NURSING & HEALTH CARE

NOVEMBER 1992 VOLUME 13, NUMBER 9

Nursing in Society

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Substance Abuse During Pregnancy
Shortage as Shorthand
A Nursing Center in Brooklyn

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November 1992
Volume 13
Number 9

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FEATURES

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Remembrance of Things Past — Present

Ellen T. Fahy, EdD, RN

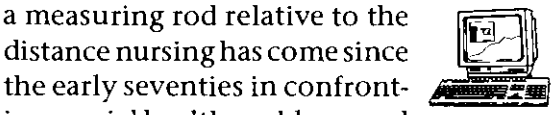
Thinking back to my beginning days in academic administration in the early seventies, they were a time of upheaval ("What do you think we have now? " I hear you ask), and change within American society. We had just come off the most tumultuous decade of the century in terms of social, political and economic unrest. When I hear The Weavers sing "Wasn't That A Time," although I am fully aware they are celebrating another era in our country, I am always reminded of the decade of the sixties. Societally, the disenfranchised among us seemed to have found a new voice; within academe, students achieved some hitherto unattainable rights; faculty's voice was broadened; protesting became a way of life. With the passage of Medicare/Medicaid in 1965, health care was declared a right not a privilege; feminism was emerging from underground. Anything seemed possible.

Beginning in the sixties with Loretta Ford's program at the University of Colorado and reaching new dimensions in the seventies, in nursing education there was much excitation about the preparation of nurse practitioners to step up to the plate and be counted in the

mélange of social change to better meet health needs in communities. Preparation in medicine had become so highly specialized there appeared to be a gaping hole in the area of primary care. Some of us believed (and still do) nursing could not only fill the bill, but in different and better ways.

Basic to our thinking was the premise that nursing and the social order were inextricably bound and should, through our education programs and subsequent practice, participate in the broadened definition of health under way in society to include poverty—racism—sexism—classism. Such a premise would necessitate significant changes in our curriculum efforts beyond the traditional approach of learning to care for the acutely ill, institutionalized individual, albeit in an excellent fashion. This was in addition to begin preparing for a more competitive role in primary care provision.

The articles in this issue of *Nursing & Health Care* might very well serve as some sort of a measuring rod relative to the distance nursing has come since the early seventies in confronting crucial health problems and providing primary care. Two are addressed specifically to women: abuse, the abused and the abuser. Another speaks to education for primary care to those who continue to fall through the cracks in our health care system. Continuing challenges to nursing education can be found. Those of us who have struggled with curriculum issues should resonate to the position. These articles are presented along with another dimension but no less important social policy question, the perpetual question of the nursing shortage. Can it be defined along less traditional lines than purely economic? Could there be some feminist issues lurking? The contents take a swipe at a broad canvas of unresolved national health issues and try to chart a place for them in both nursing education and practice settings.



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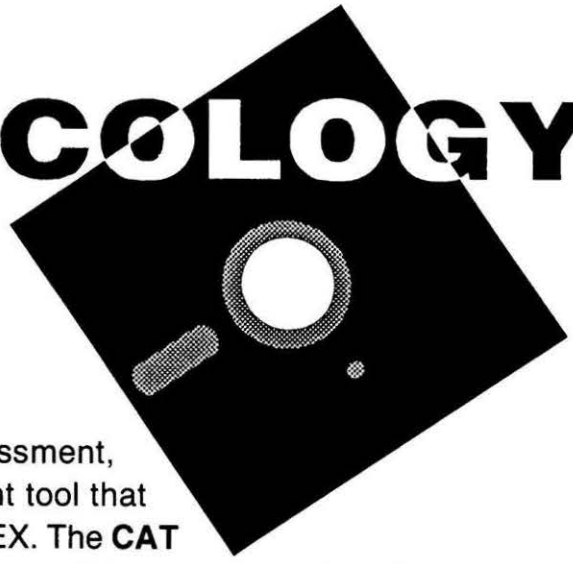

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NLN—QUALITY LEADERS IN NURSING ASSESSMENT

CALENDAR

November

1–4 "Fourth Annual AJN Conference on Medical-Surgical and Geriatric Nursing," American Journal of Nursing, New York, NY, 212/340-9261.

5-7 "Fourth Annual Nursing Conference on Current Issues and Clinical Perspectives," Contemporary Forums, San Francisco, CA, 510/828-7100.

8 "Council for Community Health Services Annual Meeting," National League for Nursing, Washington, DC, 212/989-9393.

8-11 "Insight Into Eyesight," American Society of Ophthalmic Registered Nurses, Dallas, TX, 415/561-8513.

12-14 "National Primary Care Conference," Nurse Practitioner Associates for Continuing Education (NPACE), Boston, MA, 617/861-0270.

12-14 "Revenue Diversification," American Association of Colleges of Nursing, Washington, DC, 202/463-6930.

21 "Women's Health Day Conference," included in the conference: "AIDS: A Woman's Issue," Dr. Margaret Hamburg, Commissioner, New York City Department of Health, National Council on Women in Medicine, Inc., New York, NY, 212/535-0031.

December

3-4 "AIDS/HIV Conference," Southern Council on Collegiate Education for Nursing, Atlanta, GA, 404/875-9211.

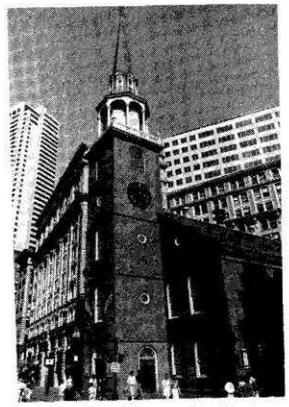
4-11 Dermatology Nurses' Association (DNA) 11th Annual Convention, San Francisco, CA, 609/582-1915.

9-11 "International Conference on Occupational Health and the Environment," Royal College of Nursing of the United Kingdom; Society of Occupational Health Nursing, Brighton, England, 071/409-3333.

10-11 "NLN Faculty Institute," National League for Nursing, West Palm Beach, FL, 212/989-9393.

March

4-6 "Expressions of Caring in Nursing: Exploring our Environmental Connections," Sigma Theta Tau/Iota Xi Chapter and the College of Nursing of Florida Atlantic University, Boca Raton, FL, 407/367-3260.



Old South Meeting House in Boston, MA. Plan now to attend the ***NLN's 21st Biennial Convention*** *in Boston June 6–10, 1993.*

Cuts in Funding Expected for Nursing Education

Cuts in the budget this year, which have jeopardized current funding levels for nursing programs, have provoked a strong, organized lobbying effort by nurses throughout the country. Such efforts may very well be the saving grace for nursing programs — at least this year.

Appropriations status

As of this writing, the House and the Senate have each completed mark-up of the Labor/HHS/Education appropriations bill and, assuming the Senate bill is passed on the floor, are awaiting a conference committee meeting to complete the appropriations process. The result of the mark-up was that nursing programs received a 37 percent cut of their total health professions training funds by the House, but a Senate increase that put financing back to almost level funding.

While the Senate has consistently been more generous to nursing programs in recent years, Senate staff cited organized grassroots efforts by nurses throughout the country as a major contributing factor in the Senate's comparatively high numbers. The table presents a breakdown of House and Senate numbers for nursing programs before conference committee meetings, which have not been scheduled as of publication deadline.

The National League for Nursing, along with members of the nursing coalition, have held several meetings with House and Senate members and their staff in an effort to raise awareness of the nursing profession's contributions to health care. As the House and Senate prepare for conference committee meetings, so will we be preparing. The League will revisit members, especially of the House, to urge them to maintain Senate numbers for funding levels. Representatives Steny Hoyer (D-MD) and Carl Pursell (R-MI) have expressed interest in "championing" our cause on the House side.

Rumors suggest that there will be an additional 1.5–2.1 percent cut in the Senate funding levels as a result of conference committee negotiations. Some of nursing's lower priority programs may be forced to take more of a cut as funds are shifted in conference committee.

Reauthorizations

Conferees have completed negotiations on reauthorization of the Nurse Education Act. While authorization levels are expected to be significantly lower than past years, they are expected to be adequate to accommodate fiscal year 1993 appropriation levels and, possibly, limited growth. Legislative staff plan to reauthorize the programs in two years to avoid an unintended ceiling on current levels of funding.

Nursing reimbursement

Senator Charles Grassley (R-IA) is still planning to offer an amendment to improve payments under Medicare to nurses in advanced practice and physicians' assistants should Finance Committee members decide to mark-up a health care package before the Congressional recess for the elections this fall. The amendment would provide direct payment levels to 97 percent of physician rates for such nurses and physicians' assistants.

Since Finance Committee members are committed to a "non-controversial" package, with savings to offset any spending items, the scope and likely success of the potential Grassley amendment is uncertain. Finance Committee staff have raised the possibility of extending direct payment to nurses in underserved urban areas, but the proposed definition of underserved areas would be limited to health manpower shortage areas. This definition is extremely limited and not of much value in terms of actual expansion of coverage or improved urban access.

Nursing groups continue to work with Senators Grassley and Moynihan, the original co-sponsors of the legislation on which the amendment is based, as well as Finance Committee staff, to move this legislation this year.

Current House and Senate Appropriations for Nursing Programs

(All figures in millions of dollars)

Nursing education program:	FY'92	Senate	House
Advanced Nurse Education	$12.4	$12.4	$ 9.2
Nurse Practitioner/Midwives	14.6	15.5	10.8
Special Projects	11.0	10.5	8.1
Traineeships	14.1	14.1	10.5
CRNAs	1.9	2.7	1.4
Undergraduate Scholarships	2.3	0.0	1.8
Loan Repayment	1.4	2.4	1.1
Disadvantaged Assistance	3.4	3.3	4.1
Totals	**$61.4**	**$61.1**	**$46.9**

National League for Nursing 1992-93 Professional Development Programs

November

CHALLENGING ISSUES IN GERIATRICS

November 13
Guest Quarters Suite Hotel
Boston, MA

November 16
Holiday Inn Union Station
Indianapolis, IN

November 20
Hyatt Regency New Orleans
New Orleans, LA

November 8

COUNCIL OF COMMUNITY HEALTH SERVICES ANNUAL MEETING

Crystal Gateway Marriott
Arlington, VA

(In conjunction with the American Public Health Association Annual Meeting)

December 10 -11

THE NLN FACULTY INSTITUTE

The Breakers
West Palm Beach, FL

January 12 -15

COUNCIL FOR THE SOCIETY FOR RESEARCH IN NURSING EDUCATION ANNUAL MEETING

Sheraton City Center
Washington, DC

January 22 -23

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AMSTERDAM I & II: Orthodoxies and Heresies

Frank R. Buianouckas, PhD

In the coming months, this column will feature writings about AIDS by a diverse group of community-based practitioners, service providers, policy makers, teachers, and activists. This month's guest author is Frank R. Buianouckas, PhD, of City University of New York/Bronx Community College, who shares his views of two recent international conferences on AIDS. He elaborates on topics touched on here in a previous column entitled, "HIV: Sole Cause or Co-Factors?"

—Marck Fedor

The city of Amsterdam, the Netherlands, hosted two separate conferences on Acquired Immune Deficiency Syndrome this past spring and summer. The first was the "International Symposium: AIDS, A Different View," which took place on May 14-16, 1992. Approximately 250 people attended. This conference was sponsored by the Dutch group Stichting Alternatief Aisdonderzoek. The second was the "VIII International Conference on AIDS/III STD World Conference," July 19-24, 1992, sponsored by Harvard University and the city of Amsterdam. There were over 10,000 attendees. Originally, this meeting was to be held in Boston, but U.S. immigration laws concerning persons with AIDS or persons with antibodies against Human Immunodeficiency Virus (HIV) are so restrictive that it became politically impossible to hold the conference in Boston.

The July conference was mostly concerned with the pathogenesis of AIDS, i.e., how HIV actually causes AIDS. There were four distinct hypotheses proposed and discussed at length, along with some 4,500 other talks, poster sessions, and minicourses. There was also a huge area set aside for the drug manufacturers, laboratory equipment manufacturers, diagnostic laboratories, book sellers, condom salesmen, and AIDS activists from the world over.

The news-making event at the conference was the forced admission that in numerous cases worldwide there exists what is essentially AIDS without HIV. One by one, researchers from around the world began to admit to encountering cases of individuals with all the symptoms of AIDS, including key defining opportunistic infections, but no evidence of HIV or its antibodies. At a press conference attended by the world's leading news reporters on AIDS and the major AIDS researchers of the United States—including the National Institutes of Health's Anthony Fauci and the Centers for Disease Control's James Curran—panelists were asked to respond to the question, "What do you think Peter Duesberg (distinguished cell biologist and member of the National Academy of Science, who has consistently stated that HIV is not the cause of AIDS) would say about AIDS without HIV?" Curran angrily replied, "HIV is the cause of AIDS! All we have to do is figure out how it does it!"

Why two conferences? Unfortunately, some of the scientists involved in AIDS research have become so intolerant and inflexible that people writing in official journals or other publications aimed at the "AIDS audience" don't hesitate to use the labels "orthodox" and "heretic" when discussing differing approaches to the nature and treatment of AIDS. The "orthodox" are those who believe that HIV is the sole cause of AIDS, and the "heretics" are almost anybody else. As these labels indicate, there is essentially no room for communication between the two groups.

From the relative sizes of the two conferences, it would appear that the orthodox far outnumber the heretics—but science is not an election. There are very strong biophysically measurable data that the heretics hold up to the orthodox to show that HIV is not sufficient to cause AIDS and may not even be necessary for AIDS. Yet the fact remains that in order to be diagnosed with AIDS, a person must have antibodies against HIV (must, therefore, have been infected with HIV), and must have had some other defining disease. There are some twenty-five defining diseases. So there is some unsupported presumption that HIV is necessary for AIDS.

What is presumed is that a person with a "high-risk" background, a defining disease for AIDS, and no HIV or antibodies to HIV, will nonetheless *eventually* test positive for HIV and is therefore treated as a person with AIDS. To be treated for AIDS in the orthodox fashion means that the equation HIV = AIDS = Death is accepted as truth. So to stave off opportunistic infections, the patient is encouraged to take highly toxic antivirals such as AZT, ddI, or ddC, along with a host of other toxic drugs used as prophy-

laxis against these various twenty-five diseases. The deadly toxicities are ignored since the person is considered doomed, and these toxic drugs are held out as the only hope of survival "until something better comes along."

The heretics more or less support the premise that AIDS is multicausal. This approach emphasizes the so-called cofactors that are invariably found in people with AIDS. The word cofactor is troublesome, however, because it still presumes HIV to be causal, when in fact all research to date shows that HIV is a marker for a somehow perturbed immune system and not necessarily the cause of the perturbation. [See "A Dangerous Talk with Dr. Sonnabend," by Michael Callen, *QW*, September 17, 1992—*ed.*] Cofactors include abuse of recreational drugs, numerous infections with other viruses besides HIV, infections with bacteria and parasites, rage at family, low self-esteem, and drug-powered compulsive sex to mention a few. Some combination of these factors almost always precede an infection with HIV. A person need not have all the factors; one or two may well be sufficient to toxify the immune system. It must be emphasized that in order to become infected with HIV, the person must be the recipient of HIV-infected blood and must be susceptible or predisposed to infection with HIV. Other high-risk factors include blood transfusions and hemophilia. Taking another person's blood into one's own circulatory system is high-risk behavior!

It should be noted here that while some 15,000 hemophiliacs were infected with tainted blood products nearly ten years ago, less than 1,800 have been diagnosed with AIDS. In Great Britain, there are only nine hemophiliacs diagnosed with AIDS. Moreover, there is a paucity of studies of hemophiliacs with HIV comparing their life expectancy to those who are HIV negative. Is it wrong to ask whether hemophiliacs such as Ryan White died from AIDS-related conditions or those related to hemophilia?

The May conference put forward two conclusions:

1 The multicausal hypothesis is the best actual working premise for the research and treatment of AIDS.

2 New criteria must be defined to determine the effectiveness of therapy and therapists treating AIDS. Studies ought to be conducted with a focus on therapies used and favored by long-term survivors.

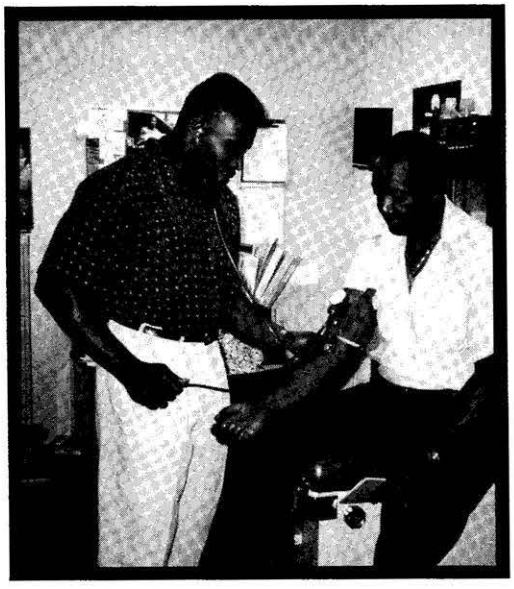
The persons with AIDS (PWAs) interviewed by Michael Callen in his book, "Long Term Survivors" did not use AZT. Each had developed a personal plan for recovery, including an emphasis on a spiritual program. The one person interviewed who was not alive for the second edition of the book died after beginning "treatment" with AZT.

One of the most exciting outcomes of the May conference is the world-wide unity of health care activists who agree that HIV should take a back-seat role in AIDS treatment. Professor Luc Montagnier of the Pasteur Institute of Paris, the discoverer of HIV, attended both conferences. At the July conference he stated, "I think we should put the same weight on cofactors [as we have on HIV]." People with AIDS ought to concentrate on keeping healthy and stay away from toxic substances. That definitely includes the severely toxic drugs like AZT, ddI, and ddC, as well as the equally toxic prophylactic drugs.

The heretics see the message HIV = AIDS = Death as a major threat to the health of patients. A large responsibility for this message rests with the medical community which has failed to inform their patients about existing PWA groups that are a repository of information on how a person with AIDS can influence his or her own malady.

Of particular note are the groups HEAL, New York, and HEAL, London, which are proposing a four-pronged program of homeopathic detoxification, nutrition, psychosynthesis, and psychotherapy through the arts; and the Compass Support Group in London, which offers outings such as mountain climbing and sailing expeditions for people who have been diagnosed with terminal illness but still have the desire and ability to live their lives as fully as possible, one day at a time.

How to START a NURSING CENTER



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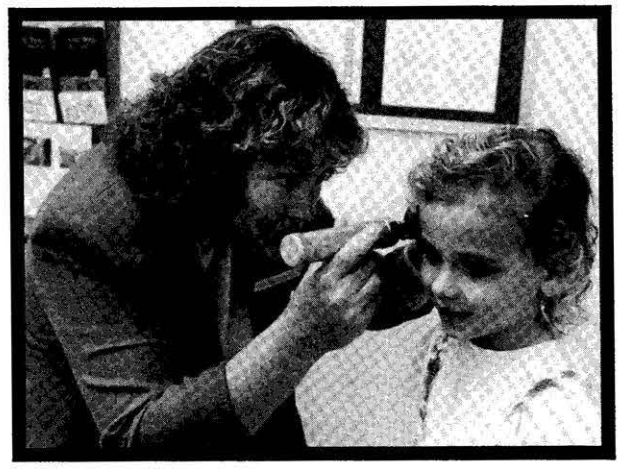

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Health & the Public Trust:
The Next 100 Years

CALL FOR NOMINATIONS
NLN Board of Governors and NLN Committee on Nominations

Over its history, the NLN's national and international leadership in health care and higher education has addressed some of the most critical concerns of the general public, diverse communities and its own constituencies. The members of NLN Board of Governors have been remarkable individuals with exciting visions and sophisticated practical approaches to building a strong organization. At the beginning of our second century, the League has never been better prepared to serve the people by working to assure appropriate and accessible health care.

Now, nominations are sought for those who will continue this tradition of public accountability. All individual members, agency members and constituent leagues are encouraged to suggest candidates for the 1993 elections for positions on the NLN Board of Governors and the NLN Committee on Nominations.

The Nominations Committee is especially interested in reviewing recommendations that will assure an NLN Board with a breadth of experience in the national and international policy discussions on health and higher education; a deep understanding of our society's multi-culturalism; and a demonstrated expertise in public/private approaches to creative systems of health care delivery and higher education.

The Nominations Process

- The NLN Committee on Nominations will prepare, from the suggestions of the membership, a slate of candidates for the following elected positions:
  —President-Elect
  —Treasurer
  —Two Governors-at-Large (one of whom must be a consumer)
  —Three members of the NLN Commmittee on Nominations

- **Individual members, agency members, and constituent leagues** may submit suggestions for elected positions to the NLN Committee on Nominations by November 15, 1992, directly by letter to the NLN Committee on Nominations on the form available from NLN.

- NLN will contact the individuals suggested for nomination to obtain their consent and to gather biographical information.

- The Committee on Nominations will review all suggestions received from agency members, constituent leagues, and individual members.

Health & the Public Trust:
The Next 100 Years

CALL FOR RESOLUTIONS
1993 NLN Biennial Convention

In our commitment to assuring quality in health care and higher education, which specific projects will NLN members take as their own? Which of the many challenges facing us should the NLN address? Attention to which of the emerging issues in our society will identify the League as it begins its centennial celebration? What will be our focus?

Resolutions discussed and voted on at the biennial convention is one way of influencing and directing NLN's activities. In most recent years, for example, the League's leadership in developing and advancing the Agenda for Health Care Reform was supported by a membership vote in 1987; our expanded attention to international concerns was passed unanimously in 1991 as was our position on direct reimbursement for nurses.

NLN's Committee on Resolutions seeks your ideas in the form of resolutions which might be considered at the League's Biennial Convention, June 6-10, 1993 in Boston. Please submit resolutions to the Committee by February 2, 1993 within the guidelines below.

Criteria for Resolutions

The following criteria govern proposed resolutions. Resolutions may: (1) declare NLN's position on social and health matters of significance to nursing; (2) support or take issue with actions of other organizations that involve or relate to nursing education, nursing research, or nursing service; (3) request action by the NLN Board of Governors for changes in NLN programs; or (4) request individuals or groups to take action on behalf of nursing. *Note:* NLN policy does not permit resolutions that single out individual persons, agencies, or organizations for commendation or honor. Such resolutions, if submitted, will be received by the NLN Committee on Resolutions "for information only" and will be directed to the office of the NLN Chief Executive Officer for appropriate action.

The Committee on Resolutions will

- review all resolutions in the order in which they are received;
- edit, rewrite, or combine the resolutions (in the event two or more resolutions call for the same action)
  a. for clarification and style,
  b. to verify that they are consistent with the bylaws and policies of NLN.
- request additional information on any proposed resolutions.

Submitting Resolutions

Resolutions proposals may be submitted directly to the NLN Committee on Resolutions by: any individual or agency member of NLN or any group of NLN members in good standing; any NLN Council or Committee; or any constituent league. Please note, however, that a member number—either individual or agency—must appear on the resolution (see below for details).

Proposals for resolutions should state, in the accepted form for resolutions (see *Robert's Revised Rules of Order*), the exact action desired and should include specific documentation/rationale to support each "whereas" statement in the preamble and the cost of implementation (if any) of the "resolves." The importance of the problem or issue being addressed will be clarified or emphasized for the Committee by the enclosure of substantiating documents.

The identities of persons, groups, agencies, or leagues endorsing or presenting the resolution and their relationship to the League must be clearly stated. The member number of the individual or agency sponsoring the proposed resolution must appear on the submitted resolution; in the case of a resolution submitted on behalf of a member agency, the signature of one of the two designated agency representatives must appear on the form, in addition to the agency's member number.

All resolutions—from individuals, agencies, councils, or constituent leagues—must be received by the NLN Committee on Resolutions by February 2, 1993. The resolutions will be published in *Nursing & Health Care* and will also be distributed at the Convention. **The only exception for the deadline of February 1 will be made for "late-breaking" resolutions—that is, those concerning last-minute (i.e., subsequent to February 2, 1993) political, legislative, or economic developments that are of crucial importance to the profession nationally.**

Resolution proposals submitted before the February 2 deadline should be mailed to: NLN Committee on Resolutions, Attention: H. Jewel Moseley, Chair, National League for Nursing, 350 Hudson Street, New York, New York 10014. Dr. Barbara Murphy at the NLN is available to answer questions or provide assistance to those wishing to develop resolutions.

Hearing and Disposition of Resolutions

The NLN Committee on Resolutions will hold an Open Hearing on Resolutions at convention to give opportunity for clarification of intent and purpose of proposed resolutions and for all NLN members to express their views on each resolution. Proposed resolutions will be scheduled within time frames with the schedule distributed prior to the open hearing. Proposed resolutions that are similar in nature or related to one another will be grouped within the same time frame. Following the open hearing, the NLN Committee on Resolutions will prepare a report recommending a disposition for each resolution received and heard during the open hearing. This report will be duplicated and distributed at the final business meeting of the convention.

Health & the Public Trust:
The Next 100 Years

CALL FOR NOMINATIONS
1993 NLN Biennial Awards

Always special, NLN Awards are especially significant in 1993 as the League begins its Centennial Celebration. Past award recipients have reflected the values of NLN membership---commitment, collaboration, a respect for the collegiality of the nursing community, and joy in the work of health care and higher education.

The NLN Awards Committee is seeking to honor those nurses and others who continue this tradition. Awards will be presented at the Opening Ceremony of the NLN's Biennial Convention, June 6-10, 1993 in Boston. The awards, their purpose and, where applicable, their criteria are listed below. Nominations can be made on the official nomination form and returned to the NLN Awards Committee by February 2, 1993.

ISABEL STEWART AWARD

For excellence in the teaching of nursing by an NLN member who is or has been a faculty member in an accredited school of nursing; is nationally or internationally recognized for creative and inspirational interactions with students from diverse backgrounds, as a wise mentor for junior faculty and a supportive colleague among peers. Award: Plaque. (This is the first year for this prestigious award.)

NLN DISTINGUISHED SERVICE AWARD

In honor of an individual, group or team for outstanding leadership and service in the development and implementation of one or more of NLN's purposes and goals on the constituent league and/or national level. Award: Steuben crystal.

MARY ADELAIDE NUTTING AWARD

In recognition of outstanding leadership and achievement in nursing education or nursing service, having more than local or regional significance, by an individual or group. Award: Silver medal.

Criteria for Eligibility: The nominee may be a nurse or non-nurse who has made outstanding contributions to the field of nursing education or nursing service in the United States and/or other countries • Groups may also be nominated, such as schools of nursing or faculties of schools of nursing; or organizations, committees, or special groups appointed for study of nursing service and/or nursing education within official agencies.

LINDA RICHARDS AWARD

In recognition of a nurse, actively engaged in the field of nursing, whose contribution is unique, of a pioneering nature and of such excellence as to merit national recognition. Award: Pin bearing the likeness of Linda Richards centered on a Maltese cross.

Criteria for Eligibility: The nominee is a citizen of the United States of America • Is active in the field of nursing • Has furthered frontiers of knowledge, or has great potential for doing so, in one or more of the following areas: nursing care; nursing education; nursing service in hospitals, industry, public health or other agencies; research in nursing and/or allied disciplines; publications • Exemplifies creativity in theory and practice • Exemplifies the pioneering spirit.

LUCILE PETRY LEONE AWARD

For contributions to nursing education by an outstanding nurse-teacher with no more than seven years of teaching experience within the last ten years, who is a member of NLN and a faculty member of a nationally accredited school of nursing. Award: Specially designed certificate and check for $500.
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In honor of a nurse who has demonstrated unusual leadership in developing and administering community health services on a local, state or national level. Award: Plaque.

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To be presented for outstanding leadership and achievement in long-term care in the community. Award: Plaque.

JEAN MacVICAR OUTSTANDING NURSE EXECUTIVE AWARD

Recognizing an individual for excellence in leadership, achievement, and creativity of national significance in the field of nursing service administration. Award: Plaque.

ISAAC K. BECKES AWARD

Presented in recognition of the contribution to NLN of a layperson of national stature. Award: Plaque.

MARTHA E. ROGERS AWARD

Recognizing a nurse scholar who has made significant contributions to nursing knowledge that advance the science of nursing. Award: Plaque.
Criteria for Eligibility: The nominee influences scholarly development of nursing knowledge through creative approaches to nursing education • Influences the evolution of nursing knowledge and scholarly development in nursing through visionary and innovative approaches to practice • Conducts and communicates distinguished research in nursing • Advances nursing knowledge through theory development • Writes scholarly works that advance nursing knowledge • Gives history of recognized contributions that advance nursing knowledge.

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Ways of Teaching, Learning, and Knowing About

VIOLENCE *against* WOMEN

Jacquelyn C. Campbell

No one doubts any more that violence is a serious health problem. No one doubts that the health care system must become involved in decreasing violence – that the criminal justice system alone can not solve the problem. Violent and abusive behavior is one of the twenty-two priority areas of *Healthy People 2000* (United States Department of Health & Human Services, 1991), the blueprint for the official U.S. approach to health care. There are 18 major objectives in that section, with one directed at reducing woman abuse and one aimed toward reducing rape. The American Nurses Association (1991) recently issued a statement about woman abuse that reflects the important nursing research that has been conducted on the issue. The American Medical Association has made violence against women a priority issue, with much public fanfare. As a nursing educator, researcher, and clinician, I have been involved with this issue for the last 15 years. I am deeply gratified to see the official health policy-making bodies recognize what many of us in nursing have been working on for a long time. I am proud that nursing has taken a leadership role in changing health care policy about violence. Throughout the struggle to effect official change, my clinical practice with individual battered women has intersected with—and has been an integral part of—the research, education, and policy efforts. Without it, I am positive I would have burned out long ago; if one just concentrates on the statistics of violence against women in general and woman battering in particular, one quickly becomes overwhelmed and discouraged. I am also positive that the only way we will get students to be excited and energized and empathetic in their practice with survivors of violence is for them to get to know these women as people just like themselves. The only way we will get students to envision a role as leaders in a new health care system that will be responsive to victims of violence and actually begin to prevent further violence is for them to he involved in that effort as students. The kinds of clinical practice we provide for them have to be carefully planned, supervised, and guided with all our expertise as nursing educators. The new principles of the curriculum revolution (Moccia, 1991) provides the framework for clinical and classroom learning experiences, taking into account the "ways of knowing" (Belenky, Clinchy, Goldberger, & Tarule, 1986) of the students themselves.

The young woman who provided the impetus for my current practice and research career and the women's stories I have heard since provide the context for how some of the principles of education from Belenky and her colleagues (1986), Paulo Freire (1976), Peggy Chinn, and Pat Moccia can be applied to nursing education about woman abuse. Such case histories about real women demonstrate the strengths of survivors of violence so often forgotten in research and clinical articles concentrating on their pathology. Nursing education, based on student dialogue with women such as these, as well as principles of

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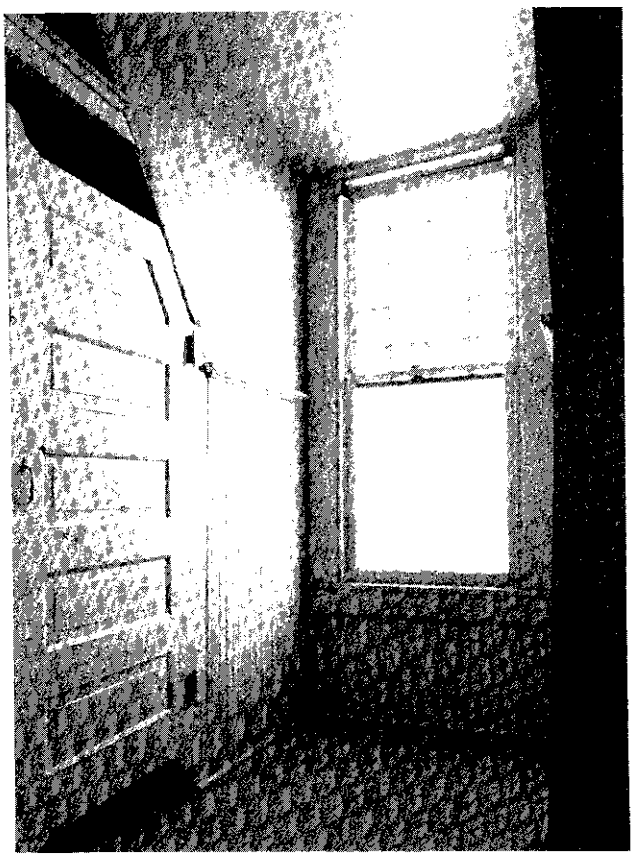
advocacy, mutuality, critique, and transformation can prepare nursing practitioners who take the lead in providing care for battered women that both individually empowers and collectively emancipates.

Abuse is obvious—if you know what to look for

Annie was 16 when I first met her. I was the school nurse in an inner-city high school in Dayton, Ohio. The year was 1970. Annie was pregnant, and unlike most parents in the African American community, her parents did not support her decision to keep the baby. They were justifiably proud of their brilliant, studious daughter and had planned for her to attend college. I also knew the father of the child, Tyrone, and found the two to be a particularly delightful couple. Tyrone always kept me laughing with his outgoing personality and his typically adolescent male highjinks and bravado. Annie was the quiet, supportive, maturer half of the duo, a young woman with the sweetest smile that ever was. I got to know both families well, and in my typical mode of nursing practice, got very involved. Because of what began to look like continued conflict between Annie and her parents, she moved out, successfully changed school policy that had previously excluded pregnant girls from school, had her son, Tyree, and against all odds, graduated from high school. I supported her in all of that, was Tyree's godmother, and continued to maintain close contact with Annie, Tyree, Tyrone (who lived with Annie off and on), and Annie's family who eventually reconciled with their daughter. I moved on to other jobs, not by choice (that school nursing job was probably the best I've ever had), but because one nurse per high school became a "luxury" school systems could not afford. I was happy to be a mentor to Annie during her first year at the local community college where I was teaching nursing part time, ecstatic to see her back in school.



In 1978 Annie was killed. Tyrone killed her, and Tyree found her dead. In trying to make sense of this tragedy, this horror, I found out that Tyrone had beaten Annie for at least six years prior to the killing, a fact that I had never known in six years of almost weekly contact. I had never been beaten personally, but at about that same time, I found out that one of my best friends, a doctorally-prepared nurse, had also been a battered woman for many years—to which I was oblivious.

> We can all easily learn about violence against women in any nursing setting where we find women.

I realize in retrospect that both women's abuse was perfectly obvious, if I had only known the signs to look for or the questions to ask. Which brings me to a fact that research has uncovered about abused women in the health care system today: At least 20–30 percent of all women in this country are in a relationship that has been or is currently physically abusive (Campbell & Humphreys, 1984). That means that 20–30 percent of the women seen in any health care setting are battered women. This has been found to be true of various health care settings: the emergency room, prenatal clinics, family planning clinics, and mental health clinics (Goldberg & Tomlanovich, 1984; Helton, McFarlane, & Anderson, 1987; Tilden & Shepherd, 1987). That means that if we as nursing educators and our students are not identifying approximately one fourth of our female clients as abused women, we do not know the signs to look for or the questions to ask. In studies of such health care problems as chronic pain, eating disorders, pelvic inflammatory disease, and depression, a history of violence is the major risk factor but was seldom assessed. In fact, research also shows that only approximately five percent of women are identified as battered in medical records (Tilden & Shepherd, 1987; McLeer & Anwar, 1989). Thus, a clinical experience with battered women can take place in any health care setting where students encounter adult women. The way to start addressing the problem is to teach students to ask.

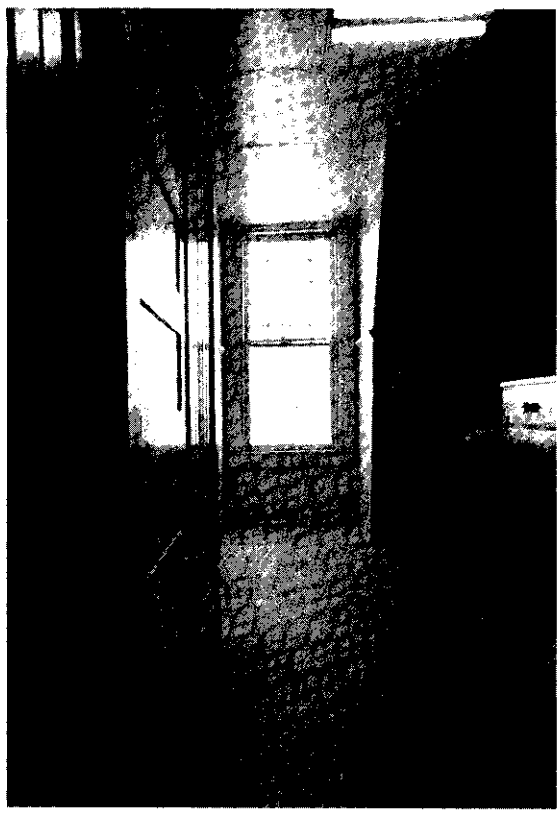
Media reports of incidents obscure true circumstances

What other health care problem that so endangers women is not routinely assessed for? Battering affects at least 1.8 million American women each year (Straus & Gelles, 1990). Homicide of women is the leading cause of death for young African American women aged 15–34 (DHHS, 1991). Three quarters of women killed are killed by a husband or lover or ex-husband or ex-lover, and at least two thirds of those killed by an intimate partner have been abused by him prior to the homicide (Campbell, 1992b). In fact, a battered woman is most at risk for being killed when she leaves her abuser or convinces him that she is leaving for good. Typically, the media describes such killings as a "lover's quarrel" or "domestic dispute" or comparable language that makes the onus of responsibility mutual, whereas the act is actually a femicide (killing of a woman). This is a perfect example of society's obfuscation of the reality behind violence against women.

> At least 20–30 percent of all women in this country are in a relationship that has been or is currently physically abusive.

Last year, there was a woman in the shelter where I practice who exemplifies the kind of abused woman who is seldom studied and who is mentioned in the media with the actual context of the incident obscured. Fortunately this woman, whom I shall call Maria, survived to tell her story. She and her husband were African American, middle-class, community college graduates, married for eight years. As is too often true in Detroit, her husband was laid off from a well-paying job and had been unable to find work for several years. They had made a mutual decision for her to return to school to obtain a baccalaureate degree while she worked part time. The closer she got to graduation, the more tension-filled the house became. He began to subtly sabotage her studying by starting fights when she was about to take an exam or needed to finish an important paper.

This is a pattern I have frequently found in my research, my practice, and my students. If you notice a last semester senior suddenly having trouble in her studies, under a great deal of stress, and not her usual self, ask about her relationship with her partner. Ask her directly, not with some vague inquiry about how are things at home. If she acts startled, tell her you are asking because this is not an unusual pattern, that the challenge to the societal norms of "manhood" or competence and control of a wife becoming a "professional" can be enormously threatening to some men and result in controlling behavior and even physical fights or pushing and shoving. Notice that it is best to ask about controlling behavior, physical fights or pushing and shoving with students and with clients. It is a relatively long way into the process of abuse that women actually label themselves as "assaulted," "abused," or even more threatening, "battered."



In Maria's case, she graduated and got a good job in spite of the tension at home. Her husband's attempts to control her continued, which precipitated a decision that Maria had been struggling to make for several years. She became certain that this was not a good marriage for her; she had put off having children because she was unsure about the solidity of the union. She informed her husband that she wanted a trial separation, or at least some marital counseling. He reacted with a great deal of sadness, terror, and anger. In the midst of the argument, he hit her, for the first time in their relationship. As she told me afterward, it was not exactly a punch but hard enough to scare her and hurt her. She reacted like many of us say we would, but I maintain few of us actually would: She immediately packed her things and left. She said she was leaving for good and went to her sister's house. The next night, in extreme distress, she had dinner with a close friend, a male friend, but only a friend. Her

husband found out from her sister where she had gone. After all, everyone was being civilized here, the sister was fond of both of them and thought there was a chance of reconciliation. He went to the restaurant, visibly distraught, apologizing and asking her to come outside and please talk to him. She didn't want to make a scene and went outside. Her husband proceeded to beat her so badly, kicking her repeatedly in the head and ribs, that she ended up in the intensive care unit. From there, good nursing care and dialog between nursing and the police got her discharged to the shelter. Her husband was released on bond, having no police record, and no record of prior violence. He was, after all, "somewhat justified in his anger," according to the judge before whom he was arraigned, because he had caught "his wife with another man."

One of the interventions that I provided for Maria was a chance to talk about her struggles with being labeled an abused woman in the hospital and sent to a wife abuse shelter. This was a label and an action completely foreign to her sense of self. She had thought abused women were pathetic, dominated, weak victims. One day she had been seen as a competent, well-educated, professional woman, who, if not totally happily married, was at least working on her marriage. Two weeks later she was an abused woman, grieving the loss of her most important relationship, and making decisions about how to save her own skin. I gave her protected space to do that, time to tell her story, some background information about abuse, but only what she needed at the moment, a realistic appraisal of her danger of being killed, answered some of her legal questions, assured her she was perfectly normal in her response, not to blame, and not alone. I also held her as she wept. I led a support group that she took part in according to the survivor model I outlined in an article (Campbell, 1986b). The nursing interventions I have learned over time from abused women and my students are in the nursing literature (e.g., Bohn, 1990; Campbell & Humphreys, 1984; Campbell & Sheridan, 1989; Landenburger, 1989; Bullock, McFarlane, Bateman & Miller, 1989).

The newspaper report of Maria's beating was buried on a back page, and referred to it in terms of an "estranged" husband attacking his wife when he found her in a restaurant with another man. It sounded as if Maria was to blame for the attack that almost killed her.

Abusive relationships entail risk of homicide

A study of homicides involving women was the first research I ever conducted. I was in the MSN program at Wright State University in Dayton under the direction of Peggy Chinn and Jo Ann Ashley when, about a year after Annie was killed, I was assigned to do some primary prevention teaching in a community health nursing clinic at the downtown YWCA. As I had been taught in my epidemiology course, I diligently went to the mortality figures to find out what I needed to be preventing among young African American women. I found that these women were most at risk, not for breast cancer or automobile accidents, but for homicide. And I was completely at a loss as to what I should teach them; my nursing education had not prepared me for this. I am afraid that even now most nursing education programs are not doing much to help nurses deal with the horrifying homicide statistics among young black men and women. Influenced by Peggy, JoAnn, Annie's death, my friend's abuse, and the violence that the young women who lived at the YWCA told me about, I decided to do my master's thesis on homicide of women. Instead of examining medical records, I examined police homicide files. (I will always thank JoAnn and Peggy for encouraging me to take a nontraditional path in nursing research.) I found mention of abuse in those files even though, at that point, police were not specifically asking anyone about battering. I found the unsolicited stories about abuse in the detective's notes from women's parents, friends, and neighbors. I will never forget the pictures and the stories in those homicide files; they are etched upon my brain forever (Campbell, 1991, 1992b). At about the same time, I discovered the first of the books and articles on battering in the literature, and I decided that if I wanted to prevent homicide of women, abused women were obviously the population at risk.

> Not all nursing educators need experience in wife abuse shelters to talk with students about woman abuse, but we as nursing educators have to think carefully about the kind of nursing education we provide about violence.

Nursing and the battered women's movement join

I found a group of women who were already doing what I wanted to do. The battered women's movement is a wonderful example of the kind of community-based, system-changing, advocacy movement that we see now in the AIDS and homelessness advocacy networks, and had seen in the now co-opted community mental health

movement. It grew out of the second-wave feminist movement of the early 1970s. Rather startling to me was that nursing was regarded with a great deal of mistrust by the battered woman's movement. We were seen as part of the system that had continued to victimize abused women, a medical system that needed radical change. I was pretty naive, not realizing that this attitude was both part of the grassroots versus establishment dichotomy and the larger nursing/feminism disagreements that had gone on since Florence Nightengale's time (Bunting & Campbell, 1990). It has taken 12 years, but I believe that nursing and grassroots feminism have taught one another enough that most of the distrust has dissipated. The Nursing Network Against Violence Against Women, a wonderfully informal advocacy organization dedicated to ending violence against women (King & Ryan, 1988) has worked together with the battered women's movement on a number of important projects. One of those projects was to include woman abuse in the *Healthy People, Year 2000* objectives for the nation's health. That document gave official recognition of the need to teach health care professionals about woman abuse, and nursing is listed separately and specifically in that document.

I started my nursing practice volunteering in wife abuse shelters in Detroit in 1980. I first provided nursing care to the women and children residents myself. Later, I led support groups, organized other nurses to provide nursing care, was on committees and shelter boards of directors, and arranged student placements in shelters for my own and others' classes. An impressive number of nurses across the country are doing and have been doing the same thing. My point is not that all nursing educators need experience in wife abuse shelters to talk with students about woman abuse, but that we as nursing educators have to think carefully about the kind of nursing education we do provide about violence. From nursing and other research, most notably studies by Tilden and Shepherd (1987), Rose and Saunders (1986), Kurz (1987), and McLeer and Anwar (1989), we find that health care personnel can learn the effects of violence and the mechanics of assessment and significantly increase their rates of identification and referral of battered women. However, we also note that identification rates go back down a year after training, that nurses and physicians attitudes about abuse reflect a great deal of victim blaming, and that nurses' practice with battered women reflects a great deal of distancing behaviors and subtle denigration. King & Ryan (1988) found that the majority of nurses deal with battered women in a paternalistic way rather than forming partnerships with them or empowering them. We have to confront attitudes, not just teach facts. We have to get away from the banking model of teaching that Freire (1976) describes as just depositing facts and progress to a pedagogy of dialogue and mutual respect and empowerment.

We find that nurses blame battered women for their abuse more if they are women of color, if they are on welfare, if they do not fit the profile of the pathetic victim, if they have ever left the abuser and returned, and especially if they do not tell us in clear unambiguous terms about immediate plans for leaving the abuser (Campbell, 1991). Yet current research on abused women, my own longitudinal research included, tells us that the majority of battered women do eventually leave the abuser (Campbell, in press; Okun, 1986). They usually leave and return to their abusers several times in that process. They first leave to make the point that the battering needs to end. They then begin to test the abuser's promises to change, their own resources, how the children fare without a father, and their own ability to survive economically and emotionally. Research is unequivocal in finding that there are no consistent personality or demographic characteristics of abused women, there is nothing about them that consistently predicts that they will be abused (Hotaling & Sugarman, 1986; Tolman & Bennett, 1990). We know that about one fourth to one third of all men have repeatedly hit a female partner and/or forced her into sex. Further, we know that when the abuser's female partner leaves him because of the battering, he will go on to

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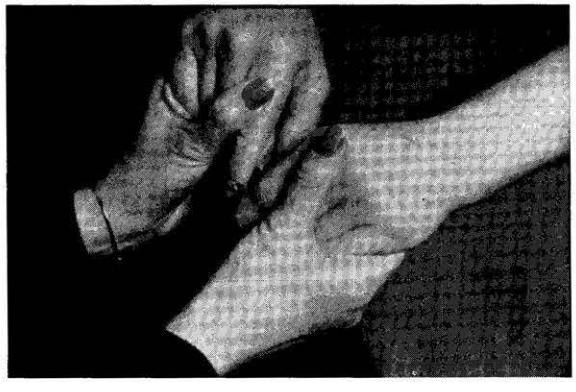

abuse his next partner unless he gets treatment specifically for battering. We also know that he certainly doesn't wear a sign saying, "I will abuse you once I am sure that you have fallen for my charms, and it will start gradually so that you will minimize it at first." Thus, it is clear that it becomes a matter of chance that any woman, any nursing educator, or any one of our students, acquires an abusive partner. When nurses get to know battered women they find that most are similar to Annie and Maria: bright, capable women who find themselves caught in a horrible dilemma.

Balancing relationships with one's own well being

From the work of Carol Gilligan (1982), Jean Baker Miller (1976), and Norma Lyons (1983), we are beginning to realize that women are both socialized to be, and perhaps are innately more attuned to relationships than men. Abused women, therefore, are caught between maintaining the relationship, economic survival, and his and the children's well-being on one side, and her own physical and emotional well-being on the other. Her fears for him and the children are usually realistic, since the abuser often threatens, and sometimes carries out his own suicide, or is able to wage successful custody battles for the children.

These realities are difficult for us and for students to understand. It is easier to categorize abused women in terms of pathological psychology and thereby distance oneself from a reality that may be only too close to home for female nursing students—which means most nursing students. Student attitudes can only be changed with dialog about these issues, sharing personal stories, and teaching about the wider context of the domination of women. The fact that woman battering is physical hitting and/or forced sex within a context of coercive control that crosses all domains of a woman's existence is a reality not captured by simply teaching this definition. Students need to get to know battered women personally in clinical experience and see role models of nurses conducting community advocacy for change.

What students may already know about abuse

My colleague, Janice Humphreys, and I found that significantly more of the students who took our elective on family violence had personally experienced such violence than those who took a nonviolence-related elective (Campbell & Humphreys, 1984). Part of that choice may have been related to their trying to find meaning in that experience as is common with abused women recovering from the abusive relationship (Campbell, 1986; Landenburger, 1989). Thus, we need to be sensitive to the possibility of such experiences in our students and realize that part of what they are doing when they talk about these issues is working through their own trauma.

Students who learn by accepting what others have to say are most comfortable when we as educators stay in the role of appointed experts (Belenky, Clinchy, Goldberger, & Tarule, 1986). They will pay close attention to what we have to say about abuse but never think of their own experience. They will be more apt to adopt a paternalistic, distanced way of relating to abused women. Even though such students are initially very uncomfortable with dialog, choices, examining feelings, and really getting to know abused women, they can make great strides when exposed to this kind of educational experience. I use novels to expose students to the realities of abuse before I expect them to become close to actual survivors of violence. Such novels as *The Color Purple* (Walker, 1982), *Beloved* (Morrison, 1987), *Sula* (Morrison, 1982), and *The Handmaiden's Tale* (Atwood, 1986), and *The Prince of Tides* (Conroy, 1986) give students a way to learn while still being able to distance themselves—by putting the book down when necessary.

Many formerly abused female students are subjective in their knowing about abuse—they only "hear" their own experience. They may be extremely impatient with currently abused women; since they were able to get out, other women should be able to also. Never-abused women are apt to define the experience of being abused in terms of one particular abused woman they have encountered or heard about. Yet these students, because of their openness to experience, will replace that kind of impression with a new experience with a survivor of violence. However, it is imperative that there be an experienced nursing faculty member, staff nurse, or shelter coordinator available to help the student process the new experience so it does not reinforce myths and stereotypes.

Students who are neither over-intimidated by experts nor reliant solely on their own experience to take objection to another's conclusions are good at critiquing others' work. Such critique is an absolutely necessary component of any course work on violence against women, since so much of what is "known" about abused women is based on either a medical-pathological or a political- and history- stripped model (Yllo & Bograd, 1988). Students at this level do not just accept us as experts, as "true experts must reveal an appreciation for complexity and a sense of humility about their knowledge" (Belenky, Clinchy, Goldberger, & Tarule, 1986). This is the level of knowing we are striving to help our students reach, and we can use a vehicle like studying violence against women to do so.

The vast majority of our students are still female and male students will find it difficult to relate to a topic like violence against women. As Lewis Okun (1986) so eloquently states, "most men were socialized to commit violence against women at the least in the form of trying to get sex by whatever means necessary." Happily, I believe the kind of men who are attracted to a career in nursing are more in sympathy with empowerment of women than many men. Such men are able to learn about violence against women with the same kinds of teaching methods already suggested.

Mutual respect engenders a new partnership

My own experience with individual battered women and community advocacy on issues of violence against women has provided me with a rich background and

commitment to this area of learning for nursing. The facts about violence as well as both the official government and professional positions on the subject require all of us to pay attention to the issue and teach it to students. We can all easily learn about violence against women in any nursing setting where we find women. Assessing for abuse in all settings will give us all extensive experience with battered women. The battered women's movement personified by the National and individual state Coalitions Against Domestic Violence afford us a chance for partnership toward social change to decrease violence against women. Nursing research has accumulated an impressive, but not yet overwhelming body of knowledge about abuse that can be easily accessed (Campbell, 1991). Teaching students about abuse can help them integrate what they learn from us about the strengths of battered women with their own subjective experience and critique of existing knowledge. Students can be encouraged to conduct their own clinical encounters with abused women so that they approximate the dialog we have with them in class. This mutual respect will help battered women themselves become partners with nursing on their own behalf.

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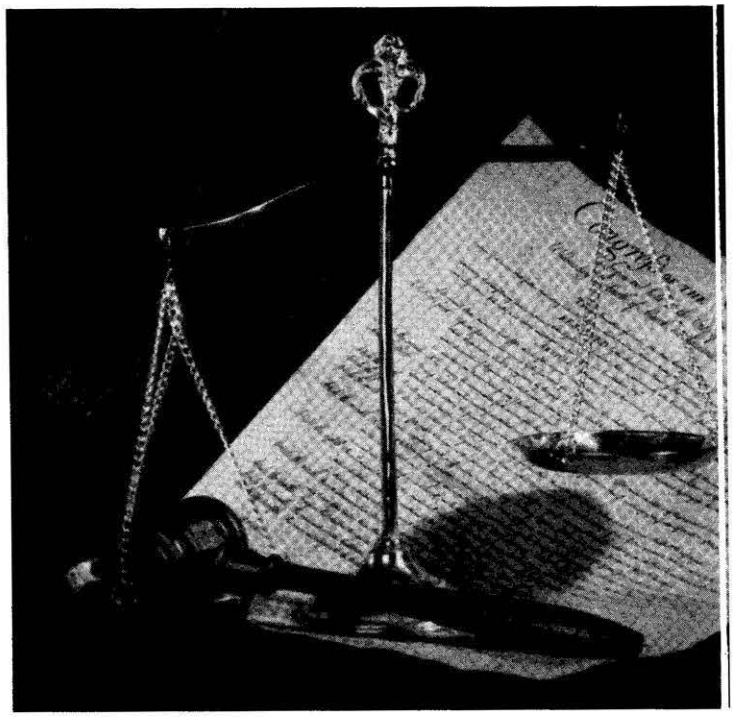
SUBSTANCE ABUSE During Pregnancy

Legal & Health Policy Issues

Jerelyn Weiss and Mary Jo Hansell



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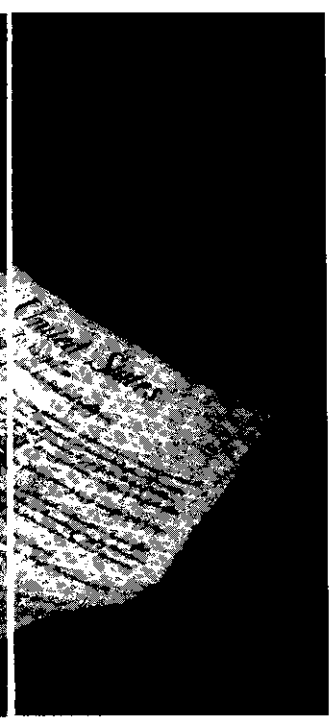
Nurses are well aware of the health hazards associated with substance abuse during pregnancy: maternal death, spontaneous abortion, preterm delivery, intrauterine growth retardation, handicapping conditions of the newborn, neonatal addiction, and AIDS (Ryan, Ehrlich, & Finnegan, 1987; Burkett, Yasin, & Palow, 1990; MacGregor et al., 1987; Fulroth, Phillips, &

Durand, 1989; Dixon, 1989). As consequences of substance abuse, these are preventable problems and nurses and other health professionals often feel angry and frustrated with the pregnant drug user. However, health professionals generally believe that addiction is a disease that can improve with treatment and tend to come out against mandatory reporting of substance abuse because they believe reporting abuse will keep substance abusers away from the health care system (Ooms & Heredeen, 1990).

Though most nurses accept at the intellectual level that in the case of drug addiction, the mother too is a victim, as child advocates, they often find themselves in conflict with the mother. Furthermore, other professional groups dealing with this group of pregnant women recommend other responses. Child welfare professionals tend to believe in mandatory testing and reporting of substance abuse because it puts them in contact with the families—ideally to provide essential support. Members of the justice system tend to want mandatory testing and reporting because they feel that the threat of prosecution will keep women from using drugs. Clearly, more research and interagency effort are needed to find the proper policy response to this complex problem. However, we need to pay special attention to the role nurses play in the various solutions being tried around the country and to review the various legal issues relevant to the problem of substance abuse by pregnant women.



Substance abuse during pregnancy: A problem with many ramifications

Substance abuse during pregnancy is creating a major national crisis. The estimate for the number of infants who have been prenatally exposed to substance abuse ranges from two percent of all live births (80 thousand infants) to 11 percent of all live births (375,000 infants) (Besharov, 1990; Chasnoff, 1988). The imprecision of this estimate leaves much room for population-based research. However, either estimate represents a tremendous challenge to health professionals.

Legal issues. An increasing number of pregnant women are being arrested for drug and alcohol abuse. These women face criminal prosecution under expanded interpretations of child abuse and drug trafficking statutes. From 1988 to 1990, approximately fifty women were arrested on criminal charges because of their alleged drug or alcohol use during pregnancy (Paltrow & Shende, 1990). Approximately 80 percent of the women affected are women of color (Paltrow, Fox, & Goetz, 1990). Though some would say these prosecutions create a conflict between maternal and fetal rights, the real conflict is between state police power and fundamental rights to privacy. Other legal issues raised are procedural due process and equal protection.

A right to privacy. In some cities, prosecutors have joined with hospital personnel to establish a procedure for prosecuting pregnant women who tested positive for the presence of illicit substances. In one public hospital, selective drug testing is performed on women who seek prenatal care or delivery. Those who test positive have their names turned over to the police. The police then go to the hospital, handcuff the women, some of whom are still recovering from the delivery, and take them to jail where they await bail. These women are charged with illegal drug use during pregnancy (Paltrow, 1990).

In other states, women are being prosecuted for drug trafficking or child abuse because they became pregnant while addicted to drugs. These crimes carry significantly greater penalties than possession or use of illegal substances.

The judicial system is penalizing women who abuse drugs and become pregnant for their decision to continue their pregnancies. In the *State of Florida v. Johnson* (1989), Jennifer Johnson was convicted of delivery of an illegal substance to a minor. The prosecutor argued that cocaine was delivered to Ms. Johnson's infant through the umbilical cord during the moments after birth but before the cord was cut. The prosecutor stated that Johnson's real crime was not delivery of drugs but the delivery of her child: "When she delivered that baby, she broke the law in the State." The court agreed, noting that Jennifer Johnson "made a choice to become pregnant and to allow those pregnancies to come to term" (*State of Florida v. Johnson*, 1989). Ms. Johnson gave birth to her son, Carl, in 1987, and to her daughter, Jessica, in 1989.

Penalizing women for their decision to continue their pregnancies constitutes a violation of the fundamental privacy guarantee that protects the right to decide whether or not to bear children (*Eisenstadt v. Baird*, 1972). The United States Supreme Court has acknowledged the "right to privacy" as a right to engage in certain highly personal activities. Specifically, the Court has characterized the following personal activities as fundamental rights: marriage, procreation, contraception, family relationships, abortion, and the right to choose between private and public education (*Loving v. Virginia*, 1967; *Skinner v. Oklahoma*, 1942; *Griswold v. Connecticut*, 1965; *Moore v. East Cleveland*, 1977; *Roe v. Wade*, 1973; *Pierce v. Society of Sisters*, 1925). The importance of protecting autonomy and the right to conceive was directly addressed by the Court in *Eisenstadt v. Baird* (1972): "If the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child."

There are three levels of scrutiny used by the Court to

evaluate an alleged governmental intrusion: rational basis, intermediate scrutiny, and strict scrutiny. When fundamental rights are at issue, strict scrutiny, the most rigorous test, is applied. Strict scrutiny requires a three-prong test. First, the government must prove that the action taken is necessary to further a compelling state interest. Second, the means used must be the most effective or narrowly tailored. Third, there must be no less onerous alternatives.

If strict scrutiny were applied to the facts given in the public hospital reporting program or the *Johnson* case cited earlier, the government would argue that the prevention of harm to and the survival of a healthy fetus are the compelling governmental interests. Authority to enact health laws and the laws that protect the public and public safety are included in the state police powers. Therefore, level one of the strict scrutiny test would be passed. However, in order to pass strict scrutiny, all three levels of the test must be met. The second prong or level is met by the government proving that the means used are narrowly tailored. In determining how great a burden a state regulation imposes on privacy interests, courts often focus on the intrusiveness of the necessary means of enforcement (Johnson, 1986). In *Griswold v. Connecticut (1965)*, for example, the Supreme Court held that a statute prohibiting the use of contraceptives violated the right to privacy in part because the state intrusions necessary for enforcement would be tremendous. Dawn Johnsen notes:

> ...in order to enforce fetal rights or state regulations dictating behavior during pregnancy, the state would necessarily intrude in the most private areas of a woman's life. The state would have to police what a woman ate and drank, the types of physical activity in which she engaged, with and how often she had sexual intercourse, and where she worked—to name only a few areas of regulation (Johnsen, 1986, p.619).

Johnsen's predictions became a reality under the terms of the State of Florida Court-mandated probation for Jennifer Johnson. Ms. Johnson was found guilty on two counts of delivery of a controlled substance to a minor. Both of the children, who tested positive for cocaine at birth, are healthy. However, the judge's sentencing requires Ms. Johnson to serve at least one year in a residential drug treatment program, during which time she will be subject to random drug testing. She must perform 200 hours of community service, must enter an intensive prenatal program if she becomes pregnant again, and is forbidden to use drugs or alcohol, go to bars, or associate with people who use drugs or alcohol—for 15 years (ACLU, 1990). Opponents to this ruling argue that this type of governmental surveillance is an unnecessarily sweeping state intrusion upon basic, Constitutionally protected individual rights and cannot be considered the most effective means to meet the narrowly tailored strict scrutiny requirement.

Finally, to satisfy the third prong of the strict scrutiny test, there must be no less onerous alternatives. Health professionals advise referral of pregnant addicts to drug rehabilitation programs early in the prenatal care process as a more productive and preventative alternative to arrest and jail sentencing. In support of a health policy versus criminal sanctions, fourteen public health and public interest groups, including the American Public Health Association, sought to file amicus briefs or "friends of the Court" articles of support for the defendant in the *Johnson* case. The California Medical Association's statement represents an example of the major concern of the health professions:

> A primary goal of CMA is to promote healthy mothers and healthy babies. While unhealthy behavior cannot be condoned, to bring criminal charges against a pregnant woman for activities which may be harmful to her fetus is inappropriate and discriminatory. Such prosecution is counterproductive to the public interest as it may discourage a woman from seeking prenatal care or dissuade her from providing accurate information to health care providers out of fear of self-incrimination. This failure concerning her health could increase the risk to herself and her baby (California Medical Association, 1989).

Though there is little research evidence one way or the other on how mandatory testing and reporting affects prenatal attendance (Ooms, 1990), many health professionals agree that the least onerous alternative is active health education and the creation of family centered treatment programs for prenatal and postnatal rehabilitation and support (Chavkin, 1990). Resorting to criminal charges for a mother's unhealthy behavior during pregnancy may be counterproductive. And in cases where one infant has already been hurt by drugs, the woman needs rehabilitation in order to prevent future pregnancies being complicated by the same problem.

We need to pay special attention legal issues relevant to substance abuse

Fetal rights. Fetal rights are a recent legal development. Historically, it was only after the fetus became a person at birth that it acquired legal rights as a separate entity (Johnsen, 1986).

Recognition of the existence of the fetus as part of the pregnant woman has been necessary to protect the interests of born persons, both the subsequently born child and his or her parents. *Cowles v. Cowles,* an 1887 case involving property law and the right of inheritance, was one of the first instances of legal recognition of the fetus. In *Cowles,* the court allowed relatives of the decedent conceived before his death but born thereafter to inherit as if they had been born in the lifetime of the decedent. For the first time in 1946, civil law acknowledged tort claims brought by children for injuries inflicted prior to birth (*Bonbrest v. Krotz,* 1946). This recognition created no conflicts between the interests of pregnant women and their unborn child.

During the last five years, courts have begun to follow

theorists like Robertson who suggest a woman who "has chosen to lend her body to bring [a] child into the world" has an enhanced duty to assure the welfare of the fetus, sufficient even to require her to undergo caesarean surgery (Robertson, 1983a, pp. 405, 456). In a small number of cases, courts have recognized fetal rights' theories and used them to the detriment of pregnant women. By granting implicit legal recognition to fetuses, doctors have forcibly, through court orders, subjected pregnant women to caesarean sections despite the patients' explicit refusal (*In re A.C.,* 1990).

In 1982, Robertson supported a theory of "contingent legal personhood" which would subject women to retrospective criminal and civil liability for all damaging acts and omissions before a child is born (Robertson, 1983b). Today, that theory has become a reality as government restraints are being placed on a pregnant woman's physical activities, diet, and lifestyle. Mothers are being held liable in tort for injuries to children occasioned by their "prenatal negligence," and terminally ill pregnant women are being excluded from the protection of "living will" statutes (Gallagher, 1987). Defining "the duty" of a prenatal patient is extremely difficult when the variables for potential harm to the fetus are so numerous. Illegal as well as legal behaviors cause damage to developing babies. "Women who are diabetic or obese, women with cancer or epilepsy who need drugs that could harm the fetus, and women who are too poor to eat adequately or to get prenatal care could all be characterized as fetal abusers. Pregnant women engage in all sorts of behaviors that could expose their fetuses to harm, including flying to Europe and cleaning their cat's litter box" (Paltrow, 1990; Wald, 1990; Guttmacher, 1984).

Thus, the potential consequences of expanding fetal rights could place prenatal women in constant fear of making the wrong lifestyle decision and thereby becoming subject to criminal prosecution.

Maternal–Fetal Conflict. In 1990, the Washington, D.C. Court of Appeals case *In re A.C.* (1990) dealt directly with the issue of maternal-fetal conflict. This case originally came before the trial court when a hospital petitioned an emergency judge for declaratory relief as to how it should treat its patient, A.C., who was close to death from cancer and was twenty-six and one-half weeks pregnant with a viable fetus. After a brief hearing the court proceeded to a balancing analysis and ordered a caesarean section to deliver the fetus. The caesarean was performed, and a baby girl was delivered. The child died within two and one-half hours, and the mother died two days later. The Appeals Court held the trial court erred in weighing the rights of a terminally ill pregnant woman against the interests of the state without first obtaining competent refusal from the patient to go forward with the surgery or finding through substituted judgment that the patient would not have consented to surgery.

This case is directly related to the issue of fetal rights because it outlines who controls the course of medical treatment when a competent patient's desires are in conflict with her unborn fetus and the medical advice of her doctor. The Appeals court held that in a case where the medical interests of the mother

to the role nurses play in the the various problems of by pregnant women.

and the fetus are in sharp conflict a trial court must determine, if possible, whether the patient is capable of making an informed decision about the course of her medical treatment. If she is, and if she makes such a decision, her wishes will control in virtually all cases.

If the court finds that the patient is incapable of making an informed consent (and thus incompetent), then the court must make a substituted judgment. This means that the court must ascertain as best it can what the patient would do if faced with the particular treatment question. Again, in virtually all cases the decision of the patient, albeit discerned through the mechanism of substituted judgment, will control.

The issues of whether or not, or in what circumstances, the state's interests can ever prevail over the interests of a pregnant patient, was not decided. However, the court emphasized that it would be an extraordinary case indeed in which a court might ever be justified in overriding the patient's wishes and authorizing a major surgical procedure such as a caesarean section (*In re A.C.*, 1990).

Finally this court addressed Robertson's theories directly by noting that even though there are those who suggest fetal cases are different because a pregnant woman has "an enhanced duty to assure the welfare of the fetus...," a fetus cannot have rights in this respect superior to those of a person who has already been born (*In re A.C.*, 1990, p.1244). This case represents the most recent court evaluation of the issue of maternal-fetal conflict. It remains to be seen how other jurisdictions will decide on this issue.

Procedural due process. The Fifth and Fourteenth Amendments of the United States Constitution prohibit government actions which would deprive "any person of life, liberty or property without due process of law." Notice of the charges and a fair hearing constitute procedural due process (Nowak, Rotunda, & Young, 1986).

Until recently, pregnant women who abused drugs or alcohol were arrested under child abuse statutes. Since these statutes were created to provide state protection to born persons from post-birth actions, the cases were eventually dismissed. A fetus was not considered to be a "person" as the word is used in the Fourteenth Amendment (*Roe v. Wade*, 1973). From 1986 to 1990, a number of states amended legislation by redefining the term person to include the fetus, thereby eliminating the possibility of procedural due process challenges (Johnsen, 1986).

Equal protection. Substance abuse during pregnancy is common regardless of race and socioeconomic status.

Penalizing women for their pregnancies constitutes a privacy guarantee that whether or not

Yet a discrepancy in reporting substance abuse to the authorities means that 80 percent of the women arrested for alleged alcohol or drug use during pregnancy are women of color (Paltrow et al., 1990).

In Pinellas County, Florida, the National Association of Perinatal Addiction Research and Education (NAPARE) found that among the 715 pregnant women they screened, 14.8 percent had a positive urine toxicology test. They found little difference between the women seen at the public clinic (16.3 percent) and those seen at the private offices (13.1 percent). Neither was there much of a difference between white women (15.4 percent) and black women (14.1 percent). However, Florida law requires that mothers known to have used alcohol or illicit drugs during pregnancy be reported to health authorities, and NAPARE found differences in the reporting according to race and socioeconomic status. According to the authors, "Despite the similar rates of substance abuse among black and white women in our study, black women were reported at approximately 10 times the rate for white women ($p<0.0001$), and poor women were more likely than others to be reported" (Chasnoff, 1988). Selective reporting and prosecution may raise race discrimination claims.

The Equal Protection Clause of the 14th Amendment provides that no state shall "deny to any person within its jurisdiction the equal protection of the laws." Strict scrutiny is applicable to government actions which adversely affect a suspect class only if the responsible governmental agency intended the action to have that effect and the action was purposeful. To date, suspect classifications have been limited to race or national origin and state government discrimination against aliens. The state prosecutions of pregnant women of color for alleged substance abuse may fall short of the Court-mandated race discrimination requirements unless challengers can prove discriminatory intent.

Also, while the state can and should enforce laws against pregnant women that apply to the general population, any action that singles out women for special penalties solely because they become pregnant discriminates on the basis of gender (Johnsen, 1986).

decision to continue their violation of the fundamental protects the right to decide to bear children.

The Equal Protection Clause protects women from discrimination on the basis of sex. Under federal law, gender-based classifications are subject only to an intermediate standard of scrutiny, in which the government is merely required to demonstrate that the gender-based classification be substantially related to an important overriding governmental interest (*Merrell v. All Seasons Resorts, Inc.*, 1989).

The Supreme Court has stated that discrimination on the basis of pregnancy does not discriminate against women, but rationally discriminates between pregnant people and nonpregnant people (*Gedulding v. Aiello*, 1974). Congress rejected this interpretation of sex discrimination for purposes of employment discrimination under Title VII, by passing the Pregnancy Discrimination Act in 1982. This Act amended Title VII's definition of sex discrimination to include pregnancy-related discrimination. However, as Johnsen points out:

> ....the Court has not to date reevaluated its holding that pregnancy discrimination is not sex discrimination for purposes of equal-protection analysis. Unless the Court reverses itself, it is likely to uphold, without even employing heightened scrutiny, any unequal treatment of the sexes that is predicated on the reproductive difference, regardless of the magnitude of the harm imposed on women (Johnsen, 1986, p.621).

Needless to say, charges of sex discrimination will not survive in a Court that refuses to recognize equality claims based on reproductive differences.

Are individuals required to behave more ethically than the society in which they live?

Beyond the legal debate, there are ethical issues to consider. Dr. Ruth Macklin maintains that pregnant women have a moral obligation to behave in ways that are likely to result in the birth of a healthy infant. However, this moral obligation assumes the woman is able to comply. For the pregnant woman who is addicted to alcohol or drugs, such an ability may not always be assumed. The woman may have no treatment programs available to her. She may try and fail to maintain sobriety. She may be so heavily addicted that she lacks the will to do anything but attain her drug of choice. Even if the pregnant woman has the moral obligation, (i.e., she is reasonably able), to keep herself in good health for the sake of her unborn child, Macklin makes the case that this should not be transferred into a legal obligation: "(1) Not everything that is immoral should also be made illegal... (2) Legal coercion of pregnant women is too strong a response to their behavior" (Macklin, 1990).

Macklin argues further that it is not ethically justifiable to "coerce, detain, or incarcerate women who use

drugs or abuse alcohol during pregnancy" when these practices differ from the legal treatment of other competent adults.

An additional issue is whether the individual should be held more accountable for her moral obligations than the society within which she lives. The United States is one of the richest countries in the world, apparently able to insure that each of its citizens has reasonable living conditions and access to basic health and social services. Yet, millions of U.S. citizens are impoverished, inadequately housed, and medically uninsured. The violence of poverty affects the lives of many more children than does prenatal substance abuse. Yet, it is more palatable to the populace and easier for politicians to deal with individual wrongdoers than to remedy societal wrongs. Is it ethical to place a stiffer legal penalty for the harm done by drug and alcohol abuse during pregnancy than for the economic violence faced by many U.S. children? Are these women being penalized because they have no power?

What can nurses do to combat the ramifications of prenatal substance abuse?

Nursing education. Currently, it appears as though minimal substance abuse content is incorporated into undergraduate and graduate school curricula (Hoffman & Heinimann, 1987; Murphy, 1989). Nursing educators must determine what knowledge and skill is essential to impart to students and evaluate nursing curriculum to determine if it meets the requirements of effective student preparation. Inclusion of information about the nature of psychosocial, physiological and legal ramifications of substance abuse will begin to prepare nursing students for the problems and health care needs related to substance abuse (Murphy, 1991). More exposure of nursing students to substance abuse in nursing schools is also likely to increase compassion for the substance abuser, as well as keener assessment, increased development of creative prevention programs, increased research and increased nursing specialization in substance abuse treatment centers.

Nursing practice. Nurses comprise the largest segment of health care professionals, yet surveys verify their educational experiences offer little to prepare them to develop substance abuse detection, treatment and prevention (Murphy, 1989). One means of determining the scope of the problem is development of an interview format or assessment tool that is adaptable to all ages and aids the interviewer in assessing multiple agent substance abuse (i.e., any combination of alcohol, cocaine, crack, heroin, methadone, over-the-counter drugs, etc.). Continuing education programs would then be needed to market the adaptable interview tool and to encourage hospitals, outpatient, school-based clinics, and private practices to utilize such an approach. History data forms would need to be redesigned to incorporate the inclusion of substance abuse information obtained from the interview. In addition, continuing education is necessary to train practicing nurses to identify, treat, or refer the substance abuser.

Research. Nursing research of substance abuse is limited (Murphy, 1991). Dr. Shirley Murphy states:

> A review of national and international nursing research conference programs held from 1982 through 1987 indicated one out of about every 200 papers was related to substance abuse. The one exception has been research regarding the impaired nurse. Alternatively, nursing leadership organizations, such as the American Academy of Nursing (1986) and the American Association of Colleges of Nursing (1987), have urged research and education in the general domains of health promotion, lifestyle behavior change, and preventive intervention (Murphy, 1991, p.24).

Dr. Murphy concludes that research of all types, i.e., interpretive and descriptive studies, are needed.

An example of much needed exploration would be a study conducted by nurses in collaboration with medical experts to investigate the effects of nursing counsel and education on pregnant substance abusers. The effects of various medical treatments with and without nursing support and counsel could be examined to see how well prenatal substance abusers adapt to the various medical regimes (e.g., methadone, acupuncture).

Nurse centers would be ideal facilities to promote nursing research and nurse-managed prenatal clinics for pregnant substance abusers. A comprehensive nursing approach would highlight thorough prenatal physical care with nutrition counsel, health education, nurse led support groups, parenting classes, home visits, day care, family planning and postpartum follow-up. Delivery service could be provided by midwives and/or obstetricians who participate in the total care plan.

Toward a unified health policy

It is likely that the solution to the problem of substance abuse during pregnancy consists of a multi-pronged response. Professionals in the health, social work, and justice systems will need to work together in what will essentially be a case management approach to the addiction problem. Probably more importantly, society needs to put additional resources into programs that promise to reduce the incidence of the problem. Improving the educational and job opportunities for all of our youth may do more to decrease drug abuse than narrowly-focused anti-drug programs.

Nurses can actively participate in bringing health, social welfare and criminal justice groups together. In the Bronx, New York, an innovative school and community-based drug prevention program aimed at high risk youths has recently been developed by collaborative efforts of the nursing faculty of Lehman College, New York, and the Assistant District Attorneys of Bronx County, New York (Lorui, Nkongho, & Wille, 1992). This program, entitled Substance Prevention and Intervention Network in Schools (SPINS) for Pupils, Lawyers, and Nurses (PLAN) Against Drugs, sends nurses and lawyers to inner-city elementary schools to talk with children who have directly or indirectly learned of the dangers of drugs.

Nurses and lawyers discuss career options in nursing and law, as well as various strategies to resist peer pressure to use drugs. Field trips to observe nurses and attorneys on the job are planned and there are opportunities for the students to act out the role of lawyer by participating in a mock court drug abuse trial.

Last year the New York Child Welfare Administration initiated a new approach to keep families together when infants are born to drug-abusing mothers. After initial screening to ascertain whether the women are treatable, those who qualify are assigned to a social worker and expected to participate in drug counseling sessions and classes on child rearing. Each week the women are tested for drugs. "Regular tests of the women who receive assistance for as long as 16 months have shown that more than 80 percent are staying away from drugs" (Treaster, 1991, p.B1).

In Oakland, California, a municipal court judge, Jeffrey T. Tauber, is combining the therapeutic principles of addiction programs and the incentive contracts used in juvenile court to prod adult offenders into drug treatments. It is working. The recidivism rate on arrest

for those in the diversion program has dropped 48 percent since last year (Gross, 1991). Cooperative versus punitive measures by health care providers, social workers, and justice department officials can promote the health of prenatal women who become substance abusers.

As respected health professionals, nurses are in a position to advocate for primary prevention programs as well as treatment programs for those already addicted. At the simplest level, nurses can talk to one another and to their employers about the need for drug treatment facilities that welcome pregnant women and mothers. Letter-writing to public officials recommending the allocation of resources to the substance abuse problem is another avenue for nursing action. Nurses are valued for the close-up experience they have and are also welcome members of local and state committees that deal with family health matters.

The problem is not bad mothers, innocent victims

The extent of the problem of substance abuse during pregnancy and the potential consequences for the next generation are profound. Too often the problem is characterized as "bad mother, innocent fetal victim." Cross specialty and multidisciplinary collaboration may be the key to the creation of broad public policy that will begin to prevent the casualties of substance abuse.

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Shortage as Shorthand

FOR THE CRISIS IN CARING

Barbara L. Brush

The perceived "nursing shortage" in the United States has been a prevalent, recurrent, and cyclical problem plaguing the American health care system for the past eight decades (Lynaugh, 1990; King, 1989; Fagin, 1988; Buerhaus, 1987; Aiken & Mechanic, 1986; Helmer & McKnight, 1988). Despite widespread attention and a myriad of recommendations from nurses, economists, physicians, hospital administrators, policy makers and others, the nursing shortage remains a persistent problem. The absence of a clear definition of "nursing shortage" and its attributes results in "confused responses that are dependent upon individual and often ad hoc interpretations" (Rodgers, 1989, p.30). Reluctance of the various aforementioned interest groups to let go of familiar ways of approaching the perceived crisis in nursing supply and demand as well as a failure to consider alternative solutions contribute to the problem's intractability.

Social historical analysis of this important and ongoing nursing problem may yield further or different understanding, interpretation, and definition of the "nursing shortage." By casting a wider net than our current understanding permits, we avoid the "shorthand" approach to a problem of considerable complexity and magnitude. We need to look beyond the "shorthand" view of the nursing shortage and consider the wider parameters of the crisis in caring.

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Authors and researchers examining the "nursing shortage" have addressed it using either an economic approach or a nursing (noneconomic) approach (Prescott, 1987; Buerhaus, 1987). For purposes of this discussion, the economic perspective will be characterized as a "rational" approach to the definition and characterization of the "nursing shortage" as it is based on reasoning and systematic measurement. The noneconomic approach, on the other hand, can be characterized as "nonrational" as examination of the concept is not limited to statistical and quantitative reasoning.

The use of the term "nonrational" is deliberate and political because it corresponds to societal assumptions about women's work. Women's work is generally the work of caring—for home, for children, for the sick. Nursing as women's work and caring as the emulation of nurses' work are difficult to measure. They are elusive to "rational," quantitative analysis.

How the shortage is defined in terms of market forces

Economists rely on assumptions about market operations when examining or defining the "nursing shortage" (Yett, 1965; Sloan, 1975). The relationship between supply of nurses or nursing, demand for nursing care, and the relative costs to hospitals to ensure adequate quality and quantity of nursing are central

ingredients. Thus, definition of the "nursing shortage" derived from a traditional market approach is concerned primarily with three things: wage structures, registered nurse participation rates, and hospital vacancy rates (Buerhaus, 1987; Clark, 1990; Prescott, 1987).

Wage structures do not fit market model

Foerst and Gareau (1972) defined the "nursing shortage" as "the difference between total demand (budgeted hospital positions) and the actual supply [of nurses]" (p.74). Others note the importance of wage and salary such that "nursing shortage" represents the inability of hospitals to fill budgeted full-time equivalent registered nurse positions at the wage hospitals are willing to pay (Ginzberg, 1967; Yett, 1970; Sloan, 1975) or when numbers of available workers increase less rapidly than the number demanded at previously paid salaries (Blank & Stigler, 1957). Ginzberg (1990a) defines the "nursing shortage" as meaning that "budgeted funds are available to cover the costs of hiring additional nurses but [the nurses] cannot be found" (p. 204).

Supply and demand is emphasized over supply and need in the economic model of the nursing shortage (Foerst & Gareau, 1972; Arrow & Capron, 1959; Prescott, 1987). Some argue that the increased demand for nurses was created by advances in medical technology combined with cost containment measures shortening patients' length of stay while simultaneously raising the level of acuity of care (Light, 1986; Aiken, 1987). High demand and short supply should yield wage inflation (Sloan & Richupan, 1975; Arrow & Capron, 1959; Blank & Stigler, 1957). However, notes Fagin (1982), "the principles of supply and demand and market pricing have not yet affected the shortage of nurses" (p.25). Studies of lifetime earnings potential of various occupational groups demonstrate that nurses have low relative salaries compared to other comparable groups, such as teachers and social workers (Aiken, 1989; Yett, 1970). Thus, the failure of wages to rise in response to the perceived imbalance between supply and demand creates a monetary disincentive perpetuating the "nurse shortage" (Aiken, 1989; Buerhaus, 1987; Hixson, 1981).

Blank and Stigler (1957) believe that a shortage existed whenever the price of a given commodity rose. In their analysis of engineers between 1950 and 1956 they demonstrated a 51.5 percent rise in average starting salaries for college engineering graduates. They argued that because salaries rose, there was a shortage of engineering manpower. But when nursing is examined using this wage theory and relative earnings approach, the sluggish or nonexistent wage response to the perceived "nurse shortage" casts considerable doubt on the very existence of a shortage of nurses (Butter, 1967). Thaker (1983) explained that shortage situations lead to price increases only in competitive markets and that nursing is not in a competitive market. Rather, he explained, nursing is a "derived demand"; it is the result of specific demand for health care services. If nursing is not in a purely competitive labor market, nurses' wages will not rise sufficiently to eliminate the perceived shortage. Some argue that nursing is not in a competitive market because hospitals exert monopsonistic or oligopolistic power (Sloan & Richupan, 1975; Aiken & Mullinix, 1987). Thus, nurses are in a "captive labor market" (Aiken, 1987). They are workers in an institutional cartel that deliberately depresses wages and perpetuates what Yett (1965) calls "market inelasticity." This phenomenon may be compounded by nursing's large female constituency who may also have considerably less geographical mobility than males and therefore, are unable to seek regionally competitive wages.

Hospital vacancy rates do not reflect need

While many question the validity and objectivity of hospital vacancy rates as an indication of demand, it remains the hospital industry's and other researchers principal empirical indicator (Aiken & Mullinix, 1987; Hixson, 1981; Olson, 1968). Vaughan and MacLeod (1985) suggest that hospital vacancy data is often based

on medical diagnosis. They noted that sick patients were defined by their medical rather than nursing needs. Hospitals with more acutely ill patients were "sicker" than those with greater numbers of chronically ill despite the high demands for nursing care for the latter. Thus, while these vacancy rates may be useful in determining the shifting supply of nurses, they are not an adequate measure of need for bedside care (Aiken & Mullinix, 1987). Hospital care equates with nursing care yet cost containment efforts and nursing personnel needs are contingent on medically-based criteria. Examined historically, the paradoxical relationship between nursing care and hospital function is appreciated.

In their early years, hospitals admitted patients specifically for nursing care. As surgical innovations and treatments (such as antibiotics) improved and scientific and technological discoveries became paramount, the focus of hospitalization shifted to medical care (Stevens, 1989; Starr, 1982). Today, as hospitals are faced with changes in health care financing and health care needs in the wake of the current AIDS crisis and emphasis on long-term care, they will be called upon to merge rather than delineate nursing from medical care.

Supply and demand is emphasized over supply and need in the economic model of the nursing shortage.

Hixson (1981) doubts the usefulness of "budgeted but unfilled" positions as an indicator of nursing shortage because he believes the term itself is ambiguous. He suggests that the "nursing shortage," as based on the criteria of hospital vacancy positions, does not reflect the general picture of nursing supply and demand. Not only are data limited to hospitals, but Hixson (1981) believes, the "shortage" is related more specifically to "a higher frequency of reported vacancies on evening and night shifts, in the more intensive and demanding specialties (i.e. ICU/CCU units), in rural and inner city hospitals and in smaller as opposed to larger hospitals" (p. 16). Certainly, studies have suggested that geographic distribution is a significant variable in reported nursing shortages (Sloan & Richupan, 1975). Further, some believe the preoccupation with hospital-based nursing shortages is linked to issues of consumerism: Buyers are willing to accept the costs of hospital care in contrast to other areas (i.e. nursing homes) that report shortages (Lynaugh, 1990; Ginzberg, 1990a).

Because of the ambiguity attached to vacancy rates as indicators of the nursing shortage, studies that analyze them for policy decisions often yield divergent outcomes. Prescott (1987) notes that reported hospital vacancy rates may be the ways and means for certain groups and interests to promote their own agendas. Vacancy rates are amenable to manipulation. If hospitals reduce numbers of budgeted positions, the shortage resolves; if hospitals increase budgeted positions, the shortage escalates. In this way, the cry of "nursing shortage" based on relatively unrelated measurements may promote and foster short-term idiosyncratic responses.

Registered nurse participation rates—too many are part time

Registered nurse participation rates reflect the degree of active employment of the registered nursing workforce as influenced by recruitment and retention efforts. Nursing's participation rate is estimated around 80 percent, which is generally high in a profession of predominately female workers. Many of the actively employed, however, are part time. These participation rates do not define the nursing shortage but attempt to explain it quantitatively. Thus, it is the perceived lack of personnel, or the inappropriate ratio of types of personnel, that contribute to the nursing shortage (Ginzberg, 1948; Brown, 1948). This implies that if enough individuals of the "right" qualification were recruited and turnover and attrition were avoided, there would be little if any problem.

On the recruitment side, efforts to attract men and minorities, as well as substitute foreign nurses, are proposed as both short- and long-term solutions to the shortage of nursing personnel (National League for Nursing, 1981; Christman, 1988; Carnegie, 1988; Ginzberg, 1990b). Christman (1988) noted that "the lack of democratization within the nursing profession is now a major reason for lack of adequate numbers to serve patients" (p. 62). The nursing shortage was a catalyst for the enlistment of nonwhites and males and the importation of foreign-trained nurses from countries like the Philippines, Ireland, and Korea—particularly after World War II (Halloran, 1990; Helmer & McKnight, 1988).

Writers differ regarding the efficacy and morality of importing foreign nurses from poor countries to richer industrialized nations. While many see the advantages of immigration as a temporary short-term solution to the critical shortage (Nelson, 1989; Grippando & Mitchell, 1989), others voice concern over the possible exploitation of foreign nurses (Maroun, 1990), the social effects in receiving countries (Ohndorf, 1989), and the impact of "brain drain" and escalation of nurse shortages in countries of foreign nurse origin (Ohndorf,

1989; Adams, 1968; Fortney, 1970; Ghosh & Ghosh, 1982). In addition, some believe nurse migration may contribute to the decline in quality of nursing care and the continuation of lower salaries in the United States, both of which perpetuate the shortage cycle (Buerhaus, 1987; Aiken, 1987). Others point out that, despite the significant attraction of foreign nurses to the United States, there was only minimal effect upon the number in the domestic nurse workforce (Mejia, Pizurski, & Royston, 1979).

Recruitment of men and minorities is another strategy for enhancing numbers of nurses. Nursing has been criticized for being "overwhelmingly female and white" (Ginzberg, 1990b, p.320). Some feel more men in nursing will guarantee more steady work participation and elevate depressed wages (Christman, 1988; Halloran, 1990). Halloran (1990) argues that more men in nursing may reduce the "economic bias associated with women's work and women's education" (p.552) and serve as a barometer to measure society's economic valuation of nurses. In essence, Halloran and Christman (both male nurses) propose the use of rational data to interpret nonrational women's work. They suggest that acceptance of men by nursing dilutes the notion of nursing as strictly "women's work," engenders social acceptance, and validates the work of caring as important. This notion must be placed in its historical context.

Men have been present in the nursing workforce for centuries. Nutting and Dock (1907) noted "...men [of priestly class, or belonging to military or religious orders] have been responsible for at least one half of the nursing service through medieval times up to a very recent period" (p.101). Roberts (1954), describing the beginnings of male nurse training programs in the United States and the advent of their nursing practice efforts, illustrated patterns of segregation and discrimination not unlike those of black nurses, who were predominately women (Hine, 1989). In determining the merits of enhancing numbers of both men and nonwhites to the nursing workforce, therefore, it is important to both understand the evolution of their growth in numbers and their roles in the advancement in nursing. Questions based on historical analysis can then be raised in light of contemporary suggestions. For instance, do men trained as nurses stay in "caring"? Are male and black nurses used appropriately?

Helmer and McKnight (1988) feel retention efforts are more effective and less expensive than recruitment strategies. They call for decentralized scheduling, staff development and educational opportunities among others strategies for encouraging the retention of older and experienced nurses. Additionally, in concordance with Aiken (1987), they advocate fewer, but better-paid, nurses rather than more nurses. Despite these authors' recommendations for retention, however, they still emphasize recruitment.

Prescott (1987) cites four major reasons for this supply-side strategy: a continuous and available supply of new nurses, the belief that it is cheaper to replace rather than retain staff, the notion that nurses are interchangeable, and the prevalent idea that adding more nurses will solve the hospital nursing shortage. The idea that it is less expensive to replace rather than keep staff is in direct contradiction to those who claim emphasis on recruitment actually keeps wages down and costs up more than if wages were elevated to retain nurses (Helmer & McKnight, 1988; Powills, 1989). Nevertheless, recruitment and the "more is better" ideology has prevailed over time.

Essentially, the economic perspective is a cannon fodder approach. Its historical precedents range from the use of student nurse apprentices for immediate hospital caregiving, through the development of practical nurse and nurse assistant programs after World War II, to the recent registered care technician (RCT) attempts. Short supplies of nursing personnel are viewed within a context of greater demand for nursing services. Advances in medical technology in particular, combined with medical insurance incentives, changes in patient mix, and hospital expansion drive much of the demand for nursing care (Aiken, 1990; Stevens, 1989; Light, 1986).

Noneconomic perspective: quality of care not quantity of nurses

The noneconomic perspective of the nursing shortage, while considering many of the economic points, incorporates job satisfaction issues into its definition. Prescott (1987) subdivides these issues into concerns about salary and benefits, control over basic working conditions, professionalization issues, and in some instances, increased and more complex technology with increased patient acuity and shifting patient demographics (i.e., the aging population). Furthermore, Prescott (1987) notes that nurses are concerned with supply and need or want rather than strictly supply and demand.

While demand is defined primarily on the basis of economic factors, need is assessed by considering the standards, values, and expectations that produce optimal levels of nursing care or service (Foerst & Gareau, 1972; Prescott, 1987). Fagin (1982) noted that need for nurses (or nursing) is a "value judgement related to quality that does not convert to 'demand'" (p. 26). Quality of care rather than quantity of nurses in service, therefore, is the central theme of the nursing or noneconomic perspective.

Maraldo (1990) claims that the root cause of the nursing shortage is poor use of nurses. For the past four decades, many studies have demonstrated that registered nurses devote considerable time to managerial, clerical, and technical tasks that could be performed by less skilled nursing personnel or non-nurses (Levine, 1969; Geister, 1957; Hughes, Hughes & Deutscher, 1958; Abdellah & Levine, 1954; Aiken, 1990). Abdellah and Levine (1954), for example, studied the activities of unit nursing personnel in three hospitals. Using work sampling techniques they attempted to answer four basic questions: (1) How much time was spent by various personnel on activities requiring their own skill level? (2) How much time was available for nurses to spend with patients? (3) How much nursing time was redirected to other activities that could be performed by other personnel? (4) What, if any, changes in staffing

might allow the nurses to nurse? Their findings showed that nurses spent anywhere from 11–22 percent of their time in non-nursing activities and 10–50 percent on activities of other level personnel. Nurses aides or orderlies spent a major portion of their time (80 percent) on patient care activities; professional nurses spent less time with patients than did any other nursing personnel. More recent work sampling studies demonstrate similar patterns of inadequate percentages of nurses' time spent in patient care (Hendrickson, Doddato, & Kovner, 1990; Misener, Frelin, & Twist, 1987; Rieder & Lensing, 1987).

Aiken (1989) contends that if the time nurses spent in direct care to patients doubled from its present 25–30 percent to 50–70 percent, the "nursing shortage" would be over. This view, supported by others, implies that the nursing shortage is less a shortage of nurse supply and more a shortage of nursing care (Hendrickson & Doddato, 1989; Jones, 1988). Thus, the "nursing shortage" provides a forum for discussion of caregiving that often goes unheeded in a society that continues to seek economic solutions to complex problems (Wolf, 1989; Lynaugh, 1990; Fagin, 1982). Nursing equates with care, yet nursing has not defined the work of caring as a monopoly. Therefore, the work of nursing may be performed by other "nurses," nurse's aides, licensed practical nurses, or more recently, RCTs. Time measurement of nursing tasks becomes the empirical indicator of adequate use, while care or the work itself remains ambiguous and diffuse. This stopwatch approach embodies the ideology of scientific management that measures work (and care) by tasks (Melosh, 1982; Geister, 1957; Benner, 1984). In this way, analyses of nurses' work are economically and rationally derived solutions to the noneconomic problem of a shortage of a more ambiguous abstraction: care.

As hospitals are faced with changes in health care financing and health care needs...they will be called upon to merge rather than delineate nursing from medical care.

A good example of how economic, highly rational solutions are used to solve nonrational concerns is the registered care technician proposal, adopted in February 1988 by the American Medical Association Board of Trustees. This proposal promoted an on-the-job training program whereby a new bedside caregiver would supplement bedside care by nurses. After an initial two-month training period, RCT trainees could do simple caregiving tasks (i.e., feeding patients), slowly progressing to more complex caregiving responsibilities as they moved through the nine months of training. It was medicine's solution to the critical shortage of bedside nurses (Davis, 1989). Bristow (1989) claimed that the RCT proposal was in line with nursing's vested interest to tap men and minorities toward health care delivery occupations without relying on foreign nurse recruitment strategies, as well as to address the needs of patients over nursing's self-interests.

The now defunct RCT proposal offered worker substitution in direct contradiction to claims by many experts that the nursing shortage is a result of growing demand rather than limitation of supply (Aiken, 1987, 1989; Helmer & McKnight, 1988; Clark, 1990). Some surmised that it would have actually further devalued the work of nursing and worsened the current shortage (Frels, Straub & Goldsteen, 1989; Bocchino, 1989). An economic analysis by Frels et al. (1989) demonstrated that while RCTs may have been a short-term solution, they were considerably less cost-effective than other proposed options. Service (1988) voiced concern that the addition of yet another patient care provider further stratified an already complex hierarchy of caregivers and challenged nursing's autonomy of practice. Proposals for worker substitution for nursing tasks have driven issues of professionalization and control of practice to the forefront in discussion of the "nursing shortage."

Fagin (1988) defined control of practice as "the power to influence decisions relating to giving and supporting nursing care through acceptance of shared priorities and regulatory standards" (p.311). Control or autonomy of practice is important in deriving a sense of work meaningfulness, empowerment, affiliation, and accomplishment (Deal, 1990). Control, in tandem with interdependence, enables nurses to implement changes in their work environment and shape a work culture (Kramer, 1990; Fagin, 1988).

Melosh (1982) defined "work culture" as "the distinctive language, lore, and social rules" created by nurses to interpret and shape their work (p.5). She centered her definition on nurses daily work experiences, making an assumption that all nurses share similar work cultures. Baer (1990) argues that nursing is actually comprised of three work cultures—practice, management, and teaching—and that they "compete for status, students' time and their piece of the meager pie assigned to nursing by the institution" (p.143). This wider view must be examined carefully because deterioration of the nurse's work environment has been implicated in the problem of recruiting and retaining nurses (Evans, 1989).

Magnet hospitals are manifestations of "cultures of

excellence" and give useful information about successful changes in the management of nursing resources (McClure, Poulin, Sovie, & Wandelt, 1983; Helmer & McKnight, 1988; Kramer, 1990; Fagin, 1988). The 150 "Magnet Hospitals" were so designated because of their ability to attract and retain nurses. Twelve characteristics contributed to their success (McClure et al., 1983):

1. An adequate nurse-patient ratio that assured quality of care.
2. Flexible staffing.
3. Flexible scheduling and elimination of rotating shifts.
4. Strong nursing and hospital administrations.
5. Primary nursing.
6. Clinical advancement opportunities.
7. Participation in management.
8. In-service and continuing education for all shifts.
9. Open communication between providers and administration.
10. Good nurse-physician relationships.
11. Longevity benefits for staff nurses.
12. Tuition reimbursement.

Thus, the successful institutions combined the economic and noneconomic concerns related to the "nursing shortage" so that nurses experienced control of practice and hospitals remained able to operate cost-effectively.

View the problem through a longer time frame

The traditional economic approach to defining and understanding the "nursing shortage" is wrought with ambiguity that makes standard quantitative research methodologies ineffective. As such, the nonrational, noneconomic perspective must be considered as carefully as the rational, economic approach if the perceived "nursing shortage" is to be adequately addressed.

Historical analysis of the relevant social, political, cultural and economic forces influencing the present nursing shortage may yield important answers to questions of cause and effect. Historical trend analysis may illuminate contemporary practices and policies related to the "nursing shortage." Lynaugh (1990) argues that the nursing shortage is not a continuation of the same problem over the past eight decades. Rather, the "nursing shortage" is a metaphor for the perception of insufficient nursing supply, inadequate control of practice, and concerns over professional autonomy that are derived from the particular time and social context in which it is proclaimed.

Historical analysis of the "nursing shortage" must also consider issues of women's work and comparable worth within the social construct of health care delivery. The works of Melosh (1982) and Reverby (1987) have given us beginning analyses of nursing as an example of women's work culture that helps explain the aforementioned nonrational concerns. Furthermore, understanding nurses' work culture may help define the nursing shortage more globally such that the nonrational, noneconomic perspective may be more readily integrated into rational economic approaches. Relying only on economic principles to define and resolve the problem is a shorthand approach to our longstanding concern and perpetuates unsuccessful strategies that may continue the cycle of the crisis in caring.

By placing the present in a longer time frame, we may help expand our present perception and facilitate the development of reliable, responsible, and cost-effective approaches in future United States "nurse shortages." It is important to consider antecedent events and consequences of long-used and unsuccessful strategies in order to influence long-term strategic planning.

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A NURSING CENTER

Sandra B. Fielo and Rae Lord Crowe

From a paper presented at the NLN Council of Nursing Centers Conference, May 1992.

A college-managed Nursing Center is blossoming in Brooklyn. Under the guidance of a faculty appointed director, faculty preceptors and both graduate and undergraduate students are providing free, case-managed care to elderly individuals living in the neighborhoods of Carrol Gardens, Boerum Hill, and Cobble Hill. Currently, there are 30 active clients with 480 home visits projected for 1992.

On a typical morning the nurses will see a 92-year-old woman being cared for by her 62-year-old son. The nurses will conduct a respiratory assessment to monitor lung congestion, and then review the use of an incentive spirometer and provide support for her son's desire to be the primary caregiver for his mother. They will visit a 72-year-old woman who is losing her sight as a result of diabetes, assist her with drawing up her insulin with a magnifying glass, and discuss products available for those with limited vision (Fielo, 1991). They will also arrange to bring a wheelchair-bound 78-year-old man to the center's afternoon exercise program.

This elderly population's access to health care is impeded by increasing age, low income, inadequate health insurance, difficulty with the English language, minimal formal education, and a lack of knowledge about available services (Gloss & Fielo, 1987). These individuals fear institutionalization and are frustrated with bureaucratic delays in obtaining needed health services. These fragile citizens do not meet the eligibility criteria for either supervised long-term care through the New York State Lombardi program, or the illness-oriented, episodic care provided by Visiting Nurse Associations or hospital home care programs.

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Center opens with cooperation of community agency

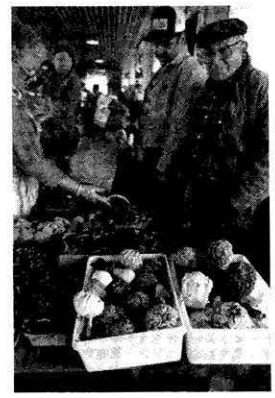
The Nursing Center opened in 1986 and was founded with the cooperation of the Heights and Hill Community Council. Heights and Hill is a nonprofit agency founded in 1970 by local residents to provide social work services to elderly people in the neighborhoods known as Cobble Hill, Boerum Hill and Brooklyn Heights.

The College of Nursing State University of New York Health Science Center at Brooklyn was familiar with the Heights and Hill Community Council since the agency was used on a limited basis as a community practice site for undergraduate students during the spring semester of each academic year. Two separate groups of students provided home care to elderly clients, each for five weeks. Nurses and social workers furnished complementary but separate professional services. Under that arrangement, however, there grew a perceived deficit in coordination and continuity. It was obvious that a permanent Nursing Center at Heights and Hill would provide a natural extension of existing services and a continuous interdisciplinary focus. This arrangement would contribute to establishing continuity of care for clients and provide a permanent site for professional practice, teaching, and research.

The steps leading to the operation of the Nursing Center are reported in *Family and Community Health* August, 1987 (Gloss & Fielo, 1987). A feasibility study identified the designated sections of Brooklyn as densely populated areas with more that 5,000 elderly persons who lacked accessible, affordable, acceptable, and managed health care. Morbidity data revealed the prevalence of chronic illness with periodic exacerbations requiring hospitalization.

The simultaneous needs for community-based programs for older adults and for a population and practice site for students and faculty were also identified. Interdisciplinary committees met to enunciate the philosophy and objectives, roles and responsibilities, service and resources, and legal and ethical

IN BROOKLYN



An interdisciplinary approach provides an efficient and effective method of distributing health care and social services.

implications. A contractual agreement was signed between the administrative agencies of the College of Nursing and Heights and Hill Community Council. The center was developed as an additional health care facility among the broad spectrum of services present in the community (Barger, 1986). As seen in Table 1, the objectives focus on management of emerging health needs and the promotion of independent, interdependent, and community-oriented health-generating behaviors (Gloss and Fielo, 1987).

Interdisciplinary approach efficient and effective

Two assumptions serve as the basis for the program. First, an interdisciplinary approach provides an efficient and effective method of distributing health care and social services. Second, clients have the right to continuity of care by providers of these services.

The interdisciplinary model utilizes the expertise and competence of each discipline, recognizes areas of overlap, and provides for changing disciplinary emphasis to meet the shifting demands of a client's situation. It uses "the best" each discipline offers in a collaborative effort to provide continuity of care (Fielo, 1989). Evashwick (1987) states that continuity of care is "an integrated, client-oriented system of care composed of both services and integrating mechanisms (structure and resources) that guides and tracks clients over time through a comprehensive array of health, mental health, and social services spanning all levels of intensity of care." The goal of continuity of care is, over time, to predict, prevent or minimize problems using early interventions and anticipatory preparation (Rothenberg, in press). This should minimize exacerbations of illness, reduce fragmented, overlapping care and health care costs, and enhance the individual's and family's development and quality of life.

Table 1

Nursing Center Objectives

Identify existing and emerging health needs or problems of a designated population in an urban environment.
Assist the community client to identify, articulate, and manage health problems.
Use a multiple strategy approach to promote health, prevent illness, and control major health problems in an urban population.
Provide health, nursing, and health-supporting services congruent with the needs and problems of the community client.
Promote health-generating behaviors that are independent, interdependent, and community-oriented.

This contractual agreement between the College of Nursing, State University of New York Health Science Center at Brooklyn and Heights and Hill Community Council established a mutually advantageous collaboration through which nursing and social work services are provided to elderly clients in the designated area. Under provision of the contract, Heights and Hill provides a rent-free operating site, telephone and utility services, two social workers, and a part-time secretary-receptionist two days a week. The College of Nursing provides a director and faculty to administer programs, precept students, and provide direct client care at least one day a week on a calendar year as well as student nurses to provide health care during those periods of time when academic programs are in session.

The college also provides daily operational supplies and equipment, learning materials, printing and duplicating, postage, advertising expenses, and computer time. During the first three years of operation, the contract was reviewed annually; however, the current contract is ongoing and is reviewed as necessary. In keeping with the policy of Heights and Hill Community Council for social work clients, no fee is charged for nursing services at this time. Funding for Heights and Hill comes through the Department on Aging, fund raising activities, and grants. The Nursing Center is funded by the College of Nursing budget and small project grants from local businesses and pharmaceutical houses. Recently the Nursing Center agreed to conduct selected teaching groups for an outside agency on a fee-for-service basis.

The Nursing Center provides nursing and health support services to the community's medically diagnosed elderly. Nurses see clients at the center located on Baltic Street, or in their homes which are within walking distance of the center. Clinical practice provides opportunities for students to observe and work with expert clinicians using an interdisciplinary approach to case management. The focus is continuity-of-care nursing which emphasizes the planning and preparing for predictable transitions and providing for the expected necessary resources and supports to facilitate the transition of care from one phase of illness or one setting to another (Rothenberg, in press). A comprehensive data base including the client's life context of home, family, community, culture is analyzed. Nursing diagnoses, goals, and criteria for evaluation are developed in concert with the client and family. Activities include an annual physical and functional assessment, teaching, medication management, illness care, screening, risk management, and referral to other health care professionals when necessary.

Table 2

When to See a Nurse

Appointments can be made to see a nurse at the nursing center or in your home, free of charge.

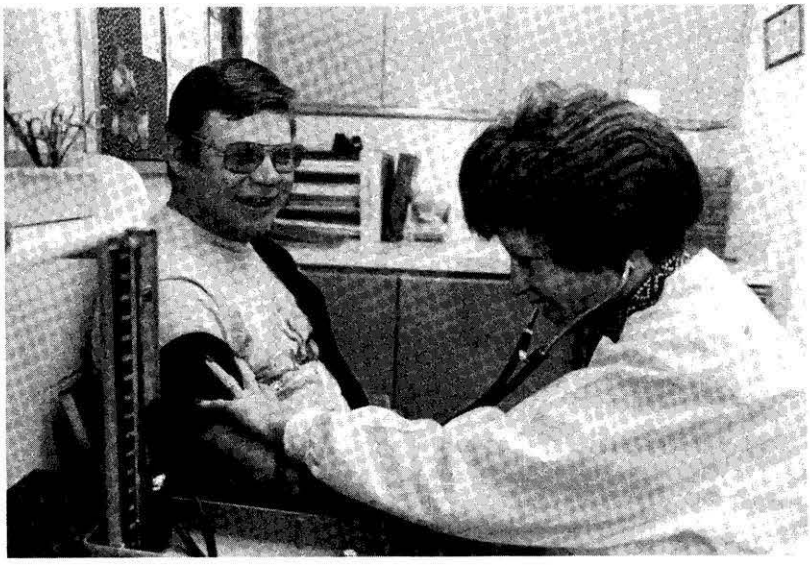
Help with staying well!
- Maintain proper weight
- Eat the right foods
- Lower dietary salt and cholesterol
- Get enough exercise
- Get enough sleep
- Reduce stress
- Take care of your feet
- Keep wax from blocking your ears
- Examine your breasts
- Know what to expect when you get older
- Know how to adapt to age-related change

Have your blood pressure checked every month
Have a yearly physical examination and health assessment
Have your home assessed for safety
Help with managing your illness
- Learn self care for minor problems
- Learn more about your illness
- Determine if you need medical attention
- Help with referrals to doctors, podiatrists, other health care professionals
- Know how to take your medicines safely
- Know what to do if you have a bad reaction to a medicine
- Know if you can take your medicines with other medicines or foods

Need help with using the health care system and community resources?
Talk with a nurse!

A list of services is posted in a heavily trafficked area alerting the community to reasons to see a nurse. (Table 2). The Nursing Center runs monthly blood pressure screenings, frequent health fairs, and numerous teaching sessions at a variety of community sites (Table 3). These activities are advertised in the local newspapers. Most recently, students conducted a mobility session for well elderly clients at a Drop In Center managed by Heights and Hill. Participants discussed ways to keep moving, performed a series of light exercises, and danced.

Comments made by the students proved extremely enlightening. Several of the RN students reported more time to focus on social and emotional issues.



Students complete course work while gaining experience

The College of Nursing prepares undergraduate generic and RN students for professional practice, and graduate students for clinical specialization in continuity of care in an urban environment. Undergraduate practice at the Nursing Center is in conjunction with the course, *Professional Nursing and Client need Disruptions in the Community*. Focus is on individual and aggregate needs for air, nutrition, safety, tenderness, activity, sexuality, and self actualization. Students are at the center one day a week over a full semester, either in the fall or spring. They complete a community assessment and apply the nursing process with individuals and groups.

Graduate students practice at the center in conjunction with two courses: *Nursing Process in Continuity of Care* and *Advanced Practice Skills in Continuity of Care for Adults*. These courses are conducted over the spring and summer semesters. The focus is the management of clients with long-term health problems and the coordination of community-based resources. In concert with this are the development and application of clinical nurse specialist functions of clinical expertise, teaching, consulting, advocacy, and collaboration. Case management and Gordon's (1991) functional health patterning assessment are two of many strategies used to plan and provide continuity of care. These students have expressed an interest in gerontology. The graduate students serve as case managers for groups of clients and work with the undergraduate students to provide needed health care services.

Students staff the Nursing Center two days a week during the fall, spring, and summer sessions. In addition, students may contract with faculty to provide care during those periods of time when academic programs are not in session. Guided study credit is earned for this work. Special projects are also awarded credit. For example, one student compiled a directory of area physicians willing to accept Medicare and Medicaid assignments and make home visits.

Clients may be managed solely by the Nursing Center or Heights and Hill or in a collaborative endeavor by both. While most clients are seen by professionals from more than one discipline, some do not require social work services or do not meet the age or catchment area criteria for social work services through Heights and Hill. These clients are managed solely by the Nursing Center. Referrals are made by either agency to the other. During the early years, most referrals were made to the Nursing Center by Heights and Hill; however, an increasing number are made in the opposite direction as people become more familiar with the Nursing Center programs, and as the center's client population increases.

Table 3

Teaching Sessions

LOCATION	TOPIC
Heights and Hill Drop-in Center	Breast self-examination
	Healthy diet
	Relaxation
	Safe use of medicine
	Keeping mobile
South Beach Psychiatric Center	Breast self-examination
	Smoking cessation
	Relaxation
	Dietary salt and fat
	Restriction
	Hypertension
Families First	Infant care
	Relax and be energized
	Totally toddler

Table 4

Survey of Nursing Center Experience by Students 1988–1991

	GENERIC n=48	RN n=10	GRADUATE n=7
lengthen experience	17%	20%	57%
work with faculty beneficial	81%	100%	71%
interdisciplinary collaboration beneficial	83%	100%	71%
participated in group teaching	83%	80%	71%
provided varying levels of care	79%	100%	57%
noted increased autonomy	44%	50%	43%

Interdisciplinary group conferences occur at the beginning of each clinical rotation, and then as often as needed throughout the year. Faculty, students, and social workers confer daily to plan and monitor strategies and frequently make home visits together. A number of students have suggested more frequent group conferences. This is being considered. While both disciplines maintain separate record-keeping systems, the records are available to either and both chart interdisciplinary input.

Students report on their experiences

At the end of their clinical practice at the center, students are surveyed to determine whether the experience helped increase their knowledge and skills related to care of the elderly in the community and whether the experience advanced their understanding of the independent role of the nurse. As seen in Table 4, the number of RN and graduate students is small since practice at the Nursing Center is recent for those groups. Graduate, generic, and RN students (57 percent, 20 percent, and 17 percent respectively) desired a longer experience. This was provided when the curriculum was revised and a full semester undergraduate community course implemented. The experience increased from 5 to 15 weeks for the undergraduate students, and from 7 to 24 weeks for graduate students. Graduate, generic, and RN students (57 percent, 79 percent and 100 percent respectively) reported opportunities to provide varying levels of care to elderly clients in the community, thus increasing their knowledge and skills. One commented, "One of my clients was very ill and I had to get her to the emergency room, but the other just needed positive reinforcement of some health teaching."

Table 5

Service Expansion 1988–1992

	1987	1992
Number of active clients	25	50
Client visits	200	400
Number of students	24	50
Faculty preceptors	1	4
Nurse consultants	0	2
Screening sites	1	2
Teaching sites	1	3

Graduate, generic and RN students reported that both interdisciplinary collaboration (71 percent, 83 percent, and 100 percent respectively) and work with faculty were beneficial (71 percent, 81 percent and 100 percent respectively). Students commented, "It was a chance to work with the pros." "They were role models, resource people. " "I will use what I saw them do in my next rotation." Two said the experience was different because the faculty was actually responsible for clients even after the students moved on. A student said, "We were not guests in someone else's house." One said the opportunity to work with a social worker provided better understanding of community links. Seventy-one percent to 83 percent participated in group teaching which provided an opportunity to apply and test didactic principles. Since health promotion and disease prevention are key elements to health care, adequate group teaching skills are essential. Graduate and RN students reported that this activity aroused a good deal of anxiety but was particularly rewarding. Forty-three percent to 50 percent reported an increase in autonomy. It was surprising that more students did not indicate an increased freedom to exercise judgment and decision making without undue external sanctions. Perhaps the operations were accomplished without the concept being adequately enunciated.

Comments made by the students proved extremely enlightening. Several of the RN students reported more time to focus on social and emotional issues and on group teaching but difficulty adapting to the less structured format at the Nursing Center. They were accustomed to a nursing practice governed by systemized procedures, rules, and regulations. They said that having graduate students serve as case managers helped in their adjustment to the center. Two graduate students employed by home care associations desired additional opportunities for client follow up. They had some difficulty adjusting to the long-term distributive nature of Nursing Center practice when compared with the episodic nature of practice in their employing agencies. One graduate student said she learned more about community resources and was finally able to make the continuity-of-care connection.

Growth and expansion of services expected in future

We anticipate that the Nursing Center case load of active clients will increase, as will the number of students and faculty using the center. (Table 5). Services will be expanded and the scope and number of monthly screening and teaching sessions will be increased. The support of the University Hospital's nursing department is evident in their recent provision of a diabetic clinical nurse specialist as a monthly consultant. Programs will be presented at additional sites. New elective courses will be designed to use the Nursing Center as a practicum, and the program to integrate the differing levels of preparation will be evaluated.

Additional interdisciplinary input from the Colleges of Medicine and Health Related Professions will be encouraged. Faculty of the Department of Family practice of the College of Medicine expressed interest in having medical students use the site in conjunction with a required course in ambulatory care. However, medical students need a weekly four-day experience that cannot be accommodated at the Nursing Center at this time, as well as medical supervision at off-campus sites that cannot be provided by the College of Medicine. Funding to allow expansion of services is being sought so that the Nursing Center can adequately serve

as a living laboratory for practice, teaching, and research in conjunction with providing affordable, accessible, acceptable, continuity of care to the residents of this Brooklyn community.

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CALL FOR POSTERS

Abstracts are being accepted for a poster session to be held at the National League for Nursing's *Ways of Knowing and Caring for Older Adults—Research, Practice, Policy, Education* symposium in San Diego, CA on January 22 and 23, 1993.

The abstract must relate to geriatrics and meet criteria listed below for abstracts. There will be no posting fee, but participants with accepted posters must register and pay fees for the symposium.

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1. Purpose of study or project
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Abstracts will be accepted through January 5, 1993 and should be sent to:

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PRESIDENT'S MESSAGE

Revisiting Nursing's Media Image

Claire M. Fagin, PhD, RN, FAAN

It all began with Nightingales...

In 1988, NLN reported nursing school enrollments at their lowest point in the decade, the Department of Health & Human Services convened a commission on nursing, and newspapers nationwide reported every day on beleaguered patients subjected to a delivery system with too few RNs.

That same year, while others labored to alleviate the nursing shortage, NBC did its part to prolong it. The network began broadcasting *Nightingales*, an hour-long comedy-drama made by Aaron Spelling, producer of the earlier hit *Charlie's Angels*.

Like the "Angels" before them, nurses in *Nightingales* were beautiful, sexy, and often scantily attired. But worse than the "Angels," who were good detectives, the "Nightingales" were incompetent nurses.

In the very fictional world of *Nightingales*, one needed no expertise or rigorous education to be a nurse, because all you did was bop along the hospital corridors and perhaps make a bed. Words like "professional" or "leader" would seem ludicrous applied to NBC's version of a nurse.

Nurses take action

Nurses responded with uncharacteristic unanimity to the *Nightingales* offense. Thousands of letters and phone calls were directed at producers, the press, the network, and finally advertisers. "I'm embarrassed that my children might watch this and think that's what I do all day," said one critical care nurse, a single mother, "And I'm outraged that the network would demean two million hard working nurses this way."

The letters worked; NBC canceled *Nightingales* in spite of the show's top-ten ratings. The Tri Council initiated a campaign, administered by the League, called "Nurses of America," which addressed the media image of nursing and worked with producers and networks to assure that the *Nightingales* nightmare never happened again. Nurses of America began a media surveillance project and put out *Media Watch*, a publication examining the image of nursing.

Back to the drawing board

How far have we come since *Nightingales*? Unfortunately, not far enough. As this goes to press, there are two networks with sitcoms featuring nursing: NBC (again) with *Nurses*, and Fox with *Rachel Gunn RN*. *Nurses* repeats tired stereotypes about hospital staff nursing, including the 1950's Dr. Kildaire fiction that nurses are taskmasters doing the doctor's bidding. The staff nurses do not report to a head nurse (a head nurse character died on an early show) but instead report to a physician.

Rachel Gunn, RN is no better. The title character is a head nurse with academic credentials at a hospital that patients would be wise to avoid. The staff nurses are zany in a sitcom way, which for nurse characters means they don't know what they are doing. Rachel Gunn is depicted as intelligent, but not as an experienced or skilled health professional; in one scene she faints from the shock of observing an operation.

The soaps still portray a myriad of nursing roles, and nurse characters appear sporadically on many evening shows. These images are more often than not inaccurate and often offensive. *Designing Women*, normally sensitive about portraying women characters, did a show depicting a nurse with tight fitting clothes ignoring a woman patient, flirting with a nearby man, and performing clinical acts that would constitute malpractice. *Empty Nest* includes a regular nurse character whose work is exclusively secretarial. It is interesting that this downgrading of nurses coincides with new depictions of valorous women physicians—usually playing real life nursing roles.

Going against the tide

Happily, not every image of nursing in recent years has been inaccurate and/or offensive. Soon after *Nightingales* went off the air, ABC debuted *China Beach*, the story of Colleen McMurphy, a nurse serving in an army hospital in Vietnam. Actress Dana Delany won two Emmys for her performance, which depicted nursing as tough, complex, valorous, and exciting. The show's producers, both Vietnam War veterans, wanted to do *China Beach* to honor

the nurses they encountered in those years. To ensure accuracy, the producers assembled a group of nurse veterans to serve as advisors; in one Emmy Award-winning show, the actual veterans told their own stories interspersed with dramatic reenactments.

The show survived four years on the air for one reason: nurse viewers were active supporters. Several times the network attempted to cancel *China Beach*, which led to a flood of letters and phone calls from viewers.

What you can do

What we learned from the pain of *Nightingales* and the thrill of *China Beach* is that nurses collectively have a powerful voice that can hold the media accountable. It is up to us to use that power. One way to do that is to write to the producers, writers, and networks responsible for *Nurses, Rachel Gunn, RN*, a soap, or any other program you notice.

You can also contact the National League for Nursing Media Project at NLN headquarters. We will be publishing *Media Watch* and continuing many of the efforts begun with Nurses of America. The League is disseminating and collecting surveillance forms that help us monitor the image of nurses and may help nurse viewers in analyzing media content.

The stakes

The image of nurses impacts not only the nursing shortage, which has a bleak prognosis as the population ages and demand for nursing services grows, but the quality of our health care system as a whole. Leadership, high levels of education, and strong professionalism are mandates for the nursing profession as we move into the future. Furthermore, as the nation rebuilds a failing health care system, nurses will take a central role as optimally cost-effective providers of badly needed care in a variety of community and acute care settings.

Will bright, capable young Americans continue to choose a career in nursing? Or will they be convinced from watching television that nurses are cartoonish buffoons instead of smart, skilled, capable oft-time heroes of American health care? A modicum of accuracy is all we are asking for. Let's make sure we ask loud enough.

Readers wishing to comment on either *Rachel Gunn, RN* or *Nurses* are encouraged to write to the following addresses:

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Robert Wright
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NBC
30 Rockefeller Plaza
New York, NY 10112

NLN NEWS

CHAP Institutes "Quality Leadership in Home Care"

The Community Health Accreditation Program (CHAP), the only consumer-oriented accreditor of home health care organizations and a pioneer in health care reform, recently announced the formation of the Institute of Quality Leadership for Home Care, an annual conference exclusively for home care CEOs and COOs.

"The Institute for Quality Leadership is designed to be the premier executive management event of the year for health care leaders," said Maria Mitchell, president of CHAP. "For the first time, CEOs and COOs will have an annual forum where they can discuss the overall management of the fastest growing industry in our health care system."

The meeting which was held on October 14–15, 1992 at the Annenberg Center at Eisenhower in Palm Springs, California, featured Peter Drucker, the father of modern management and a best-selling author. Drucker made a rare personal appearance and set the tone for the meeting with an insightful analysis of today's management challenges and visions for the future.

The CHAP Institute for Quality Leadership is the only forum for senior home care executives that fosters serious learning in an exclusive retreat environment. It is also the only event where home care leaders can create new strategies with key experts in health care, management, insurance and business. In addition, the Institute will enhance the dialogue between managed care and home care and among purchasers, providers and consumers of care.

OTHER NEWS

International Nursing Leader Dies

Dorothy Alice Cornelius, international nursing leader and executive director emeritus of the Ohio Nurses Association (ONA), died on August 4, 1992. Miss Cornelius was executive director of ONA 1957–1983; president of the International Council of Nurses, 1973–1977; president of the American Nurses Association (ANA), 1968–1970; and president of the American Journal of Nursing Company, 1967–1968.

Miss Cornelius served the United States government on numerous committees and commissions, at the request of several Presidents, starting with Dwight D. Eisenhower. Her presidential commendations crossed political lines and included Lyndon Johnson and Richard Nixon. Likewise, Miss Cornelius was appointed by several Ohio governors to many health and safety groups. In all of these efforts, her leadership, knowledge, and concern for her fellow citizens was recognized by everyone.

Friends may wish to contribute to the Cornelius Scholarship Fund, Mid-Ohio District Nurses Association, 1460 West Lane Avenue, Columbus, OH 43221.

CGFNS Certification Deadlines

The Commission of Foreign Nursing Schools (CGFNS) announced new application deadlines for nurses educated outside the U.S. who seek CGFNS certification. Applicants who wish to earn a CGFNS certificate must first show credentials that indicate the appropriate education and licensure outside the U.S. Qualified candidates then take a one-day test of nursing knowledge and English language proficiency in worldwide locations.

CGFNS offers the exam three times a year. For application materials and detailed instructions write: Commission on Graduates of Foreign Nursing Schools (CGFNS), 3600 Market Street, Suite 400, Philadelphia, PA 19104-2651.

First TV Show for Nurses

Nursing leaders from around the country recently gathered in Indianapolis, Indiana to discuss the first national, weekly, television news show created by, for, and about nurses.

"Nursing Approach," a one-half hour program, will be produced by Sigma Theta Tau International, headquartered in Indianapolis, and Samuel Merritt College's Studio Three Productions of San Francisco, California. The program premieres throughout the country at 1 p.m., Sunday, January 3rd on CNBC's American Medical Television.

"'Nursing Approach' is expected to be the single most important national forum for the nation's nurses as they prepare to care for all of us during the 21st century," says Beth C. Vaughan-Wrobel, RN, EdD, president of Sigma Theta Tau International. "Health care consumers will also find the show's information readily understandable, since nursing, as a profession, has always sought to discuss the health care of patients in terms they understand. You will see nursing's heroes as they make nursing news. The program will present nursing's many approaches to the health care of the public."

The program hosts will be Donna Hill Howes, RN, MS, executive vice president of the Academy of Medical Film from San Francisco and Karlene Kerfoot, RN, PhD, CNAA, FAAN, executive vice president, patient care, St. Luke's Episcopal Hospital, Houston, Texas.

NCPIE's 9th National Conference

"Making Progress in Medication Communication: the Outcomes Challenge," is the theme for the 9th National Conference on Prescription Medicine Information and Education to be held May 6–7, 1993 in Washington, D.C. Plenary sessions will address the role of medication compliance in achieving positive health outcomes and containing health care costs; the legal implications for physicians, pharmacists and manufacturers of the duty to warn via medicine counseling; and new compliance interventions: what patients want and don't want.

Fourteen skill-building workshops, poster sessions, a 50 booth Exhibit Showcase, and a "breakfast with the experts" will provide a variety of opportunities for in-depth knowledge and face-to-face interactions. For information write to: NCPIE 9th Conference, 666 Eleventh Street, NW, Suite 810, Washington, D.C. 20001, or call 202/347-6711.

AACN and PBS to Broadcast Live Teleconference on AIDS

The American Association of Critical-Care Nurses (AACN), in collaboration with the Public Broadcasting System/Adult Learning Satellite Service (PBS/ALSS), will broadcast a live teleconference "AIDS in the Health Care Workplace: Fantasy, Fact, and Ethics," on December 2, 1992. The program will focus on the needs, issues, and concerns of both consumers and health care workers and will examine the challenges of meeting the needs of those affected by the HIV epidemic, as well as the new drug resistant TB. Nationally known experts in epidemiology, nursing ethics, nursing education, and the law will serve as faculty. Questions regarding the program, continuing education credit, support materials, site location, and licensing can be addressed to: AACN, 1-800-899-2226, ext. 376. Inquiries on teleconference site location and licensing can also be directed to: PBS, 1-800-257-2578.

Photo courtesy of Interim Healthcare

Approximately 60% of the South Florida hurricane relief volunteers are nurses.
This fact was provided by Interim Services, Inc., Ft. Lauderdale, Florida, a provider of health care services nationwide.

ANNOUNCEMENTS

Sigma Theta Tau International honor society of nursing has presented awards to four leaders for their outstanding contributions to health care: Xerox Corporation for its family care initiatives; **Barbara Biben** for designing a women's health care network; **Thelma Wells, PhD, RN**, for her research to help elderly women; and **T. Franklin Williams, MD**, for encouraging the development of the National Institute for Nursing Research in Bethesda, MD.

Marsha H. Cohen, PhD, RN, assistant professor at Wayne State University, has been named the 1992 STTI/ANF Research Scholar.

The nine trustees elected at the recent American Nurses Association convention in Nevada are: **Michael Evans, MSN, RN, CNAA; Juanita W. Fleming, PhD, RN, FAAN; Fran Hicks, PhD, RN; Norma M. Lang, PhD, RN, FAAN; Beverly Malone, PhD, RN, FAAN; Mary Beth Mathews, PhD, RN; Ellen M. Sanders, MS, RN; Joan L. Shaver, PhD, RN, FAAN; Thomas E. Stenvig, MS, MPH, RN, CNAA.**

Barbara Ann Fowler, RN, MS, and **Lillian H. Mood, BS, MPH**, are two of nine health professionals nationwide chosen for a new leadership program sponsored by the W.K. Kellogg Foundation to explore linkages between health education institutions, primary health care providers, and communities.

Beverly P. Giordano, RN, MS, assumed the role of editor of AORN (The Association of Operating Room Nurses, Inc.) Journal. Giordano has been a clinical nurse specialist at The Children's Hospital, Denver, specializing in diabetes and endocrinology in children.

Two appointments were announced recently in Kent State University's School of Nursing. **Dr. Davina J. Gosnell**, dean of the School, has been appointed by Gov. George Voinovich to serve on the Ohio Public Health Council; and **Dr. Diana L. Biordi** has been named assistant dean for research and graduate affairs.

Martha Hill, PhD, RN, and **Diane Becker, ScD, RN**, both associate professors in the Schools of Nursing and Medicine at Johns Hopkins University have been selected to participate in the American Heart Association's National Science Promotion and Education Working Group to promote science education and science careers among the general public.

L. Colette Jones, PhD, has been named associate dean and professor at the Philip Y. Hahn School of Nursing at the University of San Diego. Dr. Jones has an extensive record of publications, is an adult nurse practitioner, and a Fellow of the American Academy of Nursing.

The 1992 Mead Johnson Nutritional Perinatal Nursing Research Grant recipient is **Mildred A. Omar, PhD, RN**, assistant professor of the Michigan State University College of Nursing.

Spalding University has announced that **Marjorie M. Perrin, EdD, RN, MSN**, has been named dean of the School of Nursing and Health Sciences.

The University of San Diego's Philip Y. Hahn School of Nursing has been awarded a $242,753 three-year contract by the Health Resources and Services Administration to begin preparing family nurse practitioners in the specialty of migrant health care. **Dr. Louise Rauckhorst**, associate professor of Nursing, will be the project director for this new initiative.

Yvonne Troiani Sweeney, RN, MSN, has been appointed director of Nursing Services at Albert Einstein Medical Center, Philadelphia, PA.

The Elisabeth Severance Prentiss Foundation has awarded Case Western Reserve University $250,250 to develop the acute care nurse practitioner program in collaboration with University Hospitals of Cleveland. The program advances nursing education to a new level, and will serve as a national model for nurse practitioners.

Call for Manuscripts and Author Guidelines

Content

Nursing & Health Care is interested in provocative articles on nursing, education, practice, and research, health policy, and social and economic issues that affect health care and higher education, as well as in reports on the latest administration and management strategies. We want articles that reflect state-of-the-art thinking about these topics and ones which are based on authors' experiences.

Style

As you write, keep in mind that you are engaging each reader on a one-on-one basis, so write as clearly as you would write to them. Visualize your audience -- they do not always read when they are fresh, alert, comfortable, and undistracted, so you must entice them to read your piece. Catch their attention and hold their interest with clear, lively writing. Do not use jargon -- it is often an imprecise use of the language. Think carefully about what you want to say, then say it as simply as possible. Read recent issues of *Nursing & Health Care* to get a feel for our style.

Peer Review

Promising manuscripts are reviewed by *Nursing & Health Care*'s editorial review board. Reviewers judge the article for originality, importance, accuracy, and readability. When we decline a manuscript, we provide summaries of the reviewers' responses. Manuscripts are sent to reviewers anonymously to ensure fairness and objectivity, **so names of authors and their affiliations should not appear in the text** but should be written on a separate page.

Format

Authors should include, on a separate page, their full names, addresses and telephone numbers; professional designations and degrees; current affiliation; and affiliation during preparation of the article.

Manuscripts should be typed double-spaced on 8-1/2" x 11" white paper, with 1" - 1-1/2" margins all around.

References should appear in APA format.

Photographs used to illustrate the article should be glossy black and white and should bear both the photographer's name and identification of who and/or what is in the picture. Evidence of permission to use/reprint the photo must be included.

Manuscripts should be mailed flat, unstapled, but paper-clipped together.

Submit one original and three photocopies of the article.

Editing

When a manuscript has been accepted, it will be edited to fit *Nursing & Health Care*'s style. Authors receive a copy of the edited manuscript before it is published to check for accuracy of content.

Manuscripts and all other correspondence should be directed to the National League for Nursing
Nursing & Health Care
350 Hudson Street
New York, NY 10014

Comforting the Confused: Strategies for Managing Dementia

by Stephanie B. Hoffman, PhD; Constance A. Platt, MA, New York: Springer Publishing Company, 1991, 208 pages, $21.95

As stated in the forward, "Stephanie Hoffman and Constance Platt have undertaken the task of seeking to limit pain and suffering of the dementia victims and their caregivers." Their task was effectively accomplished within the body of this short, pertinent and helpful book. Both authors appear well qualified and easily draw from knowledge and experience in the fields of geriatrics, psychology, psychiatry, communication, and education, resulting in germane strategies for caregivers managing patients or loved ones living with dementia.

Prefaced by an introductory overview that discusses history, symptoms, causes, risk factors, and caregiving, each of the eleven informative chapters includes learning objectives, a pretest, the meat of the chapter, a summary, learning exercises, and a posttest. This well-presented educational approach, which enables the reader to adequately test personal knowledge before and after each chapter, effectively enhances the learning process and provides for an overall satisfying learning experience.

Comforting the Confused offers insight into the personal hell of the demented individual and the caregiver, whose scope of responsibility would challenge the capabilities and resourcefulness of many health care professionals. Dr. Eric Pfeiffer, of the University of South Florida, best describes the intent of this book in this poignant statement, "The 'heart' of this book is the chapter on communicating with demented persons. [It is] worthy of implementation in all our communications with demented persons. It is also the heart of this publication because it is heart-felt." This is a book well worth reading.

Reviewed by Patricia A. Britton, MSN, MS, RN, CNA, clinical nursing instructor, Mattatuck Community College, Southbury, Connecticut.

ERRATA

Please note the following corrections to the recent Council for Nursing Informatics (CNI) newsletter, *Connections*.

Patricia Flately Brennan, PhD, RN, FAAN, of Case Western Reserve University will be the Keynote speaker at the 1993 Council for Nursing Informatics annual meeting in Boston on June 5, 1993.

In addition, Diane Skiba's e-mail address should read: **skiba_d%maui@vaxf.colorado.edu**

Donna Larson's e-mail address should read: **larsond@gvsu.edu**

Computer Applications in Nursing Education and Practice

by Jean M. Arnold, EdD, RN; Gayle A. Pearson, DrPH, RN, New York, National League for Nursing, 1992, 377 pages, $35.95

This book draws on the experience of nurses in a variety of settings in establishing and using automated information systems. It contains examplesof how nurses create, implement and use computer applications. The writings represent presentations from the Rutgers College of Nursing Annual National Nursing Computer Conference and other conferences, 1990 and 1991.

The book is divided into sections addressing issues from resources for computer applications; bedside computers in nursing practice; computer applications in nursing administration, nursing education and care planning; development of computer applications; and nursing research about computer applications. Although some of the chapters assume knowledge of computers and computer jargon, most will be readily understood by the reader with the most basic knowledge of computer systems. Each chapter stands by itself and can be used to broaden the reader's overall knowledge base or as reference for a single project.

The chapters on resources for computer applications, alone, make this book worthwhile, especially for the nurse just learning about the world of automated information systems. The listings of journals, professional organizations and conferences relating to computers in nursing provide an excellent starting point for the nurse who "doesn't know where to start."

The future of nursing care is glimpsed in the chapters on implementation and use of bedside computer documentation. The historic, current and future perspectives of bedside care are addressed in one chapter. However, the chapters on how nurses acquired, initiated and used bedside computers in a variety of settings are invaluable. The problems encountered and lessons learned from these actual nursing experiences can be transposed to any efforts to initiate computer use in a variety of nursing settings.

Other applications for computers are also addressed, although somewhat superficially. The potential for quality improvement, computer-assisted learning, patient teaching, nursing research, manual writing and development, general administrative support, financial planning, etc. are only touched upon, if addressed at all.

Nonetheless, the book brings together information pertinent to both administration and clinical practice. It documents the current state of automated information systems within the nursing profession. Most importantly, however, it provides a glimpse of the future for those nurses with the vision to pursue it.

Reviewed by Jaloo I. Zelonis, RN, CNA, MS, MPH, deputy nurse consultant, Billings Area Indian Health Service, Billings, Montana.

CLASSIFIEDS

CLASSIFIED ADVERTISING INFORMATION

Nursing & Health Care is unique among nursing journals. In addition to its award-winning editorial, the publication serves as a national marketplace for faculty job opportunities. An advertisement in *Nursing & Health Care* reaches more deans, directors, and faculty than an ad in any other nursing publication.

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Please use our toll-free hot line, 1-800-541-9129, when you wish to advertise a faculty position or when you have any questions about advertising in *Nursing & Health Care*. An insertion order must accompany all ad requests. Please specify P.O. Box, billing address of client and agency, contact person and phone number, month(s) of insertion and cost. You may FAX your order to 410/749-8769 or send the order and any material to: Classified, *Nursing & Health Care*, 606 S. Schumaker Dr., Salisbury, MD 21801.

ADVERTISING RATES

Classified advertisements are priced at $20 per line with a minimum of 5 lines per ad. A good way to estimate the price of your ad is to use 7 words, or 65 characters and spaces, per line. Final price will be deteremined by the number of lines appearing in the journal. All classified ads are set in 8-point type on a two-column format. Display ads will be accepted and priced according to size. A rate card detailing all rates is available for advertisers.

CONTACT INFORMATION

Mary Alice Mengason, Advertising Representative
NEX Publishing, Inc.
1-800-541-9129

CHAIR, DEPARTMENT OF NURSING

Arkansas State University invites applications for a 12-month tenure-track faculty position as Chair, Department of Nursing, effective July 1, 1993. The Department enrolls approximately 350 students in its NLN-accredited associate and baccalaureate degree programs and its master's program which will undergo initial NLN accreditation in Spring, 1993. The programs have taken leadership in promoting academic initiatives such as off-campus courses, interactive videotelecom mediaconferencing, and articulation agreements.

Arkansas State University is a comprehensive state university with an enrollment of over 10,000 students. The University is located in Jonesboro approximately 70 miles northwest of Memphis, Tennessee.

Qualifications include an earned doctorate with a master's in nursing, eligibility for Arkansas licensure, teaching experience at the baccalaureate and master's degree levels, appropriate nursing education administrative experience, evidence of effective communication and leadership skills, and a record of research and publication. Successful grantsmanship is highly desirable.

Salary and rank are commensurate with experience. Application review will begin November 16, 1992 and continue until the position is filled. A letter of application, current curriculum vitae, and names, addresses, and telephone numbers of five professional references should be submitted to:

James D. Blagg, Jr., Ph.D.
Chair, Nursing Chair Search Committee
College of Nursing and Health Professions
Arkansas State University
P.O. Box 69
State University, AR 72467-0069

ASU is an AA/EOE employer.

National League for Nursing Division of Education and Accreditation

DIRECTOR OF ACCREDITATION

As accreditation continues to evolve, this is an exciting moment to join the League and provide visionary leadership in this national position. In addition to the League's pioneer activities in the national movement toward outcomes and greater public disclosure, we have just begun the computerization of the entire accreditation program.

The individual we seek will, together with the Associate Director, oversee and coordinate the four educational councils, and serve as secretary to specific boards of review. The individual will have demonstrated success in:

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- Implementing creative and innovative approaches to nursing education
- Advancing closer collaboration hetween education and a variety of practice settings
- Working with diverse populations

Position requires: Earned doctorate with higher degree in nursing; sensitivity and appreciation for the challenges facing nurse educators; and willingness and availability for moderate travel. Competitive salaries. Assistance with relocation if necessary. Position available immediately; starting date is negotiable.

Please send letter of application, CV, three letters of reference and sample of written work to:

Patricia Moccia, PhD, RN, FAAN
Executive Vice President
National League for Nursing
350 Hudson Street
New York, New York 10014

We are an equal opportunity employer and especially interested in candidates with demonstrated expertise in multicultural, multiethnic and multiracial concerns.

GEORGIA SOUTHERN UNIVERSITY
DEPARTMENT OF NURSING
SEEKS NURSING FACULTY

The Department of Nursing at Georgia Southern University seeks applicants for one faculty position in our BSN program. Total Fall 1991 enrollment exceeds 13,000. The Department of Nursing now has over 300 students and advisees and more applicants waiting for acceptance. Twenty-five faculty perform teaching, grant-writing, service, and research in a closely-knit department. Position requirements: MSN or MN; Med-Surg. specialty; three years teaching experience at college level. Preferred: doctorate; three years clinical experience. Rank and salary are commensurate with qualifications. Send letter of application, unofficial transcripts of all degrees, and names/addresses of 3 references to: Dr. M. Christine Talmadge, LB 8158, Statesboro, GA 30460. Application deadline is November 30, 1992. Position available preferred January 2, 1993 or no later than September 1, 1993. Georgia Southern University is an Affirmative Action/Equal Opportunity Institution. Minorities are encouraged to apply. The names of applicants and nominees, resumes, and other general non-evaluative information are subject to public inspection under the Georgia Open Records Act.

UNIVERSITY OF MAINE
School of Nursing

Three full-time tenure track faculty positions available September, 1993 in NLN-accredited BSN, RN completion, and MSN nursing program. Qualifications: Completed doctorate (preferably in nursing), Master's in Nursing, two years teaching experience. One position has primary assignment in undergraduate adult health specialty. Additional positions have primary responsibility teaching and supervising graduate students in Rural FNP Program and require certification as Nurse Practitioner (preferably FNP). The School of Nursing has 350 students and is located on the Orono campus of the University of Maine System which has a total enrollment of 13,000. The campus is located four hours from Boston and one hour from the Maine coast. Review of applications will begin 1/5/93. Send current vitae and names of three references to: Laura Dzurec, Chair, Search Committee, University of Maine School of Nursing, 160 College Ave., Orono, Maine 04469.

The University of Maine is an equal opportunity/affirmative action employer.

TEACHING POSITION AVAILABLE

CLINICAL NURSING INSTRUCTOR. The College of Eastern Utah at Price, Utah invites applications for a nine month, tenure track position in an NLN-accredited one-plus-one program. Responsible for clinical and laboratory instruction, assisting with curriculum development, and evaluating and counseling students. The successful applicant must be qualified and licensable to practice as an RN in Utah. MSN is preferred. Recent successful experience in a health care facility or experience in instructing nursing students. Salary is commensurate with training and experience according to faculty schedule. Deadline for applications is November 25, 1992. Review of application materials will begin immediately after this date and continue until the position is filled. For further information contact: Personnel Office, College of Eastern Utah, 451 E 400 N, Price, Utah 84501 801/637-2120, ext. 240. CEU is centrally located near many spectacular Utah attractions, including Lake Powell, white water rafting on the Green River, and Arches and Canyonlands national parks. Campus life is enriched by our prehistoric museum, art gallery, theater, athletic center, and dance studio. CEU is an equal employment/affirmative action employer.

University of Nebraska Medical Center

COLLEGE OF NURSING

ADULT HEALTH AND ILLNESS FACULTY

Key faculty positions available in Adult Health and Illness Department. College offers NLN accredited BSN and MSN programs, and a Ph.D. in Nursing Program which was implemented in fall 1990. Climate supportive of research and scholarly activity with established Nursing Research Center and successful history of external funding. College is part of the only state supported University in Nebraska and of an academic health science center with recognized leadership in liver transplants, bone marrow transplants, and cancer research.

Qualifications for positions include: doctorate in nursing or related area, masters in nursing with specialty appropriate to position sought, teaching experience in nursing at the baccalaureate and graduate levels, and evidence of research and scholarly productivity. We are especially looking to hire qualified faculty who have had experience working in an advanced practice role (CNS or Adult-Nurse Practitioner). In addition, we are interested in faculty members who have a strong background in physiology and pathophysiology, clinical care or oncology. Salary and rank commensurate with education and experience. Supplementary salary incentive for funded research is offered as well as health professions appointment that permits longer period of time to qualify for tenure.

Send curriculum vitae including names of three references to:

Rosalee C. Yeaworth, R.N., Ph.D., Dean
University of Nebraska Medical Center
College of Nursing
600 South 42nd Street
Omaha, Nebraska 68198-5330

AA/EOE

University of Nebraska Medical Center

COLLEGE OF NURSING

COORDINATOR FOR RURAL NURSING EDUCATION

The University of Nebraska Medical Center College of Nursing is seeking applications for the challenging position of Coordinator for Rural Health Nursing Education. The successful candidate will have primary responsibility for identifying and coordinating the activities of the College of Nursing in rural education. S/he will coordinate the rural education activities for both the on campus undergraduate and graduate students, and coordinate the off-campus delivery of the RN to BSN program. S/he will also work with the other Medical Center disciplines in the UNMC Rural Health Education Network to facilitate and maximize interdisciplinary learning opportunities. This position requires an individual with skills in the areas of facilitation, communication liaison, and public relations.

The Coordinator for Rural Nursing Education must have a master's degree in nursing with a doctorate in nursing or in a related field preferred. S/he should have previous experience in teaching at the baccalaureate and higher degree level and in an administrative or managerial position. Experience in rural health, delivery of courses by nontraditional means and in writing and administering grants are a plus. This position carries the expectations of the threefold faculty role with rank commensurate with candidate qualifications.

Candidates should send a cover letter, vita, and names of three references to:

Dr. Rosalee C. Yeaworth, Dean
UNMC College of Nursing
600 S. 42nd Street
Omaha, Nebraska 68198-5330.

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Nursing++

Academic areas require a minimum of a Master's Degree which includes 24 semester hours of upper division and/or graduate credit in the field to be taught. ++Please note this discipline has minimum requirement exceptions.

A separate faculty application and a complete set of unofficial copies of transcripts (inclusive of degree(s) conferred) are required for each discipline for which an applicant applies. All applications must be received by the Employment Office and clocked in by **5:00 p.m. on the final closing date, March 9, 1993.** To request a faculty application and further information on requirements, please call the Maricopa Community College District **Toll-Free** Number, **1-800-25-TEACH**, or in Maricopa County, **(602) 731-8491**, Monday-Friday 8:00 am-5:00 pm. MST. AA/EOE.

Women and Minorities are Encouraged to Apply.

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MARICOPA COMMUNITY COLLEGES

QUEENS COLLEGE
CHAIR, DEPARTMENT OF NURSING

Queens College is seeking an energetic and dynamic leader to chair our Division of Nursing beginning August, 1993.

The Division grants the BSN for traditional and RN students from the Charlotte area. Candidates must hold the doctorate in nursing or related field, a master's degree in nursing, and be eligible or currently licensed to practice nursing in North Carolina. Demonstrated excellence in teaching is essential; previous administrative experience and prior teaching in a liberal arts college are desirable. The division chair should be able to provide leadership for program planning, faculty recruitment and development, and assessment.

Queens College is a residential and coeducational liberal arts college founded in 1857 and affiliated with the Presbyterian Church (USA). The college also includes an evening baccalaureate program for working adults and a small graduate school offering the MBA, EMBA, MEd, and MAT. Queens is located in a pleasant area of Charlotte, a lively and growing urban center. We are especially eager to receive applications from minority candidates.

Send a letter of application, vita, and the names and addresses of three references to: Chair, Nursing Search, Queens College, 1900 Selwyn Avenue, Charlotte, NC 28274. Applications will be accepted through Fall, 1992.

CHAIR, DEPARTMENT OF NURSING
College of Mount Saint Joseph

The College of Mt. St. Joseph seeks a faculty member to serve as Chair of the Department of Nursing in a NLN fully-accredited BSN program. Preferred starting date is January, 1993. An earned doctorate with a master's in nursing, prior experience in baccalaureate or higher degree nursing programs and experience in nursing management required. Primary responsibilities involve management of the BSN program, leadership of faculty (presently 13 full-time and several adjunct), curriculum development and evaluation, maintaining cooperative arrangements with hospitals in the Cincinnati area, and representing the department within the academic community.

The College of Mt. St. Joseph is a coeducational Catholic College of 2,600 students located in suburban Cincinnati, noted for its high academic standards and innovative programs which combine the liberal arts with career preparation.

Send letter of application, current curriculum vitae and three letters of recommendation to Ms. Marva Graham, Search Committee for Chair of Department of Nursing, College of Mt. St. Joseph, 5701 Delhi Rd., Cincinnati, OH 45233-1670. Applications will be reviewed starting November 13, 1992 and continue until a suitable candidate is found. Equal opportunity employer.

Jacksonville University School of Nursing seeks creative, dynamic individuals who enjoy teaching clinical nursing with specializations in community, critical care/emergency or adult health nursing. Positions offer clinical practice opportunities and joint appointment at affiliated medical center. Doctorate in nursing strongly preferred; M.S.N. considered if individual is near completion of doctoral studies. Must obtain current Florida license prior to contract year. Screening will begin November 15, 1992. Send curriculum vitae and three letters of recommendation to: Carole Cayer, Chairman of Faculty Development, School of Nursing, Jacksonville University, Jacksonville, FL 32211. Jacksonville University is an affirmative action/equal employment opportunity institution.

UNIVERSITY OF OKLAHOMA COLLEGE OF NURSING
NURSING FACULTY POSITIONS

Full-time tenure track/non-tenure track faculty positions available in all clinical areas: Community Health, Maternity, Medical-Surgical, Pediatric, Gerontology, Family Nurse Practitioner, and Psychiatric-Mental Health Nursing. Positions are available at the Health Sciences Center in Oklahoma City and the University Center at Tulsa. Minimum requirements: earned Master's degree in nursing with preference for doctorate in nursing or related field or doctoral study in progress. Type of appointment, rank and salary commensurate with credentials and experience. Closing date: Positions will be open until filled. Send C.V. and list of three references to Mary Jane Ward, RN, PhD, FAAN, P.O. Box 26901, Oklahoma City, OK 78190.

Equal Opportunity/Affirmative Action Employer.

NURSING FACULTY

Two faculty positions are available in a newly created BSN completion program at Eastern New Mexico University: one faculty position in Community Nursing and one faculty position in Nursing Management. Both are tenure-tract, ten month appointments; salary and rank commensurate with education and experience. Minimum requirements include: MSN degree, recent clinical experience, qualification for New Mexico licensure; previous teaching experience preferred. Positions available for Spring, 1993 term. Send letter of application and resume to Dr. Ginny Guido, Chair, Department of Nursing, ENMU, Station 12, Portales, New Mexico, 88130.

ENMU is an Affirmative Action and Equal Opportunity Employer. New Mexico is an open records state; therefore, it is the policy of the University to reveal to the public the identities of the applicants for whom outside inquiries have been made or for whom on-campus interviews are scheduled.

LUBBOCK VALLEY COMMUNITY COLLEGE is seeking applicants for the position of **NURSING INSTRUCTOR**. This is a FT fac. assgnmt. MS in Nursing & current unencumbered Registered Nursing License with min. of 3 yrs. nursing service exp. req. Documentation of coursework in the preparation of curriculum & instructional strategies as well as teaching exp. desired. Acute care clinical practice with Medical/Surgical, Gerontologic background pref. Must be able to work flexible hrs. Minority applicants are especially encouraged to apply. Position open until filled. Application review begins 11/5/92. Salary based on ed. & exp. Full benefits. For more info. contact: Personnel Office, TVCC, 650 College Blvd., Ontario, OR 97914 (Ph. 503/889-6493 Ex. 227). Anyone needing reasonable accommodation during the application process should contact the Personnel Office. TVCC is an AA/EOE.

NURSING FACULTY

University of Mary Hardin-Baylor invites applications for a pediatric nursing faculty position beginning January, 1993 for its NLN-accredited baccalaureate program. Qualifications include: master's degree in nursing required; doctorate preferred; clinical experience in pediatric nursing; teaching experience desirable; commitment to baccalaureate education a must. For further information contact: Dean, School of Nursing, University of Mary Hardin-Baylor, UMHB Box 8015, Belton, TX 76513; 817/939-4662. E.O.E.

NURSING FACULTY

NORTHAMPTON COMMUNITY COLLEGE
BETHLEHEM, PA.

Applications are invited for a tenure track position in NLN-accredited program offering the associate degree. Competitive salary and rank commensurate with education and experience. Excellent fringe benefits. Appointment begins August, 1993.

CRITICAL CARE — Master's degree in Medical/Surgical Nursing required. Certified Critical Care Nurse preferred, current licensure in Pennsylvania, minimum of two (2) years clinical experience in Med/Surg, at least two (2) years in Clinical Care Nursing, minimum of two (2) years teaching experience (associate degree preferred).

Send letter of application, resume and names, addresses and phone numbers of three references to **Personnel Office, Northampton Community College, 3835 Green Pond Road, Bethlehem, PA 18017.** Deadline is January 4, 1993 or until a suitable candidate is identified. Northampton Community College, through its affirmative action goals, is seeking candidates who will augment the diversity of its faculty, staff, and administration. Men and minorities are encouraged to apply. Northampton Community College is an Affirmative Action/Equal Opportunity Employer.

LUBBOCK CHRISTIAN UNIVERSITY
Division of Nursing
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Lubbock Christian University is seeking qualified faculty for a new upper division RN/BSN Program. Challenging positions in a developing program are available for faculty to teach in all specialty areas. A master's degree in nursing is required with a doctoral degree in nursing or a relevant discipline desired.

Lubbock Christian University is a four year private liberal arts university with a big future located in Lubbock, Texas; one of the most progressive cities in Texas.

Part time, joint appointment and full time positions are currently available. Salary range commensurate with qualifications and experience.

Contact: Ella Herriage, RN, PhD
Division of Nursing
Lubbuck Christian University
5601 W. 19th St.
Lubbock, Texas 79407
800/933-7601 Ext. 314

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