflections on Nursing Leadership and for sharing your love of nursing with the world. I look forward to reading your next issue with great anticipation.

Sincerely,

Therese Casler, MS, FNP

PhD

USA
In 1963, Florence Wald, dean of Yale University School of Nursing, saw a presentation on hospice care and what it had done for patients and their families in England. It was "like opening a door," she said. Once that door was opened, she knew she had to walk through it.

by James E. Mattson

She saw HOPE in HOSPICE

Photo by Caryn B. Davis
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LONG BEFORE considering a career in nursing, Florence Wald, RN, MN, MS, FAAN, learned ethics from her parents, Theodore and Gertrude (Goldschmidt) Schorske. Children of German emigrants to the United States, the Schorskes regarded their own lack of opportunity to acquire formal education as no excuse for being uninformed about the issues of the day.

"Both of them were very well-read," said Wald. "They read The New Republic, The Nation, The New York Times and The New York Herald Tribune. They felt it was very important to be politically alert and involved."

That passion was passed on to their children, Carl and Florence, both born in New York City, Florence on April 19, 1917. Carl, the older and, according to his sister, "by far the brightest of my parents' children," would pioneer a new way of looking at history. He would share his insights about the interplay of art, culture and history with generations of students at Wesleyan, Stanford, Berkeley and Princeton universities and document his observations in a Pulitzer Prize-winning book titled Fin-de-Siecle Vienna: Politics and Culture.

His parents cultivated "a kind of natural intellectualty," he said. "The concerts, theaters and museums that were their education became the children's education. ... On my father's two-week vacations we went by rail and ship on intensive sight-seeing trips: to New England historic sites, Civil War battlefields where my grandfather had fought in a New York City regiment, the great cities of the East and Midwest (Schorske, 1987, §7)."

It would be a mistake, however, to assume that Theodore and Gertrude Schorske had a fascination for things military. Quite the contrary, socialist and pacifist in their views, they were disturbed by social injustices suffered by immigrants living in New York City's Lower East Side and angered by America's entry in World War I against a Germany" that many of their families had only recently departed. Theodore Schorske, vice president of City-Deutsche Spaar Bank in New York City—Deutsche Sparsbank until anti-German sentiment made a name change advisable—had, according to Wald, "very strong views on economics and what government should provide."

Wald's father had a Christian background and her mother was Jewish. Both were disconnected, however, from the church and the synagogue. Antitheatrical in their views, they embraced the Ethical Culture Movement. Founded in 1876 by Felix Adler, who believed that scientific knowledge had rendered beliefs in a creator God untenable, this secular humanist religion regarded ethical values as relative and man-made, rather than innate and God-given. Despite antitheologically opposed cosmologies, faith-based and humanist-based religions often have one thing in common—commitment to social action—and it was against an urban milieu of inadequate housing, unregulated sweatshops and underdeveloped social infrastructure, aggravated by a massive influx of immigrants in the late 19th and early 20th centuries, that the Ethical Culture Movement was born. At a time when there were few government safety nets, "the only place one could turn to for help were private benevolent associations, unions and charitable organizations, most often run by religious groups, Catholic, Protestant and Jewish" (Chuman, 2005, §7). One area of social action for the Ethical Culture Movement was settlement houses, the most famous of which was New York City's Henry Street Settlement, founded by nurse Lillian Wald. (Florence Wald's late husband, Henry, is not related to Lillian Wald, though his mother did grow up on Rivington Street, the same street where Lillian lived.)

"My parents were very much aware of the Henry Street Settlement," said Florence, "and were great admirers of Lillian Wald."

In 1893, Lillian moved into the Henry Street area and offered her services as a visiting nurse. Later, she opened the Nurse's Settlement, which started with two nurses in 1893 and grew to 92 by 1913, offering a range of services that included nurses training and other educational programs and youth clubs. In 1912, she founded the National Organization for Public Health Nursing.

In 1941, upon completing a bachelor's degree in physiology and sociology at Mount Holyoke College in South Hadley, Mass., and a master's in nursing at Yale University in New Haven, Conn., Florence Wald would begin her own nursing career at the Henry Street Settlement.

With World War II came more armed conflict with Germany and, for Wald, internal conflict.

"Fighting Germany for the second time was very difficult on my parents, whose love for the German culture was so strong. I really felt like a fish out of water."

Toward the end of the war, Wald's pacifism was temporarily overcome by the loss of life and injuries suffered in the Battle of the Bulge, and she enlisted for two years as a nurse in the U.S. Army Nurse Corps.

Upon discharge, she founded. For a while, she had a management position in a surgical research service at Columbia University's College of Physicians and Surgeons, where heart and blood vessel surgery was being developed, and progressed from working in hospitals to doing research in industry.

"I did try to join the flow of medical technology, but it wasn't my medium," said Wald.

She vacillated between pursuing a doctorate in physiology and going back to nursing. She chose nursing. Studies out of New York had drawn public attention to the suffering of children separated from parents during the war, and Wald became aware of the pain that hospitalized children experienced when separated from their families.

"Working as a staff nurse at Babies Hospital of Columbia-Presbyterian, I and another nurse began allowing parents to feed their children at night and put them to bed. Pediatricians saw for the first time what a difference that made. I began to feel that changes in hospital practices were possible, that I could get back to medical care and make a difference."

In retrospect, that experience foreshadowed Wald's role in the founding of the U.S. hospice movement.

The first hospice created specifically for the terminally ill opened in France in 1842. Thirty-seven years later, Our Lady's Hospice, operated by the Irish Sisters of Charity, opened in Dublin. The sisters sought to provide a place where patients could die with minimum pain, surrounded by supportive staff, family and friends. Sixteen years later, they opened a hospice in London, known as St. Joseph's.

The modern hospice movement began in 1967 when Cicely Saunders established St. Christopher's Hospice outside London. Trained as a nurse, social worker and medical doctor, she introduced concepts in terminal care—including pain and symptom control—that she refined over the course of a decade while working as a research nurse at St. Joseph's. In 1980, Saunders was made a dame of the British Empire. In 1999, she received the Arvon Award from the Honor Society of Nursing.

A key element of patient care established by Saunders was pain management designed to get ahead of patient pain with regular and adequate administration of oral medications (heroin and morphine), instead of too-little-too-late injected medications that only added to patient discomfort. Saunders' recognition of what she called "total suffering" led to identification of non-medical sources of pain and her view of the patient as a whole person, rather than merely a condition or collection of symptoms. Augmenting these elements of care was recognition of the need to help patients prepare for dying and to provide a minister to emotional and spiritual needs of family and friends.

In 1964, from Saunders' educator, Dr. Bernard Lytton, a prologist, invited Saunders to describe her research to medical students at Yale University. Wald was dean of nursing at Yale at the time, but was unable to attend. However, her friend and colleague Virginia Henderson, who read an article by Saunders, did attend.

"When Virginia came back," recalled Wald, "she immediately cornered me and said, 'O, you've got to have her here. And furthermore, I think what you should do is get just as
LONG BEFORE considering a career in nursing, Florence Wald, RN, MN, MS, FAAN, learned ethics from her parents, Theodore and Gertrude (Goldschmidt) Schoerke. Children of German emigrants to the United States, the Schoerkes regarded their own lack of opportunity to acquire formal education as no excuse for being uninformed about the issues of the day.

"Both of them were very well-read," said Wald. "They read The New Republic, The Nation, The New York Times and The New York Herald Tribune. They felt it was very important to be politically alert and involved.

That passion was passed on to their children, Carl and Florence, both born in New York City, Florence on April 19, 1917. Carl, the older and, according to his sister, "by far the brightest of my parents' children," would pioneer a new way of looking at history. He would share his insights about the interplay of art, culture and history with generations of students at Wesleyan, Stanford, Berkeley and Princeton universities and document his observations in a Pulitzer Prize-winning book titled Fin-de-Siecle Vienna: Politics and Culture.

His parents cultivated "a kind of natural intellectualty," he said. "The concerts, theaters and museums that were their education became the children's education. . . . On my father's two-week vacations we went by rail and ship on intensive sight-seeing trips to New England historic sites such as Concord or the old ports of Maine; Civil War battlefields where my grandfather had fought in a New York German regiment; the great cities of the East and Midwest from Philadelphia to St. Paul" (Schoerke, 1987, 77).

It would be a mistake, however, to assume that Theodore and Gertrude Schoerke had a fascination for things military. Quite the contrary. Socialist and pacifist in their views, they regarded the Ethical Culture Movement regarded ethical values as relative and man-made, rather than innate and God-given.

Despite antithetically opposed cosmologies, faith-based and humanist-based religions often have one thing in common—commitment to social action—and it was against an urban milieu of inadequate housing, unrivaled sweatshops and underdeveloped social infrastructure, aggravated by a massive influx of immigrants in the late 19th and early 20th centuries, that the Ethical Culture Movement was born. At a time when there were few government safety nets, "the only place one could turn to for help were private benevolent associations, unions and charitable organizations, most often run by religious groups, Catholic, Protestant and Jewish" (Chuman, 2003, 57). One area of social action for the Ethical Culture Movement was settlement houses, the most famous of which was New York City's Henry Street Settlement, founded by nurse Lillian Wald. [Florence Wald's first husband, Henry, is not related to Lillian Wald, though his mother did grow up on Rivington Street, the same street where Lillian lived.]

"My parents were very much aware of the Henry Street Settlement," said Florence, "and were great admirers of Lillian Wald." In 1893, Lillian moved into the Henry Street area and offered her services as a visiting nurse. Later, she opened the Nurse's Settlement, which started with two nurses in 1893 and grew to 92 by 1913, offering a range of services that included nurses training and other educational programs and youth clubs. In 1912, she founded the National Organization for Public Health Nursing.

In 1941, upon completing a bachelor's degree in physiology and sociology at Mount Holyoke College in South Hadley, Mass., and a master's in nursing at Yale University in New Haven, Conn., Florence Wald would begin her own nursing career at the Henry Street Settlement.

With World War II came more armed conflict with Germany and, for Wald, internal conflict.

"Fighting Germany for the second time was very difficult on my parents, whose love for the German culture was so strong. I really felt like a fish out of water." Toward the end of the war, Wald's pacifism was temporarily overcome by the loss of life and injuries suffered in the Battle of the Bulge, and she enlisted for two years as a nurse in the U.S. Army Corps. Upon discharge, she founded. For a while, she had a management position in a surgical research service at Columbia University's College of Physicians and Surgeons, where heart and blood vessel surgery was being developed, and progressed from being made in helping at-risk patients survive intensive surgery.

"I did try to join the flow of medical technology, but it wasn't my medium," said Wald.

She vacillated between pursuing a doctorate in physiology as a physician—"a more important cornered me and said, 'You shouldn't be working in the hospitals; you should be at home helping!'"—or nursing. Studies out of London had drawn public attention to the suffering of children separated from parents during the war, and Wald became aware of the pain that hospitalized children experienced when separated from their families. In 1946, she wrote of her experience:

"Working as a staff nurse at Babies Hospital of Columbia-Presbyterian, I and another nurse began allowing parents to feed their children at night and put them to bed. Pediatricians saw for the first time what a difference that made. I began to feel that changes in hospital practices were possible, that I could get back to medical care and make a difference." In retrospect, that experience foreshadowed Wald's role in the founding of the U.S. hospice movement.

The first hospice created specifically for the terminally ill opened in France in 1842. Thirty-seven years later, Our Lady's Hospice, operated by the Irish Sisters of Charity, opened in Dublin. The sisters sought to provide a place where patients could die with minimum pain, surrounded by supportive staff, family and friends. Sixteen years later, they opened a hospice in London, known as St. Joseph's.

The modern hospice movement began in 1967 when Cicely Saunders established St. Christopher's Hospice outside London. Trained as a nurse, social worker and medical doctor, she introduced concepts in terminal care—including pain and symptom control—that she refined over the course of a decade while working as a physician-researcher at St. Joseph's. In 1980, Saunders was made a dame of the British Empire. In 1999, she received the Archon Award from the Honor Society of Nursing. A key element of patient care established by Saunders was pain management designed to get ahead of patient pain with regular and adequate administration of oral medications (heroin and morphine), instead of too-little-too-late injected medications that only added to patient discomfort.

Saunders' recognition of what she called "total suffering" led to identification of non-medical sources of pain and her view of the patient as a whole person, rather than merely a condition or collection of symptoms. Augmenting these elements of care was recognition of the need to help patients prepare for dying and minister to emotional and spiritual needs of family and friends.

In 1963, the establishment of hospice care in the United States was taken when Dr. Bernard Lytton, an anesthesiologist, invited Saunders to describe her hospice program to the St. John's College Hospital in New Haven, where she would later become a visiting professor. "You have an opportunity, you have an obligation, to do something for the terminal patient," she said of her hospice care.

"When Virginia came back," recalled Wald, "she immediately cornered me and said, 'You've got to have her here.' And furthermore, I think what you should be doing is introducing hospice for the community."

In 1971, she founded the National Hospice Organization and the following year received the Archon Award from the Honor Society of Nursing. In 1998, she was awarded the National Institute of Nursing Research's Distinguished Service Award and in 1999, she was named a fellow of the American Academy of Nursing. In 2002, she was named to the American College of Nurse Executives. In 2005, she was named to the Firsts in Nursing: Firsts for Women in Nursing. In 2006, she was named to the National Women's History Museum's Women in History, Women in Medicine.

Photos, opposite page (clockwise from upper left): Wald's mother, Gertrude Goldschmidt Schoerke; her father, Theodore Schoerke; and her brother, Carl Schoerke. Photos, this page (top to bottom): Florence Wald in 1963 as dean of Yale University School of Nursing; Dame Cicely Saunders, founder of modern hospice movement; Wald (standing) with colleague Virginia Henderson.
the nurses stepped in and encouraged the patients to frame their questions so the doctors would answer, most often the patient care with a wide spectrum of caregivers, the two, friendship, a friendship some might not have anticipated, considering their divergent religious perspectives.

"Doctors were unwilling to be straightforward in what they told the patients and the families," she told one interviewer. "If the nurses refused to go along with their questions, then the doctors would answer, most often the doctors would tell the head nurse, 'I do not want that nurse anywhere near any of my patients.'" (National Prison Hospice Association, 2005, §5).

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Wald was definitely hooked. Following Saunders' tour of "Doctors, who helps organizations achieve communications objectives. At right: Florence Hospice wall," said Wald. In 1958, about the same time Wald became dean of States were escalating in a purpose that was transmitted to her as 'a calling.' Now that she time when events in the United States were escalating in a said Wald. "When she was asked what her income was, she said she could not have done what she did had she not had a sense of an ethical framework that includes art and music.” The birth of the modern hospice movement occurred at a time when events in the United States were escalating in a synchrony that Wald regards as significant. It was a time of protest, she has stated. "It was a time of protest against the Vietnam War ... but it was also the civil rights movement. Then there began to be talk about patients' rights" (American Public Media, 2005, $3).

For Wald, ethics means doing what is right, just not what is legal, a perspective effectively articulated by William Sloane Coffin, a Presbyterian minister who became chaplain of Yale University in 1958, about the same time Wald became dean of nursing there. In the decade that followed, Coffin became a leader in the civil rights movement and, later, an outspoken critic of the war in Vietnam.

Medical students and faculty who participated in civil rights activism with Coffin came back to Yale and began focusing on other human rights issues, including patients' rights and the role of doctors. As protestors from Yale's medical campus intermingled with protestors from other disciplines, a cross-institutional process occurred, said Wald, which eventually challenged the long-held belief in medicine that the doctor was the captain of the team.

"That was important for nurses," she said. "The doctors thought they were doing the patients good by not breaking down their hopes, by never telling them what was actually going on and why they were doing what they did."

Wald was definitely hooked. Following Saunders' tour of the United States, where she visited 18 hospitals and talked to patients with a wide spectrum of caregivers, the two women began corresponding and soon established a close friendship, a friendship some might not have anticipated, considering their divergent religious perspectives.

Saunders' biographer has noted that it was not until (Wald) came to know Cicely personally that she realized how important the religious side of the work was to [Saunders]" (du Boulay, p. 223). When asked about that, Wald replied: "Cicely has thought about that a great deal, and her description is that she simply could not have done what she did had she not had a sense of purpose that was transmitted to her as 'a calling.' Now that she is at the end of her life [Saunders died 10 days after this interview], she still has that spiritual resource. She used to worry about me, that I wouldn't be able to do this work without having a religious background. Certainly, there is no question that her career has been much more important than mine, but I have muddled through, so to speak, without religious resources, but an ethical framework that includes art and music.”

Deciding that the right of patients to die with minimum discomfort and maximum support from family and caregivers could not be justifiably denied, Wald took what she saw as the next logical step. In 1968, at age 50, with support and encouragement from her husband, Henry, she resigned her deanship and took an appointment as principal investigator of a nurse's research study of the terminally ill. It evolved into an interdiscipli¬nary study sponsored by Yale University School of Nursing. With the proceeds from a small grant, the research team was able, over a two-year period, to take care of 22 patients in a hospice located in the Yale New Haven Hospital, in the patients' homes and in nursing homes.

"Wasn't it a major adjustment to resign a secure position as dean of nursing at Yale to pursue a research project with an uncertain future?"

"One challenge was that my income was diminished," Wald responded with a laugh. "And I thought it was better for me to do this on a part-time basis than a full-time basis, so my income was even further reduced. My husband was very supportive, and he didn't have any trouble with that." In fact, Henry Wald, an engineer and partner in Wald and Zigas Consulting Firm, decided to make his wife's dream his personal dream.

"It was after he met Cicely Saunders," said Wald, "when we crossed paths in the late 60's related to St. Christopher's [Hospice] while it was being built, that he became so interested. It was at that point that we decided that he, too, could make a career change. He sold his part of the partnership and went back to Columbia University to enroll in a remarkable program in the School of Architecture, health facility planning. He wrote a feasibility study that clarified the role of hospice in the Greater New Haven community.”

With the benefit of hindsight, it's clear that Wald's decision to become involved in the hospice movement was a prescient one that has dramatically improved health care for thousands of terminally ill patients. In 1974, the first hospice in the United States was established in New Haven, Conn., began providing care. Today, there are more than 3,000 hospices in the United States. Wald is still active in the movement, but these days her focus is largely on prison hospices.

"I became involved in prison hospices through Fleet Mailau, a prisoner with 25 years on death row for trafficking drugs, in Springfield Federal Penitentiary in Missouri, a hospital prison. He began to help inmates who were dying and was so good at it that the warden got the Springfield hospice to help train inmates so they could be volunteers." Today, Mailau directs the National Prison Hospice Association in Boulder, Colo., which is developing prison hospices across the United States. Wald, a member of the association's board of advisors, is active in Connecticut Department of Corrections' hospices in both men's and women's prisons.

Until Saunders' death in mid-July of this year, Wald and Saunders maintained their close friendship, communicating regularly. Even though advanced in years and waging a painful battle with bone cancer, Saunders continued making contributions to the understanding of pain by working with other physicians to keep them informed on what she was experiencing during the course of her illness. On the Saturday before my interview of Wald, the two women had spoken to each other by phone, and Wald had said she just received contact from the parole board of a friend. Before reading an excerpt from that correspondence, Wald explained: "Cicely is really having a hard time right now, but she just finished reading a book, The Staircase of Waiting, published in 1982 by W. W. Nourse. Cicely has always talked about the Garden of Gethsemane, where Christ was awaiting torture and rejection."

From Saunders' letter, Wald read: "It is something that speaks very clearly to my experiences with patients. When people ask me why I am so enthusiastic about genetic research, I can only say that God is giving the world an advantage and, at the end of their bittered lives, God is alongside them in their suffering through love." For Saunders, the waiting is over, and she has made the journey for which she helped so many others prepare. Wald will miss her good friend and colleague. Although their spiritual views differed, they had one thing very much in common: They cared about people in pain. By identifying much-needed changes in the care of the terminally ill, changes that are being embraced, they gave birth to a worldwide movement. As reference, page 11.

James E. Mattson is editor, Reflections on Nursing Leadership. Florence Wald on current ethical issues ...

- Euthanasia means a good death. For me, the natural death is the good death, however, not out of the context in which it happened, but out of the clinical case in which legal authority was obtained to remove a woman's feeding tube, what the husband thought was a good death and what the parents thought was a good death were different. Euthanasia is what the person believes.

- What is going to make a big shift is when we get the genetic issues and when I am supposed to agree with anything of George Bush's, but I do feel that stem cell research is too much of an attempt to cure rather than prevent. I am much more enthusiastic about genetic research than stem cell research.

- Nursing has moved too much into medicine and curm and not enough toward health and disease prevention. If you look at all the work of the National Institutes of Health, it was concerned with how people lived. Major infectious diseases were carried, the kind of working conditions people had.

- People are being cured of illnesses, particularly in later life, but are being taxed to compensate for the economic impact of working with other physicians to keep them informed on what she was experiencing during the course of her illness. On the Saturday before my interview of Wald, the two women had spoken to each other by phone, and Wald had said she just received contact from the parole board of a friend. Before reading an excerpt from that correspondence, Wald explained: "Cicely is really having a hard time right now, but she just finished reading a book, The Staircase of Waiting, published in 1982 by W. W. Nourse. Cicely has always talked about the Garden of Gethsemane, where Christ was awaiting torture and rejection.

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Nursing ethics and Hägar the Horrible

Many strive for moral clarity, but arriving at that much desired destination guarantees neither truth nor a positive outcome.

by Mary Ellen Wurzbach

HÄGAR the Horrible, asked by his son to explain what life is all about, responds: “I guess life is like a long road ... a long, winding, bumpy road with some nice scenic views.”

Warming to the opportunity to teach his son how to make good choices, he continues: “When you reach the fork in the road, take the road on the right—the High Road. When you reach the crossroads, go towards Goodness. When the sign says City of Worldliness, you stay on course for City of Your Soul.

“Now this is where it gets tricky!” says Hägar, as he points to a bevy of signs that inform passersby they have just entered Inertia and directs them to destinations beyond that include Moral Ambiguity, Rationalization, Deep Denial and Self-Delusion. As if to emphasize that little time is allowed for decision-making, another sign warns, “No Loitering.”

One of the primary choices we make in life is choosing to appreciate moral uncertainty, sometimes called moral ambiguity, or choosing to search for moral certainty, sometimes called moral clarity. Often, people positioned to make choices for the rest of us choose moral certainty without seriously considering the moral uncertainty surrounding those choices. Much of my research has been an examination of moral behavior surrounding these two concepts. Moral certainty is defined as absolute belief to which a person is psychologically committed without a doubt. This conviction is based on evidence the person believes to be credible and right. Thus, moral certainty is absolute belief, coupled with what the person regards as irrefutable evidence, leading to willingness to take action. If institutional constraints make action impossible, moral distress may result. To avoid such distress, one nurse included in my research took the following action.

“I’ve had a situation,” she told me, “where the doctor ordered an extremely large dose of a narcotic. I drew up the narcotic, gave him the syringe and said, ‘I don’t feel comfortable giving this. I think you should.’ And you know what? He didn’t give it.”

Many other nurses who acted with moral certainty indicated that they were trying to avoid moral regret. As one nurse explained: “We had a woman come in complaining of back pain, and I didn’t say too much. Before she was discharged, I didn’t say she was complaining of back pain. We sent the lady home with instructions; she came back within four hours in shock with a ruptured tubal pregnancy. I regretted at that point not pushing the issue of the back pain further. That’s when I made up my mind: If I ever had a suspicion about something, I was going to say it and then deal with the repercussions later, because that lady almost died. If you raise the issue and are ignored, at least you have raised the issue and have no regrets.”

Conversely, moral uncertainty arises when one is unsure of what values or principles to apply to a problem. When faced with moral uncertainty, individuals feel loss of control, frustration, anger, depression, stress and anxiety, each of which occurs because the person is faced with lack of knowledge, lack of experience or a unique situation. This all leads to an inability to determine the “right” course of action.

One nurse I interviewed described the moral uncertainty she experienced in withholding tube-administered nutrition and hydration in a nursing home. “Even though I know they are in a vegetative state and that they probably aren’t aware of it, I still feel like, well, how do we ... how much do we know they are aware of? Don’t they feel the pain and hunger? Am I respecting their wish, but am I really doing what ... am I really ... am I letting them ... you know, am I ... is what I have done making them die an agonizing death?” Because moral uncertainty is so uncomfortable for this nurse, as it is for most people, moral certainty is sought because it seems imperative to the decision-maker. The person wants to “know how to do.”

Whether one is morally uncertain (confronted with moral ambiguity) or on a journey seeking moral clarity, I suggest cultivating the following values: persistence, patience and commitment. Calvin Coolidge said: “Nothing can take the place of persistence. Talent will not; nothing is more common than unsuccessful men with talent. Genius will not; unrewarded genius is almost a proverb. Education will not; the world is full of educated derelicts. Persistence and determination alone are omnipotent.”

Patience is also essential. Patience has not always gotten a good rap. Ambrose Bierce (1993) once described patience as “a minor form of despair, disguised as a virtue.” But stand by patience as an essential virtue.

Finally, commitment is necessary. Augustus William Hare asserted, “Half the failures in life arise from pulling in one’s horse just as he is leaping” (Hare & Hare, 1827). When I speak of commitment, I am talking about taking action based on a cherished value or a conviction.

Conviction allows individuals to “stand up” or “speak up” for the things in which they believe. It makes advocacy for a person or a cause possible. It provides a converse argument in situations where possibly only one viewpoint would otherwise be heard. It has many benefits for the person, agency and society. Yet, absolute conviction also has a more pervasive aspect. In my research the nurses I studied did not tend to question their own beliefs or actions. They did not describe dialogue or discussions of possible alternatives to their chosen action. Because there was little dialogue, mistakes could have been made and unnecessary adversarial feelings created.

Moral certainty or clarity can also be positive and admirable. How, then, does one know the difference between a justifiable action based upon reflective moral conviction and an unjustifiable action based upon unfounded zeal or self-deception? Lichtenberg, a philosopher, suggests developing an attitude of detachment from one’s own beliefs in order to see the possibility that one might be “blinded by passions, interests, upbringings, and might be mistaken” (Lichtenberg, 1994).

Moral certainty pulls one toward a definite conclusion, a resolution to an uncomfortable situation. It compels one to act. One is driven to follow a particular course of action. Yet, moral certainty does not guarantee a positive or appropriate outcome. It does not guarantee truth, and one may be mistaken.

Because experience seems to make moral certainty or clarity more likely, bioethicists convey to decision-makers that sometimes reserving judgment is the more prudent avenue to take, that allowing for the possibility of revising a judgment is the wise decision to make, and that relying totally on moral intuitions based on experience may not be in anyone’s best interests. An aspect of moral certainty is insensitivity to new information. One must cultivate moral
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killing as caring: could it happen again?

Caring is often associated with nursing, but for nurses employed at Nazi Germany's Hadamar Institute, caring came to mean killing. by Linda Shields

In the permanent Holocaust exhibit at the Imperial War Museum in London is a film showing a uniformed nurse helping a naked man into a gas chamber. This is a shocking reminder that nurses have not always done what is right. How did nurses justify their involvement in the murder of the sick and innocent, those people for whom they are supposed to care? For them, killing was part of doing right, and it is timely to remind ourselves that nurses' caring role can assume a sinister aspect.

Those who enter nursing usually do so through altruistic motives and a genuine desire to care for people. Occasionally, individual nurses abrogate their responsibilities and use their positions to do harm, but these individuals are usually caught, charged as necessary or, at the least, have their license to practice revoked. Education for registration in nursing is universally centered on principles of caring, and caring is seen as the essence of nursing.

However, there was a time and place in history when some nurses did not care, or, to be more precise, they cared in ways that were detrimental to their patients. Much has been written about the role of doctors in the Nazi era; they were tried at Nuremberg and in subsequent war crimes trials (Annas & Grodin, 1993); but scant attention has been paid to nurses. Only a small number of nurses were tried at Nuremberg; most have never been brought to account for the awful crimes they perpetrated, and few have ever been asked to explain why.

Nursing in Germany in the early part of the 20th century was inculcated with ideas of obedience and submission to the medical profession (Steppe, 1992). Perhaps slightly different from the development of nursing in Nightingale-influenced countries, German nursing was not seen as a middle-to-upper-class profession, where young women from "good" families became nurses for altruistic motives and no pay. Rather, it was a way for young women to gain a permanent job and some education. Implicit in their training was strict obedience, with no right to question an order.

Some men joined the nursing profession as a way of gaining employment, working mainly in psychiatric institutions (McFarland-Icke, 1999). There were no prerequisites for nursing. Prior employment as a domestic or a gardener in a hospital was often enough to secure a nursing job. The quality of training programs varied, but they always contained implicit assumptions about the rightness of unquestioned obedience to orders from above and the threat of dismissal if such obedience did not occur.

This model of nursing developed in a time of ideas and investigation in medicine—particularly psychiatry—that included the so-called "science" of eugenics. Two German doctors, Hoche and Blinding, published a book that became extremely influential in Europe and America (Burleigh, 1994). They suggested that there were some people who should not have been born, who were "untitlable," and who, if they were unfortunate enough to have been born, should never be allowed to reproduce. These were the handicapped and the mentally ill.

Hitler's rise to power following massive depression in the Weimar Republic made everyone, including nurses, concerned about their jobs. Those who had been members of communist parties quickly lost their jobs and were often sent to Dachau and other concentration camps for "re-education" (Burleigh, 2005). Nursing positions could require Nazi Party membership. The Nazis developed a comprehensive community-nursing program and, in 1938, passed laws about what we today would call the "scope of nursing practice." (German Government, 1936). This document, a catalog of nursing duties, mentions the need to keep the Aryan race pure.

Propaganda abounded about the drain on society caused by the mentally and chronically ill and handicapped (Burleigh, 1994). School children learned arithmetic by calculating how much "useless feeders" in asylums cost a community. Signs on billboards advocated "mercy killing" of those who were a burden to the nation. Films made by respected directors included stories in which those "untitlable" were removed from society. One particular film, "I Accuse," was about a young woman who gave her husband permission to kill her because she had multiple sclerosis.

Soon after Hitler became chancellor, laws were passed to force sterilization of people considered unfit to procreate. Later, the euthanasia programs began (Friedlander, 1993). They were called that because "euthanasia" means "a good death," but there was nothing good about how these people died.

In 1939, planning began in a house in Berlin at Tiergartenstrasse No. 4, and the program was nicknamed "T4." The Nazi government drafted legislation for euthanasia programs, but this was never ratified, probably because they were killing German citizens. Essentially, the programs were illegal (Burleigh, 1993). People with schizophrenia, depression, and other mental illnesses; epilepsy; chronic alcoholism; and, in children,
killing as caring: could it happen again?

Caring is often associated with nursing, but for nurses employed at Nazi Germany's Hadamar Institute, caring came to mean killing. by Linda Shields

In the Permanent Holocaust exhibit at the Imperial War Museum in London is a film showing a uniformed nurse helping a naked man into a gas chamber. This is a shocking reminder that nurses have not always done what is right. How did nurses justify their involvement in the murder of the sick and innocent, those people for whom they are supposed to care? For them, killing was part of doing right, and it is timely to remind ourselves that nurses' caring role can assume a sinister aspect.

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However, there was a time and place in history when some nurses did not care, or, to be more precise, they cared in ways that were detrimental to their patients. Much has been written about the role of doctors in the Nazi era; they were tried, and in subsequent war crimes trials, and have been asked to explain why.

Nursing in Germany in the early part of the 20th century was inculcated with ideas of obedience and subjugation to the medical profession. Perhaps, slightly different from the development of nursing in Nightingale-influenced countries, German nursing was not seen as a middle-to-upper-class profession, where young women from "good" families became nurses for altruistic motives and no pay. Rather, it was a way for young women to gain a permanent job and some education. Implicit in their training was strict obedience, with no right to question an order.

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In 1939, planning began in a house in Berlin at Tietgartenstrasse Nr. 4, and the program was nicknamed "T4." The Nazi government drafted legislation for euthanasia programs, but this was never ratified, probably because they were killing German citizens. Essentially, the programs were illegal (Burleigh, 1995). People with schizophrenia, depression, and other mental illnesses; epilepsy; chronic alcoholism; and, in children, who were "unfit for life," and who, if they were unfortunate enough to have been born, should never be allowed to reproduce. These were the handicapped and the mentally ill. Notice to nurses not to question orders. Notice to nurses to "receive orders, carry them out, and be silent when questioned." Notice to nurses to "save the nation" by killing the unfit. Notice to nurses that they were part of a moral decision to save the nation. Notice to nurses that the Nazi euthanasia program were buried in mass graves.

We must always take sides. Neutrality helps the oppressor, never the victim." — Elie Wiesel
Conditions such as cerebral palsy, Down syndrome and the range of incurable pediatric problems were killed. People were encouraged to institutionalize their disabled children—or dependent adults. After a time, a letter would arrive announcing the child’s death from “pneumonia” or some relatively common illness, along with a request that the recipient collect the ashes and pay cremation costs.

As the war took its toll on the German economy, food and medicine went to the army first and civilians last. Diabetic people—“useless feeders”—were said to contribute nothing to society and took food and resources away from the military and the fighting effort. Some taken to a better place (McFarland-Icke, 1992). Some refused to participate, and while some were moved to another institution or another part of the hospital, many nurses in Nazi Germany truly believed that the people for whom they were caring would be better off dead, that the weak must be sacrificed for the good of the strong, and that one’s moral duty lay in delivering killing as caring.

A nurse was asked, “If I didn’t do it kindly, someone else might have been rough with the patient; therefore, it was better for me to do it,” or “the patients knew and trusted me,” or “it was kinder to do it gently and with dignity.” In other words, they saw killing as caring. As a result of social and cultural conditions, combined with pressure from the state to conform at all costs, many nurses in Nazi Germany truly believed that the people for whom they were caring would be better off dead, that the weak must be sacrificed for the good of the strong, and that one’s moral duty lay in delivering them from a worthless existence.

Could it happen again? If so, how would I respond? These are questions every nurse should ask.

What was the role of nurses? Those who objected were not sent to T4. Those who objected were not sent to the Russian front to fight for the Fatherland were murdered. Nurses who had been hardened by their work in the euthanasia programs were sent to the Russian front to kill wounded German soldiers (O’Donnell, 2004). The killing methods changed as the war developed. Initially, lethal injections of drugs such as morphine were used, but soon all morphine was needed at the front (Burleigh, 1995). Children were given ever-increasing doses of phenobarbitone by nurses.

Starvation was a cheap but slow alternative, so more efficient killing methods were devised. As buses with blocked windows traveled between hospitals, passengers were gassed with carbon monoxide. Eventually, an engineer designed air-tight chambers where large numbers of people could be gassed simultaneously, and crematoria were built in the basements of hospitals so bodies could be disposed of efficiently. These were the prototypes for the death camps, and systematic killing methods for large numbers of people were refined (Friedlander, 1995). Usually, people were treated kindly during these processes. They were given food parcels for their bus journey, helped onto the buses or into the chambers by “compassionate” nurses and told they were going to a better place (McFarland-Icke, 1992).

No nurses were forced to be part of T4. Those who objected were not sent to a concentration camp or executed; rather, they were moved to another institution or another part of the hospital (McFarland-Icke, 1992). Some refused to participate, and while some were threatened with firing, no reprimands of any kind ensued. In other words, the nurses who worked in the T4 programs did so of their own free will.

What was the role of nurses? Those who actively killed were few, and the majority did not know what was happening. Some thought they knew but were never sure, while others knew and objected. Still others knew and helped by holding hands, comforting people as they went to their deaths (Benedict, 1999).

Why did nurses become involved? Fascism has at its core an insidious undermining of individual rights. The individual is nothing the state is always right, and obedience to the state is paramount. Nurses involved genuinely believed they were doing it for the “good of the State” (Steptoe, 1992). Many were unrepentant when asked why they took part in killing. They reasoned, “If I didn’t do it kindly, someone else might have been rough with the patient; therefore, it was better for me to do it,” or “the patients knew and trusted me,” or “it was kinder to do it gently and with dignity.” In other words, they saw killing as caring.

As a result of social and cultural conditions, combined with pressure from the state to conform at all costs, many nurses in Nazi Germany truly believed that the people for whom they were caring would be better off dead, that the weak must be sacrificed for the good of the strong, and that one’s moral duty lay in delivering them from a worthless existence.

Could it happen again? If so, how would I respond? These are questions every nurse should ask.

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22 Third Quarter 2005 Reflections on Nursing LEADERSHIP
Inside out

by Bethel Ann Powers

We wear our clothing right side out. When it is inside out we see the seams, the ragged edges, loose threads and tangled imperfections that hold it all together.

So life viewed from the right side out, is held together by the seams and ragged edges of experience.

With what we know of right and good reflected in the mirror of our imperfections. Thus the task before us is to view life inside out more often.

To better remember what it is we hope to see when we put it on right side out.

Bethel Ann Powers, April 2005

WHAT COUNTS as an ethical matter? We are used to examining values and principles that guide decisions in problematic situations. However, the moral elements of the usual, familiar activities of our everyday lives generally escape such scrutiny, not because we do not care, but because we see what we manage naturally as a matter of course as settled, unproblematic and under control.

If we were to reflect deeply on the ethical implications of everything we do as we do it, life's business would suffer and our work would never get done. Yet, daily experience is laden with taken-for-granted moral aspects that we consider without much thinking and act upon out of habit. The following sequence of events in the life of one family is common to many. Turned inside out, however, it is an invitation to consider, from an ethical perspective, the substructure of ordinary things.
September 2002. We are holding my mother in our arms as she sob...
We may decide that circumstances are about her preference for death over me. It gives no quarter. Independently is a ruthless adversary.

September 2002. We are holding my mother in our arms as she sobs, “I never thought you would do this to me.” She has been clear and vocal about her preference for death over me. It gives no quarter.

December 2002. Mother’s holiday letter to family and friends is accompanied by a collage of photos we have taken of her in the chapel, at the ice cream parlor, by the fountain in the courtyard, on a hayride. “...She is laughing and smiling. Her memory for the past is like a fleeting shadow, as she lives mainly in the present. Her contemporaries congratulate her on a successful retirement to a life in a nursing home. But the loss of memory, speech and ability to live independently is a ruthless adversary. It gives no quarter. She has been clear and vocal about her preference for death over me. It gives no quarter.

December 2002. We are holding my mother in our arms as she sobs, “I never thought you would do this to me.” She has been clear and vocal about her preference for death over me. It gives no quarter.

Betty Cornell, the author's mother

What is it like to override the wishes of a parent who does not want to live in a nursing home? The moral issue involves competing goods. That is, it is good to respect a parent's wishes but, at the same time, it is good to ensure his or her well-being. We may decide that circumstances are such that overcoming a loved one’s resistance is the right thing to do. Others may applaud the decision, and there may even be an element of relief. But doing right does not always result in feeling good about a situation.

Emotions of family members range from regerpetual acceptance or resignation to depression, guilt, shame and a sense of failure. The decision may cause the family discord. The loved one may feel anger, fear, confusion and a sense of abandonment. How staff members assess family dynamics and respond to individuals sets the tone for relationships across the nursing home stay.

What values underlie concerns about the physical safety of older adults? Eradicating to see that another comes to no harm and avoiding negligence that leads to harm—the ethical principle of nonmaleficence—guide actions aimed at preventing misadventures, such as falls. However, people can be harmed in more than just physical ways.

When physical safety becomes the dominant concern, other values often are called into question, such as beliefs about respect for the right of people to choose how to manage their own lives—the ethical principle of autonomy. Restraint minimization programs in nursing homes recognize the need to protect older residents’ rights to personal freedom against risk factors associated with physical injuries. Since no setting is risk-free, this situation can pose dilemmas when the ethical principle of autonomy is relevant.

Alerting the nursing home staff can help ensure a safe environment for all residents, but this may not always be possible. Restraint minimization programs in nursing homes recognize the need to protect older residents’ rights to personal freedom against risk factors associated with physical injuries. Since no setting is risk-free, this situation can pose dilemmas when the ethical principle of autonomy is relevant.

What is a good death? People respond differently and with varying emphasis on both the dynamics of the dying process as well as the existential meaning death has for them, as informed by cultural experience and spiritual or philosophical beliefs. Certainly, individuals have major concerns about the adequacy of physical-comfort measures to ease the work of dying, including access to hospice care, prevention of pain and symptom control. Advance directives further help guide the clinical management of death by relieving uncertainty about how people who cannot speak for themselves wish to die.

It is easy to become preoccupied with these kinds of details. However, an ethical stance demands equal attention to emotional and spiritual elements of the experience that offer support and consolation to families and lend dignity to this final life passage.

Betty Cornell, the author's mother

“A good death” was a cherished lifelong memory. She left a legacy of correspondence with her patients and their families sustained over more than 60 years.

We dishonor older people when we fail to see them in the light of who they are, not as they may come to us, frail of mind and body, but as they are on life’s stage, in terms of the meaning and purpose of their lives.

We should ask ourselves: How do we wish to be remembered? She took the familiar words to heart.

“I solemnly pledge myself before God and in the presence of this assembly, to pass my life in purity and to practice my profession faithfully.” She was a take-charge professional.

“I will abstain from whatever is deleterious and mischievous, ...” “I know what you need. ...” “I will not take or knowingly administer any harmful drug.”

“I will do to all in my power to maintain and elevate the standard of my profession.”

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Epilogue: Betty Cornell (1917-2004) was a graduate of the Philadelphia Osteopathic Hospital School of Nursing (Class of 1939). She attended the University of Pittsburgh with encouragement from Annie W. Goodrich, spearheader of collegiate-based nursing education in America, whose support was a cherished lifelong memory. She left a legacy of correspondence with her patients and their families sustained over more than 60 years.

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The ICN Code of Ethics for Nurses

Helping nurses make ethical decisions
by Tesfamicael Ghebrehiwet

NURSES and other health care providers are constantly challenged to make ethical decisions about life and death issues in providing care to individuals, families and communities. To be relevant and ethical, these decisions need to be considered in the broader context of personal, societal, cultural and professional values and ethical principles (Fry & Johnstone, 2002). The nursing profession uses regulatory mechanisms, codes of ethics and other means to ensure ethical behavior. For example, The ICN Code of Ethics for Nurses asserts, "Inherent in nursing is respect for human rights, including the right to life, to dignity and to be treated with respect" (ICN, 2000, p. 2).

To locate ethical issues within the context of nursing, it is vital to understand the International Council of Nurses (ICN) definition of nursing itself: "Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled, and dying people. Advocacy, promotion of a safe environment, research, participating in shaping health policy and in patient and health systems development. It follows that nurses must develop a thorough knowledge of professional nursing practice, expansion of knowledge, and advocacy or policy development. For example, The ICN Code of Ethics for Nurses asserts, "Inherent in nursing is respect for human rights, including the right to life, to dignity and to be treated with respect" (ICN, 2000, p. 2)."

This definition incorporates the three components of bioethics as outlined by Fry and Johnstone (2002), including norms of nursing practice, expansion of knowledge, and advocacy or policy development. It follows that nurses must develop a thorough knowledge of ethical issues, policies and procedures related to the protection of people as part of their responsibility as professional nurses.

Ethics and nursing responsibilities
As medical and scientific technology advances, individuals and society face dilemmas and difficult ethical decisions. Nurses, as part of society and as frontline health care professionals, daily face ethical dilemmas related to life and death and equity in health care. These include:

- The right to health and access to health care
- End-of-life issues such as euthanasia and extending life
- Quality of life for people with terminal illness
- Experimental research on humans
- Stem cell research
- Cloning and reproduction

While these issues continue to attract public attention, they present nurses and other health care providers with real ethical dilemmas in their clinical practices and professional responsibilities. The ICN Code of Ethics for Nurses (2000) affirms that nurses have four fundamental responsibilities:

- Promoting health
- Preventing illness
- Restoring health
- Alleviating suffering

As Fry and Johnstone (2002) have indicated, a nurse's professional responsibilities can result in ethical conflicts. Nurses' responsibility to promote health is related to the basic right to health care enshrined in the constitutions of governments, the World Health Organization and the position statements of the International Council of Nurses. Yet, ethical questions often arise when promoting health. For example, providing contraceptive information to a woman whose religious beliefs disapprove their use can test the nurse's ability to promote health.

Nursing responsibility in disease prevention is supported by ethical concepts of advocacy and caring, but that responsibility can conflict with ethical principles of privacy and confidentiality. For example, a nurse who is aware of a man who refuses to tell his partner of his HIV-positive status may face an ethical dilemma, as disclosing this information without his approval may constitute a breach of confidentiality. On the other hand, failure to disclose that information can lead to HIV infection of the partner.

In alleviating human suffering, there is a thin line between pain management and assisting death in terminally ill and dying patients. Similarly, in restoring health, what is the role of the nurse in administering a blood transfusion to a Jehovah's Witness who refuses this procedure on religious grounds? While the responsibilities of the nurse seem clear, nursing decision-making is complicated by the complexity of these ethical issues.

Nurses and other health professionals often suffer from a "dual loyalty complex" (DLC) resulting from problematic ethical and human rights issues. This might arise from competing loyalties between the interests of patients and employers and can occur either willingly or under pressure (Myser, 2000). For example, nurses working in prison services can face dual loyalty. While the primary responsibility of a nurse is the health care of prisoners, prison authorities may coerce the nurse to assume the role of a prison guard.

The ICN Code of Ethics for Nurses provides a clear resolution of this dual loyalty when it states: "The nurse's primary professional responsibility is..."
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The ICN Code of Ethics for Nurses provides a clear resolution of this dual loyalty when it states: "The nurse's primary professional responsibility is..."
to people requiring nursing care" (ICN, 2000, p. 2). Also, the ICN position statement "Nurses’ Role in the Care of Prisoners and Detainees" affirms that "nurses employed in prison health services do not assume the functions of prison security personnel, such as body searches conducted for the purpose of prison security" (ICN, revised 2003).

The debate around euthanasia, assisted suicide and right to die continues unabated. While some argue that euthanasia should be permissible on grounds of the ethical principle of autonomy (Sullivan, 2001), others assert that facilitating euthanasia is incompatible with the fundamental role of a health care provider, especially the nurse (Zimbelman & White, 1999). As the law lords of the House of Lords in the United Kingdom put it, “Human rights were aimed at protecting the right to live with dignity, not a right to die with dignity” (Haggar, 2001).

The ethical dilemmas faced by nurses and others are complex, and they need direction in making ethics-related decisions. The ethical analysis and decision-making process outlined in the ICN textbook Ethics in Nursing Practice: A Guide to Ethical Decision Making (Fry & Johnstone, 2002) is aimed to do just that.

ICN code of ethics

As the worldwide voice of nurses and nursing, the International Council of Nurses has provided leadership with regard to ethical issues since its founding in 1899. As early as the 1930s, ICN established the Ethics of Nursing Committee to identify ethical problems encountered by nurses. Although the committee’s work was interrupted by World War II, an international code of ethics for nurses was established in 1953. Since then, the code has been revised and updated.

The ICN Code of Ethics for Nurses is a fundamental document that aims to ground nursing actions in ethical principles. Laying the foundation for ethical behavior of nurses in all roles—including clinician, teacher, manager and researcher—the code begins by highlighting the nurse’s role:

“Nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering. The need for nursing is universal...” (ICN, 2000, p. 2).

The ICN ethics code has been translated into some 20 languages and continues to serve in lieu of national codes and as an international reference. In fact, most national codes of ethics for nurses are based on The ICN Code of Ethics for Nurses. Recently, the ICN code for nurses has been adapted for use by nurses affiliated with the International Federation of Red Cross and Red Crescent Societies.

The ICN Code of Ethics for Nurses was revised in 2000 and has been widely disseminated throughout the world. Another revision is scheduled for release later this year.

Hågar the Horrible

Hågar the Horrible (continued from page 19)

sensitivity to other viewpoints and make an effort to hear alternative solutions. As one nurse research participant observed, “Continuing dialogue leads to less uncertainty and also less moral uncertainty.”

In philosophy, the word “knowledge” usually implies some degree of certainty. In moral philosophy, moral knowledge is said by some to come from principles. Some say it comes from the virtue or character of the decision-maker. Still others say that contextual variables in the situation and the experience of the person determine the outcome. In my own research, nurses’ experience with an issue and the situation surrounding a decision account for those nurses having the greatest moral conviction.

Although the virtues of persistence, patience and commitment lead toward moral clarity, I caution nurses not to be satisfied with certainty. Appreciate, cultivate and welcome the moral uncertainty and ambiguity that you experience along the way. Take the path toward moral clarity, but appreciate the journey.

Moral clarity is important, but it is moral uncertainty or ambiguity that raises the ultimate questions. It is from moral uncertainty that consensus arises. It is from uncertainty that a search for knowledge and experience comes. Questioning, investigating, and delving deeply into a moral dilemma are essential aspects of moral behavior. As someone once said, “Indecision is the key to flexibility.”

We all face ethical dilemmas. Don’t go down the road marked “Moral Clarity” until you have explored the road marked “Moral Ambiguity.” Question the reasoning, acknowledge and pay heed to the ambiguities along the way. As Hågar the Horrible said, “Stay on course for the City of Your Soul.”

Mary Ellen Warbach, RN, MSN, PhD, is a professor in the College of Nursing at the University of Wisconsin-Oshkosh.

Honor Society of Nursing, Sigma Theta Tau International

Dear Colleagues,

I write this update on the heels of attending, with President-Elect Carol Picard, the 2005 Quadrennial Congress of the International Council of Nurses (ICN). The theme of the congress, held in Taipei, Taiwan, was “Nursing on the Move: Knowledge, Innovation and Vitality.”

We marveled at the parade of nations that began the opening ceremony. Many nurses wore native dress and contributed to the kaleidoscope of diversity that was present. It was interesting to note that knowledge, learning and service, the foundation upon which our honor society was founded, resonate with communities of nurses around the world. It was also interesting to ponder how Nursing Knowledge International®, one of the subsidiary corporations of the honor society, might serve as a platform to help nurses help others in the development of a worldwide nursing knowledge network.

Stephen Lewis, special envoy of the secretary-general for HIV/AIDS in Africa, delivered a passionate keynote address about health and human rights in which he stated, “Nurses can always be counted on for principles, caring and tenacity.” He further observed that “nurses are the centerpieces of society.” As he traveled to and from Africa, Lewis saw the devastation of the AIDS pandemic as well as the value of nursing care for the sick and dying. Women and children are especially vulnerable and need special attention in covenants designed to protect and support the balance of relationships between health and human rights. Unfortunately, many nurses and other health care workers have contracted HIV/AIDS and are dying.

Carol Picard and I talked about how the honor society needs to respond to the global nursing concerns that surfaced at the congress. As we looked to the future, we identified efforts that need to be considered alongside our newly developed strategic directions. I appreciate the effort of members who are drawing attention to the value of nursing in their part of the world. I also admire those who make individual contributions on a daily basis to support beneficence, autonomy and justice. It is a constant challenge to do the right thing and uphold the ethical standards of our profession.

Many of the outcomes anticipated in the Board of Directors Oversight Plan are being realized. At our June meeting, we applauded the work accomplished by many of our members and task forces. Watch for a final version of the honor society’s strategic directions. Anticipate the posting of new policies approved regarding global development, nurse migration and ethical recruitment.

Expect a new policy and resource paper on global health and nursing research priorities, created by members of the Research and Scholarship Advisory Council. Look forward to a Web-based resource that identifies global leadership development programs. Be ready to access the resource paper on effective practice from the Resilience Practice Task Force. Anticipate learning about reflective practice at the 2005 convention. Be prepared to act on recommendations and bylaws changes suggested by the Governance Committee.

Look for invitations to participate in focus groups and feedback sessions on the work of the Chapter and Community Building Advisory Council. Give thanks to your regional coordinators, as they have been very actively supporting and sustaining healthy chapter initiatives. The Leadership Succession Committee is busy putting final touches on a ballot for the 2005 election at the House of Delegates. Members of headquarters staff are getting ready for the convention.

President-Elect Picard and I met with the board and staff to begin planning for the transition to the next biennium. Members in the organization have taken my call to renew seriously. We continue to build a strong organization that is ready for the future. I am forever grateful for your commitment, support and encouragement. It is not too early to begin making plans for the convention. Register by Oct. 5 for that early discount! Exciting events are planned. I believe the convention will be informative and educational and will provide opportunity to celebrate biennial achievements. I’ll see you soon in Indianapolis.
to people requiring nursing care" (ICN, 2000, p. 2). Also, the ICN position statement "Nurses' Role in the Care of Prisoners and Detainees" affirms that "nurses employed in prison health services do not assume functions of prison security personnel, such as body searches conducted for the purpose of prison security" (ICN, revised 2003).

The debate around euthanasia, assisted suicide and right to die continues unabated. While some argue that euthanasia should be permissible on grounds of the ethical principle of autonomy (Sullivan, 2001), others assert that facilitating euthanasia is incompatible with the fundamental role of a health care provider, especially the nurse (Zimbelman & White, 1999). As the law lords of the House of Lords in the United Kingdom put it, "Human rights were aimed at protecting the right to live with dignity, not a right to die with dignity" (Happell, 2001).

The ethical dilemmas faced by nurses and others are complex, and they need direction in making ethics-related decisions. The ethical analysis and decision-making process outlined in the ICN textbook Ethics in Nursing Practice: A Guide to Ethical Decision Making (Fry & Johnstone, 2002) aims to do just that.

ICN code of ethics

As the worldwide voice of nurses and nursing, the International Council of Nurses has provided leadership regarding ethical issues since its founding in 1899. As early as the 1930s, ICN established the Ethics of Nursing Committee to identify ethical problems encountered by nurses. Although the committee's work was interrupted by World War II, an international code of ethics for nurses was established in 1953. Since then, the code has been revised and updated. Today, the ICN Code of Ethics for Nurses is a fundamental document that aims to ground nursing actions in ethical principles. Laying the foundation for ethical behavior of nurses in all roles—including clinician, teacher, manager and researcher—the code begins by highlighting the nurse's role:

"Nurses have four fundamental responsibilities: to promote health, to prevent illness, to restore health and to alleviate suffering. The need for nursing is universal..." (ICN, 2000, p. 2).

The ICN ethics code has been translated into some 20 languages and continues to serve in lieu of national codes and as an international reference. In fact, most national codes of ethics for nurses are based on The ICN Code of Ethics for Nurses. Recently, the ICN code for nurses has been adapted for use by nurses affiliated with the International Federation of Red Cross and Red Crescent Societies.

The ICN Code of Ethics for Nurses was revised in 2000 and has been widely disseminated throughout the world. Another revision is scheduled for release later this year.

Conclusion

Issues such as mapping the human genome, cloning, euthanasia, access and equity in health care have brought ethical dilemmas to the forefront and have complicated nursing responsibilities in health promotion, disease prevention, care and treatment. The International Council of Nurses, its member national associations and other organizations continue to provide direction and leadership in ethical decision-making. In this way, they aim to ensure that the nursing practice continues to be grounded in ethical principles compatible with human dignity, quality of life and patient safety.

Hägar the Horrible (continued from page 21)

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Daniel J. Petrot, PhD, APRN, BC, FAAN

The President

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www.nursingsociety.org/about/position_GHNRPRP.doc
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www.nursingsociety.org/about/brpt_POST_265.pdf
www.nursingsociety.org/convention/index.html

Tenth Quarter 2006 REFLECTIONS ON NURSING LEADERSHIP
RNL goes online

AT THE Honor Society of Nursing, Sigma Theta Tau International, we have the best of both worlds. We are steeped in the traditional world of the nursing profession. Our organization is among the oldest, most prestigious and certainly the most academically rigorous of any nursing group. You need only attend an induction to see the proud ritual and ceremony that underpin our organization. Throughout the years, successive boards have voted to uphold rigorous admissions criteria, and a look at the bright faces of today’s initiates is to know that membership remains an honor and a privilege.

As you peruse this issue, you will be offered the opportunity to renew your memberships online, foregoing what some consider the quick and easy way to rework the site. We were proud of the original Virginia Henderson International Nursing Library, launched in 1990 on the Internet, before the existence of the World Wide Web. State of the art at the time, it became dated and slow as more libraries went online with increasingly powerful search engines and more efficient registration.

We are especially proud that our new site offers:

- More useful and powerful search capabilities
- Expanded definition and breadth of content
- Improved navigation
- Ability to connect to nurses with similar research interests

It has taken two years and thousands of person-hours to enhance the value of your membership and evolve as an organization. We are excited to announce that we will bring you RNL, our perceptive executive officer, Nell Watts, foresaw the day when the publica­tion would become an eye-popping, full-color magazine. A lot has changed in those 30 years. One thing has never changed, though, over the course of time:

"Reflections on Nursing Leadership (RNL) is among the oldest, most prestigious and widely read nursing journals of the professional literature..." - Nancy Dickenson-Hazard, chief executive officer

When we began publishing a four-page, black-and-white newsletter more than 30 years ago, it is unlikely that even our visionary president, Sister Rosemary Donley, or our perceptive executive officer, Nell Watts, foresaw the day when the publication would become an eye-popping, full-color magazine. A lot has changed in those 30 years. One thing has never changed, though, over the course of time: excellence. We were just notified that Reflections on Nursing Leadership received five awards this year for its design and editorial excellence. With this issue, we begin moving by some feature content, RNews Capsules, plus Noteworthy, Announcements and portions of Inside the Honor Society exclusively online. Feel free to print out any online content and post it on your area bulletin boards. We encourage you to fill out our card enclosed in this issue, providing a current e-mail address, so that we can better meet your informational needs. To see the first online RNL, go to www.nursingsociety.org/RNL. Reflections on Nursing Leadership will be exclusively online in 2006.

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At the same time, we wholeheartedly embrace the new technology that has paved the way for our growth and global expansion. We can now communicate quickly with the most distant of our members, and an increasing number of you are opting to renew your memberships online, foregoing what some consider the encumbrance of paperwork and a trip to the post office.

We continue to enhance the value of your membership and evolve as an organization, so we are excited to announce that we will bring you Reflections on Nursing Leadership (RNL) in an online format beginning with this issue. We look forward to bringing this award-winning publication to you in this new way.

By going online, we will be able to bring you:
- Expanded content
- Bonus information and features
- Timely information
- Hyperlinks to related sites
- Printer-friendly capability

With this issue, we begin by moving some feature content, RN News Capsules, plus Noteworthy, Announcements and portions of Inside the Honor Society exclusively online. Feel free to print out any online content and post it on your area bulletin boards. We encourage you to fill out our card enclosed in this issue, providing a current e-mail address, so that we can better meet your informational needs. To see the first online RNL, go to www.nursingsociety.org/RNL. Reflections on Nursing Leadership will be exclusively online in 2006. When we began publishing a four-page, black-and-white newsletter 30 years ago, it is unlikely that even our visionary president, Sister Rosemary Donley, or our perceptive executive officer, Nell Watts, foresaw the day when the publication would become an eye-popping, full-color magazine. A lot has changed in those 30 years. One thing has never changed, though, over the course of time: excellence. We were just notified that Reflections on Nursing Leadership received five awards this year for its design and editorial excellence (see sidebar at right). Now it is time to move this publication forward and expand its reach. The world—certainly the world of our organization—becomes a smaller place by virtue of shared technology and the demographic wealth and diversity of our members.

--- Nancy Dickerson-Hazard, chief executive officer

A visit to the library overdue?

If you haven't visited www.nursinglibrary.org, please do. A number of the studies are exclusive to the site. Whether you are a researcher, educator, administrator, clinician or nursing student, it will help answer your knowledge needs. Recently relaunched, the Virginia Henderson International Nursing Library is—first and foremost—user-friendly.

It has taken two years and thousands of person-hours to rework the site. We were proud of the original Virginia Henderson International Nursing Library, launched in 1990 on the Internet, before the existence of the World Wide Web. State of the art at the time, it became dated and slow as more libraries went online with increasingly powerful search engines and more efficient registration.

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- More useful and powerful search capabilities
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- Improved navigation
- Ability to connect to nurses with similar research interests

--- Linda Finnis, RN, PhD, director of professional development

Additional content online...

Building a global community of nurses

When nurses describe their experience as a Sigma Theta Tau international member, they use words such as energizing, renewing and inspiring. Whether it's attending honor society events, serving at the chapter level or networking with other nurses, these experiences create an emotional connection, fulfill members' needs and foster learning and growth.

To learn how the board of directors is elevating the honor society to build a stronger community, go online to www.nursingsociety.org/RNL and select "In Touch." How one university hospital system is training nurses to become globally literate

It is no longer acceptable for nurses to deliver health services solely from a national or local point of view, writes Rita K. Aikens, RN, M. Ed., CMAC. It is important for them to familiarize themselves with what is going on at a global level. To learn more, visit the online version of Reflections on Nursing Leadership at www.nursinglibrary.org/RNL and select "In Touch."
Oct. 5 cutoff for convention discount

T he 38th Biennial Convention is quickly approaching. Register, reserve your hotel room and plan your schedule now! Attend cutting-edge educational sessions and enjoy all that Indianapolis has to offer.

Convention highlights include:

- More than 600 educational presentations showcasing solutions, innovations and new science in nursing;
- Awards that recognize the accomplishments of both nurses and non-nurses;
- An exhibit hall with more than 100 booths displaying products and services specifically for nurses;
- Dedication of the brick paver garden recently installed at honor society headquarters.

Tours available

Plan to arrive in Indianapolis early to visit the Hill-Rom International Headquarters in Batesville, Ind., on Friday, Nov. 11, where you can see the future in patient rooms and work spaces for nurses. Hill-Rom is the industry leader in design and development of integrated care process solutions and products that meet and exceed future needs of health care institutions. Participation is limited. To sign up or for more information, e-mail Indy5065@indianapolis.org.

The Indianapolis Convention and Visitors Association is offering a city tour on Saturday morning, Nov. 12, that includes downtown museums, attractions and honor society headquarters. Participation is limited to 50, so make plans soon! To sign up, e-mail mtnowbridge@indianapolis.org.

Register by Oct. 5 and save!

Visit www.nursingsociety.org/convention to register online, or to learn more.

Tribute Book of Letters

A special book of letters is being created to provide support for friends and colleagues of Daniel J. Pesut to acknowledge his contributions as the honor society’s president during 2003-2005. Please send letters of tribute in PDF format via e-mail attachment to mgregor@indy5065@indianapolis.org or to Marge Wilson, Honor Society of Nursing, 500 West North St., Indianapolis, IN 46202, USA. Letters are due before Oct. 31, 2005. The letters will be collected and presented to President Pesut during the 38th Biennial Convention.

Leadership grants give back to members

NOW, members who need financial assistance to attend honor society events and leadership-training programs may apply for Leadership Education Grants offered by the Sigma Theta Tau International Foundation for Nursing.

Inspired by the foundation’s Edith Anderson Membership Subsidies, a program that helps members overcome financial difficulties by underwriting a portion of their membership fees, these Leadership Education Grants provide financial assistance for individuals to participate annually in the research congress and the Omada and Chiron mentoring programs. Biennially, individuals may apply for assistance to participate in Chapter Leader Academy and the honor society’s biennial convention.

Jane Kirschling, foundation board chair, sees these grants as an opportunity to give back to honor society members. “The foundation is pleased to be able to offer these grants to help members actively participate in the biennial convention and other activities,” Kirschling says. "As always, we are very appreciative of all the members who support these and other areas through their philanthropic gifts to the foundation."

Tuong-Vi Ho, Beta Beta Chapter (Houston), was one of the first two recipients of these $400 awards. "This leadership grant helped me with some of the financial burden," says Ho. She presented a poster during the recent research congress on the early detection of cervical cancer in underserved populations, and this was her first honor society conference.

Thongpoy Sitanon from Psi-Atch-Large Chapter was the other research congress award recipient. Sitanon says, “The International Nursing Research Congress provided me a great opportunity to share my knowledge and experience as a presenter to other nurses and researchers around the world. However, the airfare and other fees were very expensive for a full-time, international nursing student.”

Indeed, the fees are prohibitive to many, and several deserving applicants applied and were declined during these first round of Leadership Education Grants. The same is true with the Small Research Grants awarded annually by the honor society. Each year, several qualified applicants are turned down due to lack of funding. If you are interested in increasing available resources for Leadership Education and Small Research grants, or in finding out more about these awards, please visit the foundation’s Web site at www.nursingsociety.org/giving or contact a member of the foundation staff at +1.317.634.8171.

-- Lauren Aklam, assistant director Sigma Theta Tau International Foundation for Nursing

 Notification of membership dues increase

Effective Jan. 1, 2006, the international component of membership dues will increase to $50 U.S. high income, $24 U.S. middle income and $12 U.S. low income. In addition, the following adjustments will be implemented:

- An additional increase in the Consumer Price Index since November 2004.
- Decreased number of fee increases for categories based on a country’s per capita GDP as defined by the World Bank basic indicators.

During the 2003 Biennial Convention, the House of Delegates approved a change to the honor society’s bylaws that grants for the International Board of Directors’ financial award over fees. This means that in addition to other financial factors, the board now has the ability to make incremental dues adjustments, based on the rate of inflation. This enables the board to fully manage the honor society’s resources—allowing it to respond to economic conditions, inflation and the increased costs of doing business—all while strengthening member services.

This necessary adjustment to dues will allow the board to fully ensure that the honor society continues to meet its mission to provide leadership and scholarship in practice, education and research to enhance the health of all people.

For more information regarding membership dues, please contact the Constituent Center via e-mail at mmgstaff@indianapolis.org or by phone at 1.888.854.7075 (U.S./Canada), +1.317.634.8171.
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Tours available

Plan to arrive in Indianapolis early to visit the Hill-Rom International Headquarters in Batesville, Ind., on Friday, Nov. 11, where you can see the future in patient rooms and work spaces for nurses. Hill-Rom is the industry leader in design and development of integrated care process solutions and products that meet and exceed future needs of health care institutions. Participation is limited. To sign up or for more information, e-mail lindy@566thi.edu.

The Indianapolis Convention and Visitors Association is offering a city tour on Saturday morning, Nov. 12, that includes downtown museums, attractions and honor society headquarters. Participation is limited to 50, so make plans now! To sign up, e-mail mtrowbridge@indianapolis.org.

Register by Oct. 5 and save!

Visit www.nursingsociety.org/convention to register online, or to learn more. am

Tribute Book of Letters

A special book of letters is being created to provide a tribute for friends and colleagues of Daniel J. Pesut to acknowledge his contributions as the honor society president during 2003-2005. Please send letters of tribute in PDF format via e-mail attachment to memserv@stti.iupui.edu or to Margie Wilson, Honor Society of Nursing, 550 West North St., Indianapolis, IN 46202, USA. Letters are due before Oct. 31, 2005. The letters will be collected and presented to President Pesut during the 38TH BIENNIAL Convention.

Leadership grants give back to members

NOW, members who need financial assistance to attend honor society events and leadership-training programs may apply for Leadership Education Grants offered by the Sigma Theta Tau International Foundation for Nursing.

Inspired by the foundation's Edith Anderson Membership Subsidies, a program that helps members overcome financial difficulties by underwriting a portion of their membership fees, these Leadership Education Grants provide financial assistance for individuals to participate annually in the research congress and the Omada and Clorton mentoring programs. Biennially, individuals may apply for assistance to participate in Chapter Leader Academy and the honor society's biennial convention.

Jane Kirschling, foundation board chair, sees these grants as an opportunity to give back to honor society members. "The foundation is pleased to be able to offer these grants to help members actively participate in the biennial convention and other activities," Kirschling says. "As always, we are very appreciative of all the members who support these and other areas through their philanthropic gifts to the foundation."

Toung-Vi Ho, Beta Beta Chapter (Houston), was one of the first two recipients of these $400 awards. "This leadership grant helped me with some of the financial burden," says Ho. She presented a poster during the recent research congress on the early detection of cervical cancer in underserved populations, and this was her first honor society conference.

Thongousy Sistanon from Psi-at-Large Chapter was the other research congress award recipient. Sistanon says, "The International Nursing Research Congress provided me a great opportunity to share my knowledge and experience as a presenter to other nurses and researchers around the world. However, the airplane and other fees were very expensive for a full-time, international nursing student."

Indeed, the fees are prohibitive to many, and several deserving applicants applied and were declined during those first round of Leadership Education Grants. The same is true with the Small Research Grants awarded annually by the honor society. Each year, several qualified applicants are turned down due to lack of funding. If you are interested in increasing available resources for Leadership Education and Small Research grants, or in finding out more about these awards, please visit the foundation's Web site at www.nursingsociety.org/giving, or call a member of the foundation staff at (317) 634-8317.

— Laura Klaum, assistant director, Sigma Theta Tau International Foundation for Nursing

Notification of membership dues increase

Effective Jan. 1, 2006, the international component of membership dues will increase to $50 U.S. (high income), $24 U.S. (middle income) and $12 U.S. (low income). The dues increase was necessary due to an increase in the Consumer Price Index since November 2002, date of the last dues increase. Five categories are based on a country's GNI per capita as defined by the World Bank Basic Indicator Index.

During the 2003 Biennial Convention, the House of Delegates approved a change to the honor society’s bylaws that grant the international board of directors fiscal authority over fees. This means that in addition to other financial Realities, the board now has the ability to make incremental dues adjustments, based on the rate of inflation. This enables the board to fully manage the honor society’s resources—allowing it to respond to economic conditions, inflation and the increased costs of doing business—all while strengthening member services.

This necessary adjustment to dues allows the board to fully ensure that the honor society continues to meet its mission to provide leadership and scholarship in practice, education and research to enhance the health of all peoples.

For more information regarding membership classes, please contact the Constituent Center via e-mail at memserv@stti.iupui.edu or by phone at (317) 634-7057 (U.S. Canada), (317) 634-8317.
The University of Michigan invites nominations and applications for the position of Dean of the School of Nursing.

Consistent with the vision of the University, the School of Nursing supports excellence in research, provides outstanding undergraduate, graduate, and professional education, and demonstrates commitment to service through partnerships and collaborations that extend to the community, region, state, nation, and the world.Ranked among the top five nursing schools in the United States, it is recognized nationally and internationally for its leadership and innovation in research, education, and practice.

The Dean is the chief academic and administrative officer of the School of Nursing and reports to the Provost and Executive Vice President for Academic Affairs. The Dean is expected to maintain high academic standards and a preeminent national standing for the School. The Dean must be a proponent of the University's research mission, advance the School's initiatives within the University, and effectively articulate the School's contributions and perspectives in local, regional, national, and international arenas of nursing, health care, and policy. The Dean will lead the School in promoting a research environment conducive to multidisciplinary endeavors, in advancing innovative educational programs, and in facilitating practice initiatives and health care policy. The Dean must play a pivotal leadership role in fundraising for the School of Nursing.

The ideal candidate will possess the following: national and international recognition as a scholar with a PhD in Nursing or equivalent degree; a demonstrated commitment to diversity; administrative experience and fiscal acumen; record of coalition building; commitment to promote, support, recruit and retain outstanding tenure track faculty; ability to champion nursing research, education and service within a preeminent research institution among a wide range of constituencies; and credentials commensurate with a tenure track faculty appointment at the Professor rank in the University of Michigan School of Nursing.

Nominations and applications will be reviewed beginning July 1, 2005, and will be accepted until the position is filled.

Individuals from underrepresented groups are encouraged to apply. All inquiries, nominations, and applications will be treated in a confidential manner. Materials and inquiries should be submitted, preferably electronically, to:

Antonia M. Villarruel, PhD, FAAN
Chair, School of Nursing Dean Search Advisory Committee
Professor of Nursing
University of Michigan
3074 Fleming Administration Building
Ann Arbor, MI 48109-1340
nursing.search.chair@umich.edu

The University has retained the services of The Hollander Group to assist the Search Advisory Committee in this process. Telephone: 202-486-9097. E-mail may be addressed to: Clifford@thehollandergroup.net

"Our chapter contributed to the paver campaign because it is committed to ensuring the future of nursing, one paver at a time. One of our longtime members, Marlene Ruiz, always says if you want to grow, reach out and help someone else succeed. That's what our chapter wants to do, help other nurses succeed."

—Melodie Daniels, president, Comma Chapter

Oct. 1 is last chance to contribute for paver installation by convention. For more information, visit www.nursingsociety.org/giving.
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