

The JOURNAL

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Editorial

While we were putting together this edition of the *Journal*, two notions came to mind. The first is that of a potpourri, one definition of which is a “mixture of flowers, herbs and spices that is usually kept in a jar and used for scent; a miscellaneous collection” (*Webster’s Ninth New Collegiate Dictionary*, 1983, p. 920). The content of these pages is indeed a collection of various works whose commonality is that they all relate to the potpourri of nursing in one way or another. The articles were written by and for a diverse population of nurses from different generations and ethnic backgrounds, of different genders and in various facets of the profession – a wonderfully spicy and beautifully scented potpourri. And yet we are related by the very fact that we are all New York state nurses committed to enhancing the care of our clients.

The second thought we had is that of serendipity. The *Dictionary of Word Origins* (1945) tells us that this word comes from a Persian fairy tale, “The Three Princes of Serendip,” in which one hero starts out to find his father’s donkeys and finds a kingdom in the process of his search. It is the “happy faculty of finding what one did not seek; it is the treasure of every artist” (1945, p. 319). We hope that as you peruse this potpourri of articles you will discover treasures, insights, and information of value, even though you might not have known you were looking for them.

“Rachel’s Story,” by Champlin, takes us to the heart of nursing, at the patient’s side, and lets us share her shock and horror when she is abruptly told she needs a bone marrow transplant for Stage III breast cancer. The author provides a checklist of appropriate nursing interventions that could help women like Rachel manage their care in this highly stressful situation.

Next we travel into New York’s rural areas, familiar to some of us and foreign to others. In “Survey of New York State Rural Nurses: Practice Characteristics, Needs, and Resources,” by Crosby, Ogden, Heady, Agard, Kerr and Cook, we discover the responses of 420 nurses who participated in a survey about their scope of practice, resources, barriers, and needs. Their answers to the survey questions give us some insight into the support needed by these rural nurses to facilitate their practice and also lets us mentally compare our own practices with theirs.

Spencer and Bryant help us to think in more depth about the phenomenon of dating violence. In their article, we learn how prevalent this phenomenon is among university students and the implications for nursing assessment and intervention.

The importance of disseminating nursing research to the health care consumer is the focus of the article written by the previous NYSNA Council on Nursing Research. Our colleagues provide us with pointers on how to translate research jargon into language that is understandable to the lay person.

Finally, Dollinger, in her article “Professional Associations: Ethics, Duty and Power,” highlights the need for nurses to support their professional associations. Actually, she considers it a duty to do so. She provides examples of how these associations develop standards and exert power by influencing health policy in order to make her point.

We hope you enjoy your journey through the land of Serendip as much as we have enjoyed providing you with a map of the territory. On this journey you may find many ingredients for new and unusual potpourris. If you do, please share them with us.

May we also remind you that your own submissions to the *Journal* are always welcome?

Rona Levin, PhD, RN
Gail Malloy, PhD, RN

Webster’s Ninth New Collegiate Dictionary (1983). Springfield, MA: Merriam-Webster.
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Rachel's Story

Anne Champlin, EdD, RN

ABSTRACT

This is a story about a woman who has been told she must undergo bone marrow transplant for Stage III breast cancer. The initial shock and horror she experiences as well as the many responsibilities she has to contend with in managing her care are overwhelming. How she perceives what is happening and the significance of the event are observed in the oncology waiting room. Instrumental Friendship is used to begin the process of connection between nurse and patient. The dialogue associated with this connection reveals the deepest needs that this patient is feeling. The analysis of this interaction leads the author to highlight appropriate intervention strategies. A guide to those things that nurses do all the time but which go unnoticed concludes the discussion.

On Tuesday, April 5, 1994, Giselle, the young woman that I, an oncology nurse, had driven into the city for six months of chemotherapy, was having her last treatment. I was finishing an ethnography, a complete study of the cancer experience of one patient (Champlin, 1995). Giselle had mixed feelings about this last treatment. She was glad they were ending, but wondered if the cancer would reoccur when she stopped the treatments. Waiting to be seen by the oncology fellow, we sat in the chemo waiting room of a large medical center. We passed the time by studying the faces of the newest group of patients, who were beginning the six-month course of chemotherapy treatment. Just as we finished our study of our surroundings, I walked Rachel, a striking-looking woman in her 60s.

Rachel wore a black hat, pink sweater, a long pearl necklace, and a flowered skirt. She smiled briefly and without talking, took a seat by the door. Her face looked swollen and

puffy. She sat quietly. After 15 minutes had passed, tears began to stream down her face. She dabbed at the tears with her handkerchief, but they continued to be squeezed out of her eyes as though under pressure.

Now people in the room made eye contact with each other. "What should we do?" they seemed to be wondering. "Leave her alone? Talk with her?" Everyone saw what was going on but no one said anything. Prior to this, the room had been quite noisy. Now all conversation was suspended. When the tears stopped, Rachel began to scribble furiously on a pad, and the others in the room resumed their idle chatter.

Carrying containers of coffee from the cafeteria, a young Hispanic man and his mother returned to the room and took seats across from Rachel. Seeing her tears, the young man said to her, "You can't do that in here, Abuela." Rachel replied, "Go ahead. Pull out a knife."

I looked at the young man who was embarrassed. He made a gesture with his head,

thrusting out his chin, but said nothing. I felt very bad for him. Just then his mother was called by the doctor, and he went with her without a backward glance.

Rachel then turned to us and explained why she had no patience with the young man. "I hope you understand," she began. "I just received bad news two minutes ago: the results of my breast biopsy. I just couldn't stand to listen to somebody sucking his teeth. Of 12 nodes, 10 were involved. I have to have a bone marrow transplant. I was telling Dr. Tisch about my breast incision. He said to me, 'Rachel, I don't give a shit about your incision now. You have 10 positive nodes. You have to face a bone marrow transplant. Most people with bone marrow transplants die. You need to have aggressive chemotherapy.'

"I had no idea I would hear this," she continued. "My ex-boss called to ask me how I was and to let me know he was thinking of me. I used to work for this law firm, and I didn't get along with the office manager who

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*“It is not so much the illness itself that makes people suffer,
but the impact... on the person’s self and...
that person’s personal identity.”*

happened to be the son of the senior partner. My boss fought for me. I heard there were shouting matches. He lost, and I lost. When I lost my job, I lost my insurance. Now I am applying for Medicaid.”

Rachel was obviously shocked to learn about the 10 nodes, all but two giving evidence of metastasis, and about the impending bone marrow transplant. She turned to Giselle, asking her many questions about her surgery. Rachel explained that she had missed a mammogram one year. After a lump was found, she delayed five months before having the lumpectomy. She seemed to be looking for a reason for the metastasis.

“I really feel good about the fact that my boss called,” she added. He is worried about me and how the biopsy results turned out. He is the only one who cares.”

Giselle asked if she had any friends, to which Rachel replied, “Yes, friends from work and friends at Temple, but no one who can come here with me.” Giselle felt terrible that Rachel was facing this all alone.

Rachel said she had been introduced to a volunteer who had had breast cancer. When Giselle asked her who, it turned out to be the same one Giselle had met. Rachel asked Giselle if she had met with the volunteer a second time, and Giselle said, “No.” Rachel hadn’t either. Rachel asked if Giselle had called organizations like CANCER CARE and others to which the social worker had referred them. Giselle said no. She did not have the energy to make all the calls. “The social worker gave me a lot of pieces of paper with the names of agencies to call, but I couldn’t do it. I couldn’t track down all the information needed by Social Services for the Medicaid application. They want me to go back three years and identify every check that I have written that was larger than 500 dollars, just for starters!” Rachel agreed, saying she hadn’t done it either.

Giselle was then called for her last chemo treatment. While she was gone, Rachel asked me if I was familiar with the Upper East Side. She recommended a restaurant called Easy Delicatessen, which offered good values. Large pitchers of orange juice and granola cereal with fresh fruit were on the menu all day. She said there was an identical one on the West Side, and that J.F.K., Jr., and Darryl Hannah had been seen there at 7:30 one morning, having breakfast. “That is how New Yorkers found out they were having a relationship. Who would have a date 7:30 a.m.? It had to be an affair.” Rachel was confiding her best gossip.

Rachel went on to report that she had recently purchased a new TV at the SONY building on 57th Street between Second and Third Avenues. “I met an honest salesman. I told him I wanted a well-known brand, but he said they make that particular television in Mexico now and the quality was not as good as when they made them in Japan. He recommended another make. I got it for \$250.00.” Next she discussed the recent capture of a serial rapist. “Stuyvesant Town used to be such a nice place to live. Now, they let anyone live there.”

Dr. Gage called Rachel. Before she left the room, she turned and said, “Thank you for distracting me. It helped not to think about all this bad news. Now I have to make sure Dr. Gage goes along with Dr. Tisch’s plan for a bone marrow transplant.”

When she had gone, an Israeli woman who had accompanied her sister to the treatment turned to me, smiling, and said, “She is a real New Yorker. She knows everything about what is happening in New York. What fun! Delightful.”

After listening to Rachel, I recognized that her story had a poignant life of its own. Unlike Giselle, she did not have somebody picking her up, taking her there, listening to her talk about all of her experiences.

Bone marrow transplant is a highly technical procedure that involves the use of radiation and chemotherapy to destroy the patient’s diseased bone marrow, followed by hematopoietic rescue with marrow or blood stem cells (O’Connell & Schmit-Pokorny, in Whedon & Wujcik, 1997.) Instead of a hopeful prognosis, Rachel, like 30% of Stage III breast cancer patients who undergo bone marrow transplants, had a less positive prognosis (Foelber, 1998; O’Connell & Schmit-Pokorny, in Whedon & Wujcik). This was compounded by all the positive lymph nodes and the perceived bluntness of the medical team. Once the statistical odds of survival are given, the meaning and perception of time changes; time is now marked and running out. (Haberman, 1995).

This vignette about Rachel offers a perspective on the problems this patient experienced when confronted with the knowledge she may die. Fear, powerlessness, and vulnerability are some of the issues she dealt with as she waited for the next healthcare provider to see her. Patients are usually overwhelmed by their diagnosis and are unfamiliar with treatment options (O’Connell & Schmit-Pokorny, 1997).

According to Steeves (1988), it is not so much the illness itself that causes people to suffer, but the impact the illness has on the person’s self and the integrity of that person’s personal identity. Bone marrow transplant patients like Rachel believe the future and their lives are no longer their own. They are told there is no time left, and they have been given no choices about their future. This is a critical point in the patient’s experience of illness. If only an oncology nurse could have been with Rachel, she might have had someone to bear some of the burden of emotional support through this difficult period. The nurse is the most readily available source of information for the patient and could help Rachel and others like her find what she needed to make the best response to this crisis. Oncology nurses need to be present to help these patients live in time, present or future (Steeves, 1992).

According to Radziewicz (1997), cancer patients need a person to whom they can tell the truth of how they feel. Nurses can open opportunities to share the grief and to offer the support that is needed for patients to move on to a greater understanding. Anticipating questions, reflecting on common experiences, and normalizing feelings that commonly occur are ways that nurses guide patients through their personal uncertainty. Patients perceive the nurse as powerful and protective and look to the nurse to support them as they wait and endure this treatment (Steeves, 1992; Ersek, 1992; Haberman, 1995).

One of the manifestations of suffering that Rachel displayed after she was informed about the metastasis and bone marrow transplant was crying. Giselle and I sat there, helplessly watching the tears running down Rachel’s cheeks form a wet track on her make-up and smear the meticulously drawn eyeliner of the lower lids. She dabbed care-

fully at her cheeks and the area under her eyes, attending to the areas of black liner, and wiped away traces of the smear. By her careful attention to her appearance, she seemed to be trying to show that she was not falling apart, that she was still in control. Nevertheless, tears gushed from within and did not stop. They were continually escaping through the narrow slits of her puffy eyes. Rachel seemed to be pouring out energy, generated by the assault on her senses, which she could no longer contain. Many people like Rachel, whose bodies are falling apart as a result of metastasis, have to deal with so many chores of coping: organizing visits to the hospital, arranging for rides and treatments, and tending to the endless paperwork required to receive health insurance. They have very little energy left to fight their disease. Then, when their condition deteriorates relentlessly, when it seems it cannot get any worse, it *does* get worse. It seems to be overwhelming and the only recourse is to cry.

None of the health professionals saw Rachel crying. If they had, they might have known that this was a patient in shock after hearing that she had to have a bone marrow transplant. They would have recognized that Rachel had questions and needed validation and support. The fiscal realities of health care today have limited the numbers of nurses assigned to the oncology clinic (Aiken, Sochalski, & Lake, 1997; Schulmeister, 1999; Sochalski & Patrician, 1998; Sochalski, Estabrooks, & Humphrey, 1999). Those nurses on duty in the clinic were busy doing assessments and administering chemotherapy for large numbers of patients who must be monitored closely for reactions to the chemotherapy treatment. There were no nurses assigned to stay with patients for companionship, support, and psychological assistance. Therefore, no one intervened, because no one was available to do so, although this was a prime opportunity for intervention at a critical stage of the patient's response.

Personnel responsible for staffing units are often physically oriented in their analysis and look at different stages of treatment to determine how nurses will be assigned. For example, they may consider who is needed to deliver chemotherapy or radiation therapy, and who is needed to give physical treatment to the patient, but consider nurses who are not giving physical treatment as extraneous. Yet a psychiatric patient who had been given medication would be assessed as having a lot to cope with, and nursing care would be

provided. The nurse would not be dismissed. Similarly, the oncology patient's body and mind have received an assault (Steeves, 1992; Spiegel, 1990) and it is unwise that no nurse is present.

Cancer is one of the most powerful symbols of horror and of the unknown (Sontag, 1977). Patients need to be cared for by somebody who is knowledgeable about this illness, who can describe that "this many people" who report at "this stage" of illness with "these" symptoms may be seen to have "these results" in the long term.

Hospitals in which nurses are strongly positioned in the organizational structure and in which nurses are autonomous in clinical decision-making, control their practice environment, practice primary nursing, and are well-compensated, have a significantly lower mortality rate than hospitals which do not have these characteristics (Aiken, Smith, & Lake, 1994).

"Then...when it seems their condition cannot get any worse, it does get worse."

Other studies have shown there is a significant correlation between the RN-to-patient ratios, or RNs as a percentage of the total nursing personnel, and patient mortality (Biegen, Goode, & Reed, 1998; Prescott, 1993).

Illness drives people to look for meaning in the sense of knowing what the illness means to them and how they will manage its effects. (Haberman, 1995; Frank, 1991; Steeves, 1992). The meaning Rachel attaches to her illness will affect whether she will be able to carry on the normal routines of her daily life with little interruption or instead, become incapacitated as a result of it. Rachel sought meaning in her attempt to understand the rules of reality that allowed her to become ill. As she said, "I missed a mammogram one year. Then after the lump was found, I delayed five months before having the lumpectomy." She was trying to work out a rationale. The professional nurse is a person

who can recognize the significance of a comment like this and use it to help the patient find meaning in the illness experience.

According to Haberman (1995), patients' feelings, values, and personal meanings, their own self-understandings, are critical to the re-establishment of human wholeness. The nurse can speak for the patient and help the patient learn some of the strategies of survival. We have to inform the patient: "This is how you are going to have to think about your life in order to survive. You have to bear a lot of the responsibility for helping yourself survive." People who hear that their future might be truncated are profoundly affected by the news. Because of their history and their daily work, nurses live with this day-by-day, minute-by-minute attack on the soul. They know that there is not only a sick body, but a life that has been disrupted (Gordon, 1997); both must be attended responsibly.

Rachel, and people like her, need someone to talk to, someone who will say, "You've really had bad news—how do you feel?" It is most important to help her talk and to listen and respond to the answer about how she feels. Questions that guide patients in telling their stories help them express their fears about what they have heard. Just sitting with the patient without talking is affirming to the patient as it reinforces that he or she still "counts." Recurrence of cancer is considered one of the most stressful times in the illness experience because it indicates that the disease is not under control (McEvoy & McCorkle, 1990). The decision to undergo a bone marrow transplant produces uncertainty and ambiguity. Nurses can play a supportive role in helping patients explore the factors that surround the decision and the lingering ambiguity that may persist after the decision is made. Efforts to minimize uncertainty should be recognized as a patient's way to regain a sense of control (Haberman, 1995). That researcher reports that uncertainty also surfaces when patients are unable to develop a clear mental picture of what they are about to undergo. Nurses can provide specific information about transplantation to help the patient know what to expect and to provide information about the sequence and timing of diagnostic tests.

The nurse has a repertoire of helpful and non-threatening questions. The nurse can ask who is in this with them — any family members? Does the family accept how sick they are? Many families with a critically ill family member have so much unchanneled anger and

confusion that the family situation is in an uproar most of the time. People at home, close to the patient, may not want to hear any more about the disease. Family members may suffer because they have shared the burden of this illness along with the patient, and they, too, are worn out. Metastasis of the cancer is too great a burden for them and they may respond like Archie Bunker (“All in the Family,” TV series) who tells his wife Edith to “stifle” when she begins to process the emotional and social issues in the family. “Stifle” is shorthand for, “I don’t want to hear any more.”

Nurses are able to share the experience of illness through direct, focused caring. According to Noddings (1986), caring is a response to suffering, a commitment to reintegration of the person and humanity as a whole. Nurses help patients deal with their fear and anxiety, not only as related to their disease, but also as related to the people who are supposed to cure them (Gordon, 1997).

According to Mayeroff (1990), in order to care, we have to know the person. We have to be able to understand the other’s needs and respond to them. Nurses are able to know the other by sharing the experience of illness. Rawnsley (1990) uses the metaphor “Instrumental Friendship” to refer to caring that is integral to the special case of human bonding that is nursing. By placing value on the other as worthy of being loved, the nurse is able to move toward an appreciation of the personal meaning of the illness experience to the patient and toward an appreciation of the unique, irreplaceable self of the other.

As a nurse, I recognized Rachel’s needing someone to whom she could talk. Instrumental Friendship is a deliberative choice preceded by a moment (or “throb”) of recognition. Rawnsley verifies that this is the beginning of the motion forward to connect (personal conversations, 1998), an insight phase where you see the opportunity. I began the process of connection by listening to her story, but I had to leave her. Someone else was needed to pick up where I had left off. A nurse was needed. No other discipline could provide instrumental friendship, but there was no nurse available.

In today’s growing population of people over 60 years of age, one in four is likely to be diagnosed with some form of cancer. According to Landis, Murray, Bolden, and Wingo (1998), 44% of African-Americans and 60% of whites diagnosed with cancer will survive the 5-year watershed mark and be considered survivors. To deal with this growing patient group, nurses are needed who can perform these various functions where critical patient populations are found. They must report what they do and acknowledge what their fellows do, and they must contribute to the protocol of psychological and social support for patients with cancer and other catastrophic illnesses. As more patients undergo the physical, social and chemical stresses of the post-industrial age, we need more, not fewer, registered nurses to handle the silent epidemics of cancer and isolation.

I began to realize that a set of working notes, along with other recent measures and treatment theories, would be useful to remind nurses of what we do, which echoes the pioneering work of Florence Nightingale and Clara Barton for whom the Crimean War and the U.S. Civil War were the crisis medical labs for new nursing problems and advances.

The following 10 point protocol describes what you know and do all the time, but here it is made explicit. Think of it as a “field guide,” parallel to Florence Nightingale’s attempt to prevent the spread of infection, a protocol for nurses who are attending dying patients, a guide, taking practitioners through a war zone where everyone is trying to survive. This protocol is a work in progress. Nurses who use it have to add to it, to help answer the question: What can we do for the Rachels of this world?

The Guide

1. *Target a staff person to be with the patient as she integrates the information and meaning of the news that she will need a bone marrow transplant (BMT).* The nurse and physician know that hearing about metastasis causes increased anxiety for the cancer patient. If the patient is not expecting this news, the effect will be the equivalent of being hit over the head with a sledgehammer. Many people may not understand the jargon used by the professionals and may ask, “Did I hear right?” This problem is compounded if the patient does not have anyone with her.
2. *Sit with the patient as she waits.* Your presence validates that she matters. Being with the patient requires the nurse to be present emotionally as well as physically. Let the patient direct interpersonal interaction. Patient autonomy and individuality are enhanced when the nurse allows the patient to direct the flow of interaction (Winters, Miller, Maracich, Compton, & Haberman, 1994).
3. *Get a reading through body and verbal language on how the patient is handling the information received from the physician about the need for a BMT.* Recognize that emotional responses to cancer vary according to individual style. Some immediately seek out family and friends with whom they can share their grief and process the news. Others ask questions to satisfy their need for understanding and control. Still others retreat inwardly (Post-White, 1998).
4. *Find out if there is someone the patient can call.* Patients need to link up with a source of support. It should be identified early. Note if there is a need to find a support system.
5. *Consult with the hospital chaplain about a Spiritual Assessment if the patient desires this.* Knowing a patient has an inner source of strength helps direct our intervention.
6. *Find out if there is a pet.* Sometimes a pet is all the family a patient has. Pets live “in the moment” and give unconditional love. They can be wonderful friends and companions for those without family support (Jarrett, 1993). One of the concerns a patient might have is how a pet will be taken care of while she is ill.
7. *Get the patient to tell her own story.* By telling her own story which is a self-revealing process, the patient puts her experience into words and gains insight into the events of her own life. Encouraging the patient to tell her own story assures the patient that her life has purpose and meaning and may bring about a sense of mastery and self enhancement (Heiney, 1995). Help her start by using carefully worded questions; for example: “Tell me what happened when you first found out about the lump.” Questions keep the focus on the patient’s experience and help her clarify and understand what she needs. They also help lead the patient to a deeper understanding of her own concerns and cancer-related issues (Lewis & Zahlis, 1997).
Listen to the patient describe the cancer experience in her own words. You can learn what cancer means to the patient and her family and help rehabilitate and empower her as you validate the importance of her story (Heiney, 1995).
Focus on what is being expressed instead of guessing at the latent meaning of the words (Lewis & Zahlis, 1997).
Avoid forming judgments about how well the patient is or should be functioning.
Use attentive silence to magnify the importance of each person’s words.
Legitimize what is being reported and create space for self-discovery (Lewis & Zahlis, 1997).

8. *Have the nurse communicate with the patient.* Tell the patient how she will go through the treatment sequentially. Describe how other patients of the same age and diagnosis got through the experience. Communicate what the patient needs to know authentically, sensitively, and with hope (Radziewicz, 1998). Use pictures, cartoons, posters, or printed cards to convey information on such topics as the treatment process, how to deal with the side effects of chemotherapy, and the importance of nutrition. Brief pointers about what foods to avoid and how to deal with side effects like nausea can be presented on small cards easy to carry in a wallet or shirt pocket. All printed material should depict people with cancer in a positive light.
9. *Single out an issue to work on.* Take one manageable piece of the problem and work on it with each patient. Focus on the choice by asking, "What do you have the energy to do at this time?"
10. *Develop a checklist of those things that the patient should do to get support services from various cancer agencies.* Find someone in the community, such as a retiree, who would be willing to:
 - Make telephone calls to see what services are provided by selected agencies and what information they require.
 - Review the patient's checkbooks to find checks written over a specified amount if applying for Medicaid.

- Find out the best places to buy a wig and when to purchase it.
- Shop or find items for the patient.
- Transport and stay with the patient during visits to the hospital.
- Take notes when the physician tells the patient what she is to do and record anything the patient wants jotted down for later reference.

Since the 1980s, the increase in the number of patients undergoing BMT (Wingard, in Whedon & Wujcik, 1997) indicates the demand for comprehensive nursing care will also increase. Nursing care for BMT patients and their families is based on an understanding of the emotional, psychological, and physiological aspects of transplantation.

The nurse plays the lead professional role in the care of the transplant patient. According to the American Society of Clinical Oncologists and the American Society of Hematologists (ASCO/ASH, 1990), the nursing team is the single most important aspect of a successful BMT unit. It is imperative that nurse administrators and nurse managers recognize that the desirable outcomes are influenced by the patient's initial encounters with members of the health team in ambulatory care. The existing BMT psychosocial nursing literature describes how patients respond to BMT and how these responses follow a trajectory of biophysical and psychosocial adaptation (Winters, et al., 1994).

These are some of the things I thought about and wished I had been able to do for Rachel. Perhaps this guide, which is meant to be a work-in-progress, will be strengthened by the contributions of those nurses who live the cancer experience on a daily basis.

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Survey of NYS Rural Nurses: Practice Characteristics, Needs, and Resources

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ABSTRACT

Four hundred twenty registered nurses randomly selected from 44 New York State counties predetermined to have rural areas were sent questionnaires asking them to describe characteristics of their scope of practice, resources, barriers, and needs. These responses were compared based on the extent of rurality of their area of residence and contrasted with a group of nurses from more urban areas. The questionnaire contained 109 items arranged in four sections with closed response options. Statements used to construct the questionnaire were determined through focus group methods. The return rate was 33%, which was equally representative of the six surveyed groups created on the basis of rurality estimates.

Findings indicated that practice characteristics were generally similar in all county types, regardless of extent of rural areas. There were more resources perceived than barriers or needs overall. Third party payment for services was limited in the more rural areas. Distance limited educational opportunities in the more rural sections. Nurses in more rural areas reported feeling they had greater insight into the holistic needs of patients because they were all part of the same community. Recognition of the needs, resources and barriers described by rural colleagues in New York are presented to provide insight into the support needed by these nurses to facilitate their practice.

Introduction

Rural health services are changing in response to the rapid evolution of health care delivery in the United States. Health professionals and agencies are rebounding from the impact of managed care, system alignments, acquisitions, mergers, downsizing, restructuring, and other trends. Rural nurses, often the backbone of rural health care, are being challenged to guide patients through the transitions, deliver high quality services and, perhaps, acquire new skills to survive in a changed environment. Questions arise regarding these rural nurses. What are their

needs? What do they perceive as their resources? What are the characteristics of their practice? Are these conditions unique to rural nurses or are they similar to non-rural nurses? This study sought answers to these questions to provide insights that might help nurses in academia and professional organizations support their rural colleagues.

Background

Rural people have been viewed as an underserved group with complex health needs and limited available resources. An amendment to

NYS Public Health Law (Section 1, #2959) created a state rural health council to monitor research and reporting, increase cooperation and communication, and improve access to care of citizens in rural areas (Senate-Assembly, 1997). A national rural nurse organization has been formed and a chapter recently has been established in New York state.

Shaw (1997) described rural citizens as multigenerational individuals at risk for compromised health, whose geographic isolation contributes to scarce resources and limited access to health care. Shaw noted that the barriers to health care indicated by rural

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adults were inconvenient office hours, lack of transportation, prolonged waiting time, and lack of child care. Letvak (1997) found that elderly women in rural settings needed to experience connectedness with family or neighbors, but also needed to have control over the boundaries of relationships. They are people with a strong sense of independence and self-reliance. Family members who were caregivers in rural areas experienced more stress than urban counterparts, in part due to lack of information and supportive resources (Conley & Burman, 1997). These findings have implications for health care providers in rural settings.

The needs of rural people and the changes occurring in health care affected nurses in rural areas. Nurses in rural Montana were relied upon to meet diverse health care needs and function in a variety of roles, often as the only resident providers in small communities (Long, Scharff, & Weinert, 1997). A survey of 3,500 registered nurses reported on their reasons for choosing rural practice and the factors that contributed to job satisfaction and retention (Dunkin, Juhl, & Stratton, 1996). They described rural nurses as older than non-rural ones, experienced (X=14 years), most often associate-degree prepared, employed full time, in acute care, mostly in staff nurse positions, followed by administrative positions in long term care. Personal reasons were cited for choosing a rural practice. Job availability was the reason given for selecting their present position. Professional reasons noted for rural practice included the ability to provide personalized care and to maintain long term relationships with patients and their families. Factors that would precipitate a job change were pay incentives, spouse job change, moving, closing of the agency, and retirement (Dunkin et al.). Weins (1990) reported that nurses enjoyed a sense of autonomy in rural settings. Busby (1991) described rural nurses' concerns with implementing quality management activities due to time and resource constraints. Burns (1994) identified perceived barriers to practice in a national survey of advanced practice nurses in rural areas. In focus groups, rural nurses said their greatest need was for accessible educational opportunities, their greatest challenge was to "wear many hats" or be an expert in many areas, and their greatest resource was their connection to their community (Crosby, Ogden, Kerr, & Heady, 1996).

Purpose

The purpose of this study was to describe the characteristics of rural nursing in New York in terms of scope of practice, resources, barriers, and needs. Characteristics were compared among nurses based upon the extent of rurality of the area in which they resided, and contrasted with a group of non-rural nurses. Members of the Medical Surgical Clinical Practice Unit of the New York State Nurses Association

(NYSNA) requested that the NYSNA Board of Directors appoint a committee to advise the association regarding rural nursing and rural health issues. Results of this study were expected to suggest ways in which the committee could be responsive to rural nurses in the state.

Methods

The Rural Health Nursing Committee of NYSNA conducted a two phase exploratory study, using both qualitative and quantitative data collection methods. First, focus groups were conducted in three rural areas to identify professional issues relevant to rural nurses (Crosby et al., 1996). Then a mail survey instrument was created from the focus group information and used to collect quantitative data from a larger sample of nurses in upstate New York. This article reports on results of the mailed survey.

The study received Human Subjects Review Board approval at the School of Nursing, State University of New York at Buffalo. Participation was voluntary and agreement was inferred from return of completed questionnaires. Confidentiality was assured and maintained by coding the survey. The survey, along with an explanatory cover letter and a stamped, return envelope, was mailed to a randomly selected sample of New York state nurses, stratified according to rurality of the county of their mailing address.

The questionnaire was developed from the information generated in the preliminary groups regarding scope of rural nursing, resources available, and barriers/needs. A draft of the tool was piloted by nine rural nurses who had been in the focus groups and refined based upon their feedback. It was then reviewed for content and face validity by members of NYSNA's Research, Education and Practice councils and committees, and refined according to their comments.

The instrument, *Describing Rural Nursing in New York State*, contained 109 items with closed response options, arranged in four sections. Section 1 contained 28 statements that described practice characteristics, with response options to indicate the extent that the item represented the nurse's practice, from greatly (5) to not at all (1). Section 2 included 33 conditions that reflected resources. Section 3 presented barriers and needs for practice in 42 items. Sections 2 and 3 requested a two-part response — first, the availability of the condition (yes/no), and second, its impact on practice, from great (3) to none (0). The remaining six items in Section 5 obtained information about respondents. Figure 1 is an example of an item from Section 3.

Sample Selection

Of the approximately 180,000 RNs in New York, a subset of nurses in upstate New York counties with designated rural areas was sought. The target population included RNs from counties having rural populations averaging 25% or more. Rural counties have been defined by New York state as those having a population of 200,000 or less, a condition met by 44 counties (Rural Health Resources Guide, 1995). Dr. P. Eberts at Cornell University further classified the state's counties in a typology based on ruralness for research purposes (Rural Health Resources Guide, 1995). His three criteria were: (a) extent to which people live in communities of less than 2,500 people, (b) size of largest municipality in the county, and (c) extent that people commute outside the county for employment. Eberts' typology classified the state's counties into six types, (I) Downstate Metropolitan, (II) Upstate Metropolitan, (III) Rural-urban-suburban, (IV) Rural-Urban, (V) Rural-suburban, and (VI) Rural periphery. A listing of 32,000 RNs from the 44 counties was purchased from the official agency that issues professional licenses, the State Education Department.

Figure 1. Example item from Section 3, Barriers/Needs

BARRIER	OCCURS		IMPACT ON YOUR PRACTICE			
	Column I		Column II			
	Yes	No	Great	Moderate	Minimal	None
64. Short staffing limits educational leave time	Y	N	3	2	1	0

Table 1. Number and Percent Response Rate by County Type

County type	# sent	# returned	# ineligible	response rate (%)
I Upstate urban	70	24	5	37
II Upstate Metro	70	18	4	29
III Mix:Rural, Urban/suburban	70	16	10	28
IV Rural/Urban	70	17	8	29
V Rural/suburban	70	25	10	42
VI Rural periph.	70	27	0	39

For the present study, counties were sorted according to Ebert's typology for types II to VI. Substitution was made for type I, since downstate counties were not part of the target population. Urban areas with rural areas of less than 12% from county types II were identified to create an upstate urban comparison group (I). They included Rochester, Albany, Buffalo, Syracuse, and Schenectady. In Type II, rural areas ranged from 12.1% to 43.5%, and those counties with over 25% rural were included. They were Broome, Dutchess, Oneida, Orange and Onondaga. Type III ranged from 39.8% to 73.9% rural and encompassed Cayuga, Fulton, Madison, Montgomery, Oswego, Rensselaer, Saratoga, and Putnam counties. Type IV, ranging from 27.3% to 76.9% rural areas, included Chemung, Cattaraugus, Clinton, Cortland, Steuben, Jefferson, Otsego, St. Lawrence, Tompkins, Ulster, and Warren counties. Type V included 55.4% to 87.2% rural areas in Columbia, Greene, Herkimer, Livingston, Orleans, Schoharie, Washington, Wayne, Wyoming, Schuylar, and Seneca counties. Counties in type VI ranged from 68% to 100% rural and comprised Delaware, Chemung, Essex, Franklin, Hamilton, Lewis, Sullivan, and Alleghany counties. Using a table of random numbers, 70 nurses were randomly selected from each county type for a total sample of 420 nurses. This random sample of nurses, stratified by county type, was mailed a coded survey, a cover letter explaining the study, and a return envelope.

Results

One hundred twenty-seven registered nurses returned completed questionnaires. Seventeen nurses returned uncompleted ones, noting that they had retired. Twenty additional ones were returned, address unknown, reducing the sample to n=383. The overall response rate was 33%, which was generally representative of each county type. See Table 1 for summary of the sample response by county type.

Data from the respondents were entered into an SPSS file and frequency distributions were performed. Because of the low response rate, inferential statistics were not used to analyze the data. Rather, trends based upon frequencies are noted and general observations about the samples are presented.

Demographics of the sample included educational preparation of the respondents, with more than half having an associate nursing degree, followed by a baccalaureate (31%) and a hospital/diploma (28%). The greatest number of nurses with associate degrees were found in county type III, the least in urban areas. Masters and baccalaureate prepared nurses were mainly in urban areas, and the greatest concentration of nurse practitioners was found in county type III. Most respondents described their role as direct care givers (52%), while 23% were administrative or supervisory personnel, and the remaining were in education or had other roles. Most had full time positions (69%). Employment settings were described as acute care (40%), home health (13%), long term care (12%), schools/colleges (12%), ambulatory care (8%), public health (3%), or "other" (12%). Nurses in all county types reported a similar mix of work settings.

Scope of Practice Characteristics

The first 28 items presented practice characteristics, with response options of 1=not representative, to 5=greatly representative. Five overall themes were reflected in the items: autonomy (4 items); flexibility (5 items); community image (7 items); skills (5 items); and provisions of holistic care (5 items). The mean scores of the individual items in each theme did not reveal outstanding differences that distinguish the rural nurses from their more urban colleagues. The individual item means were collapsed into the five themes for the six county types, and are presented in Table 2. Autonomy was moderately representative of upstate New York nurses, with county type IV having the highest overall and item means. Flexibility was moderately to greatly representative of their practice, and highest for county type VI, the most rural. One item, "need to be prepared for general and specialty care," was greatly representative of the more rural county types (III-IV), while only moderately so of the more urban areas (I and II). A favorable community image was perceived as somewhat representative of practice, with visibility and recognition highest in county type IV and lowest in III. Recognition as an expert was highest in county type II. A variety of skills was moderately to greatly reflective of one's practice, with the highest mean for county type V. Provision of holistic, patient centered care ranged from somewhat to moderately representative of all county types' practice. The overall mean and county type mean scores for the themes of practice characteristics are presented in Table 2.

Table 2. Mean scores, Scope of Practice Characteristics Themes by County Types

Themes	Overall Mean	County Type I Mean	County Type II Mean	County Type III Mean	County Type IV Mean	County Type V Mean	County Type VI Mean
Autonomy	3.94	3.99	3.95	3.86	4.13	3.78	3.94
Flexibility	4.38	4.35	4.05	4.16	4.57	4.45	4.70
Community Image	3.57	3.74	3.81	3.16	3.73	3.57	3.40
Skills	4.30	3.98	4.14	3.96	4.36	4.79	4.56
Provider of Holistic Care	3.94	3.82	3.87	3.87	3.78	4.16	3.99

Resources

Conditions that were considered resources were delineated in 33 items in Section II. Respondents indicated the extent to which that resource impacted upon their practice and if it was available to them. The scoring option was: great impact (3), moderate (2), minimal impact (1), or none (0). Mean scores were calculated to describe the extent of the resources' impact on practice. Availability was described as "yes" (available), "no" (unavailable) or "mixed" if the respondents were split

on yes/no reply within the county type. Most resources (73%) were considered to have a moderate impact upon practice. Some conditions considered to be resources were available across all county types. Availability of others was more varied. Few were unavailable in most county types, and most of these were considered to be of lesser impact on practice. Results of the resources' mean impact on practice and their availability by county are presented in Table 3. Trends on the basis of rurality were not observed.

Table 3. Mean Impact and Availability of Resources by County Type

Resources	X Impact	Availability by County Type		
		Yes	Mixed	No
Collaboration, trust among providers	2.41	I, III, IV, V	II, VI	
Staffing based on patient needs	2.41	I	II, III, IV, VI	V
Continuity of care	2.39	II - VI	I	
Staff development valued	2.33	I, III, IV, V, VI II		
Change quick, no bureaucracy layers	2.30			I-VI
Nurses have good reputation in community	2.30	I-VI		
Cooperative attitude among providers	2.29	IV, V	I, II, III, VI	
Knowing family = insight	2.26	I-VI		
MDs aware of RNs' skills	2.26	I, II, IV, V, VI	III	
MDs seek/respect RNs' opinions	2.25	I-VI		
Nurses have positive attitudes	2.25	I-VI		
Nurses know limits, seek help	2.25	I-VI		
Nurses' recommendations are implemented	2.25	I, IV	II, III, V, VI	
Patient planning is interdisciplinary	2.25	I-VI		
Close relations = understanding of one another's skills	2.24	I, III, IV, V	II, VI	
Nurses use external resources	2.10	I-V	VI	
Reference materials available	2.11	I-VI		
Limited resources require efficient utilization of staff	2.09	I, V, VI	II, III, IV	
Administrators available	2.07	IV	I, II, III, V, VI	
Low nursing staff turnover	2.07	II, IV	I, V	III, VI
Cultural sensitivity in care	2.04	I-VI		
Common education=little diversity	1.99		II, IV, VI	I, III, V
Have and use tech equipment	1.92	II, IV, VI	I, III, V	
Must be creative to make do with available equipment	1.79	I	II-VI	
Nurses give community education	1.77	II, IV, VI	I, III, V	
Small number of providers helps communication	1.67	V, VI	I-IV	
Nurses draw on lay community help	1.44	I, III, IV, V, VII II		
Small agencies share resources	1.36	II	IV, V, VI	I, III
Some services too far away	1.25	I, II, III	IV, V	VI
Auto available	0.78	II		I, III-VI

Barriers

Seventeen barriers were listed and nurses were asked to indicate if they occurred (yes/no) and the extent to which they impacted upon practice (greatly=3, not at all =0). The mean extent of impact was calculated for each. Whether it occurred or not, or was mixed for each county type was determined. Ten barriers moderately impacted practice. Changes in delivery systems were limiting upstate New York nurses, especially regarding educational opportunities. Specifically, "short staffing" (x=2.03) and "downsizing" (x=1.0) limited educational leave for all nurses. A gap between administrators and nurses moderately impacted practice. It was reported as occurring in county type II, and was mixed for the other county types. "Staff complacency limits growth" was viewed as moderately impacting practice (x=1.89). "Confidentiality threatened by community size" was moderately impacting on practice, occurred in county types IV and VI, was mixed in county types II,III,V and did not occur in county type I. "Traditional in-service not meeting needs" was a moderate barrier for all nurses. "Distance limits educational opportunities," having moderate impact, was a barrier for group VI, lesser so for county types II, IV, V and not a factor for those in county types I and III. "Feeling of isolation" was a moderate barrier to practice (x=1.54) occurring in nurses of county types V and VI, not in I through IV. "Peers not viewed as sources of education" was viewed as a barrier that moder-

ately impacted on practice (x=1.51), occurring in county type V on a mixed basis, but not in the rest of the county types.

The remainder of the barriers had a minimal impact on nursing practice. Included were "bargaining unit not meeting nurses' needs," which occurred for county type III nurses, "population density not supporting specialists," "second opinion not available," and "sophisticated equipment limited" reported by county type VI nurses. Other conditions of minimal impact were "driving distances uses up time," "being not prepared for activities asked to do," and "specialist care follow-up being difficult because of unavailability of the provider," which occurred on a mixed basis or not at all for all county types.

Needs

Needs were delineated in section III of the questionnaire in 25 items. Nurses indicated the extent to which the item was viewed as a need and whether it was available to them or not. Item means for extent of need and availability to nurses by county type were ascertained. These are presented in Table 4.

The majority of respondents indicated that needs had a moderate impact upon practice. County type I nurses, those in the urban areas, indicated more of the needs were available to them. For the most part, however, the availability of the specified need is mixed or not available, especially in the rural areas.

Table 4. Needs and their Availability to Rural Nurses

Resources	Item Mean	Availability by County Type		
		Yes	Mixed	No
Collaborate mental health care	2.56	I, VI	III, IV, V	II
Increased salary	2.47		I-IV, VI	V
Car telephone	2.46			I-VI
Course in health care finance	2.45			I-VI
Accessible patient transport	2.44	I, VI	II-V	
More aides to assist RNs	2.42	I	III, IV	II, V, VI
Pilot money for new ideas	2.38			I-VI
More local continuing education	2.34		I-VI	
Public education re nurses' role	2.28		IV	I-II, V, VI
Creative in-service	2.25		I, II, VI	II, IV, V
Patient advocate	2.24	I-IV, VI	V	
Inc. cross training education	2.23		I, III, IV, V	II, IV
Satellite degree program	2.20	I	II-IV	
Local clinical site for degree program	2.19		I-VI	
Restructure nurse staff	2.18	I		II-VI
Clinical ladder	2.18	I	III-VI	II
Wider experience, more skills	2.18	I	II-V	VI
Access to current literature	2.16	I-III, V, VI	IV	
Computer for documentation	2.15		I, II, IV	III, V, VI
Increased interagency	2.14	I	II-VI	
Literature search capacity	2.08	VI	I-V	
Higher degree programs	1.84	I-IV	V, VI	
Common language across agencies	1.73	I, VI	II-V	
3 rd party pay for nurse	1.71		I, IV	II, III, V, VI
Transport for aides	1.11		I	II-VI

Discussion, Conclusions, and Recommendations

It has been assumed that nurses in rural settings have some unique conditions affecting their practice and impacting their needs and constraints. Results of this survey suggest more commonalities than differences among nurses in different regions across Upstate New York.

Even the observed variation did not suggest a clear pattern of resources, barriers, or needs in relation to geographic designations. Flexibility was the characteristic most representative of all groups, and received the highest mean score from the most rural nurses. Use of multiple skills was greatly reflective of all respondents, with the highest mean scores attributed to the two most rural groups.

Collaboration and trust among providers were the resources having the greatest impact on practice, and were available to most groups of nurses. Their availability, however, was mixed in those nurses in groups II and V. Some resources having moderate impact on practice were mixed in their availability to the various county types of nurses. Staffing decisions based upon patient needs, of moderate impact on practice, was a condition available to nurses in the urban counties, but was mixed or unavailable in the rural counties. The process to implement nurses' recommendations and opportunities for creativity have moderate impact on practice, yet are of mixed availability to these sample nurses. Rapid change was unavailable to all. Provision of continuity in care was scored as having moderate impact and was available to all groups of nurses except those in the most rural areas. The opportunity to access external resources was viewed as a resource of some importance to practice and was available to nurses in all but the most rural counties.

Barrier conditions that imposed limitations on professional practice generally were considered to have moderate to mild impact on practice. Short staffing was the predominant barrier, and this was consistent across all categories of counties.

Needs, conditions that positively contributed to professional practice, were also addressed. Overall, needs had greater impact (moderate mean scores) on practice than conditions considered as barriers. Generally, when the needs were specified, nurses in the urban counties indicated more of the conditions were available to them than nurses in other county types. Most of the needs were either of mixed availability or unavailable to all groups of rural nurses. Needs unavailable to all groups of nurses, such as a car telephone, a course in health care finance, and pilot money to test out new ideas are recommended as ways to improve practice conditions regardless of the locale. Nurses in all areas indicated the need for a salary increase. The need for greater numbers of aide personnel was noted and available for nurses in urban counties only. The need having greatest impact on practice was collaboration for mental health care, which was available in the most urban and most rural areas, but less so in other county groups. Other needs that could improve practice include educational offerings in accessible locations, and marketing the nurse's role to the public.

Nurses in upstate New York have many similarities, regardless of their county type based upon degree of rurality. Although the study

had a low response rate and lacked statistical analysis to determine statistically significant variations among county types, the following points are presented for consideration:

- Upstate New York nurses perceive having more resources than barriers or needs, and resources have a greater impact on practice than do barriers and needs.
- Nurses in the most mixed county type, III (urban, suburban, rural) reported less visibility or presence in their community.
- Isolation was perceived as greater in the more rural county types.
- Distance and reduced resources limited educational opportunities, especially in the more rural areas.
- Technical skills were viewed as important, because there is less back-up in the more rural areas.
- Nurses in the more rural areas felt that they had greater insight into patients' needs because they live in the same community.
- Understanding the needs of nurses in general and specific to county type can enable professional organizations and academic centers to plan initiatives and target resources with sensitivity to geographic factors.

One recommendation related to resources is to alter the process for implementing change to a quick method without bureaucratic layers as obstacles. This is viewed as a strong resource, but is unavailable to nurses in all locales. A mechanism that bases staffing on patient needs is also important to practice, but is limited for rural nurses although available to urban ones. So perhaps a comparison of staffing practices would be helpful. A cooperative rather than a competitive attitude among providers is a resource available to the more rural nurses. Consideration of the dynamics in the most rural settings could be helpful for urban nurses. Education regarding health care finance is recommended for all Upstate nurses. It could be offered by a university, and prepared in a format suitable for distance learning.

A mechanism for enabling rural nurses to share information and support initiatives would help reduce the feeling of isolation. A professional nursing organization, such as New York State Nurses Association, could create an electronic mail group or chat site for rural nurses or, perhaps, a newsletter specifically for the rural nurses. Universities with a rural presence, such as a satellite classroom could offer outreach courses to make educational opportunities more accessible. Creativity is the key to supporting rural practice and rural nurses.

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University Students' Dating Violence Behaviors

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ABSTRACT

One in three college students has either experienced or been the initiator of violence in dating relationships. Violence perpetuated by an intimate partner is one of the most underreported crimes on campuses; thus, the estimates of dating violence vary greatly. This study examined the use of violence by students in their present dating relationships at a public university in upstate New York. The Conflict Tactic Scale, developed by Strauss (1979), was used to measure students' behaviors. Thirty-seven percent of students engaged in the use of violence in a dating relationship in the past 12 months. A greater number of male respondents indicated use of very severe violence and sexual violence than did female respondents. Students who were freshmen and sophomores were more likely to participate in minor violence and very severe violence than junior and senior students. These findings suggest that certain segments of the university student community need to be targeted for educational programs addressing conflict resolution and sexual aggression.

Introduction

The incidence of courtship violence is predicted to be as high as the rate of domestic violence. Researchers estimate that one in three college students has experienced or been the initiator of violence in dating relationships (Lloyd, 1991; Thompson, 1991). Estimates of violence between dating couples ranged from a low of 15% to a high of 78% (Riggs & O'Leary, 1996). The purpose of this study was to examine university students' use of violence in their dating relationships as measured by the Conflict Tactic Scale (Straus, 1979). The following research questions were addressed:

1. What is the prevalence of dating violence in a sample of university students?
2. What is the relationship between selected demographic characteristics and the use of violence in dating relationships?

Background

Prevalence estimates of dating violence in college students range from 17% to 62%, while estimates of acquaintance rape vary from 15% to 44% among college students (Clark, Beckett, Wells, & Dungee-Anderson, 1994; Waryold, 1996; White & Koss, 1991). Researchers report that minor violence behaviors (e.g., throwing something, pushing,

shoving, and slapping) occur most frequently in dating relationships (Koval, 1989), and that psychological abuse and sexual abuse in dating relationships, also considered to be forms of dating violence, are found to be very common in college populations (Neufield, McNamara, & Ertl, 1999; Stermac, Du Mont, & Dunn, 1998). These variations in rates are due to methodological differences that include: differences in the composition of students within samples (e.g., social class and racial group); differences based on region of the country where studies were conducted; and differences in the way that dating violence is operationalized and measured (Gyls

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& McNamara, 1997; Kasian & Painter, 1992; Koval, 1989; Neufield, McNamara, & Ertl, 1999). Although dating violence prevalence rates vary, the specific types of dating violence behaviors reported by researchers include all categories identified in the Conflict Tactic Scale (Straus, 1979).

The role that gender plays in dating relationships is somewhat controversial. Research studies that have explored the question of which sex is more violent have been found to be inconclusive (Koval, 1989; Stith, Jester, & Bird, 1992; Tontodonato & Crew, 1992). Some studies have identified men as more likely to perpetrate violence and women as being more likely to be the victim (DeKeseredy & Kelly, 1993; Makepeace, 1983; Stets & Henderson, 1991). An example of this is the report by Barnes, Greenwood and Sommer (1991) that 42.6% of the college men in their study used physical abuse in their current stable relationship.

Other studies have found that more women than men acknowledge abuse in their dating relationships (Gray & Foshee, 1997; Riggs, O'Leary, & Breslin, 1990). However, other studies have found that the majority of students report mutually violent behaviors (Gray & Foshee, 1997; Spencer, Bryant, & Fields, 1996; Stith, Jester, Bird, 1992; Tontodonato & Crew, 1992). These conflicting findings indicate that researchers should not assume on the basis of gender that a student will always be either the victim or the perpetrator of dating violence.

With regard to sexual violence in heterosexual dating couples, most studies agree that males are the perpetrators. There are many situational factors on college campuses that support this type of violence. Often male-peer environments, such as fraternities and sports, reinforce the use of alcohol to overcome women's sexual reluctance (Pezza & Bellotti, 1995). Bohmer and Parrot (1993) found that fraternity pledges were more likely to rape than non-fraternity men. Men attracted to fraternities have been found to have a more narrow view of masculinity and sexually objectify women (Bart & Moran, 1993; Stomble, 1994; Thio & Calhoun, 1995).

Young women living on college campuses are especially vulnerable to dating violence and sexual assault. Reasons cited for this vulnerability are: they are often living away from home for the first time; their peers and intimate partners play roles that are more important in their lives than their family members; they often misinterpret jealous and controlling behaviors as signs of love and affec-

tion, and they interpret their partners' protectiveness as a sign that they are special to them (Pezza & Bellotti, 1995).

The problem of dating violence is well known among students, but it often goes unreported to college and university officials (Makepeace, 1981; Palmer, 1993; Pezza & Bellotti, 1995). Most students report knowing other students who experienced dating violence. The Campus Violence Prevention Center (1990) surveyed 3300 university officials and found that only 56.4% of reported physical assaults resulted in an institutional penalty. Rape and sexual assault resulted in a penalty in only 36% of cases (Lloyd, 1991). When violence on campus is underreported, underprosecuted, and underpunished, ignorance is fostered and feelings of vulnerability are increased, resulting in decreased incentives for victims to seek assistance and a weakening of the justice system (Pezza & Bellotti, 1995). "Where campus attitudes support the failure to report, prosecute, and punish, the adaptive behaviors of those at risk and those already victimized are not encouraged and the maladaptive behaviors of perpetrators are not discouraged" (Pezza & Bellotti, p. 108, 1995).

Methods

Setting

The study was conducted at a public university located in upstate New York. It is situated in a suburban setting, 10 miles from a city of 53,000. The university is composed of four professional schools, a graduate school and a liberal arts college. Approximately 9,500 undergraduate students were enrolled at the time of the study. The student population is composed predominately of Caucasian students (71%), while Asians comprise 14%, Latinos 5%, African Americans 5%, and Native Americans .002%. International students comprise 5% of the student population.

Sample

Approval to conduct the study was obtained from the University Human Subjects Review Committee. Respondents were invited to voluntarily participate in the study, and consent to participate was implied by their completion of the questionnaire. Anonymity was maintained as respondents were not asked to give their names, and all data were reported at the aggregate level.

A voluntary sample of 346 undergraduate students participated in the study. Subjects were surveyed in selected classes in order to

get the most representative sample of the undergraduate students attending the university. Physical education classes were surveyed, as all students must take at least two of these classes to complete the wellness criteria for the general education requirement. Africana studies classes were selected in order to survey students from different racial and ethnic backgrounds.

Sample Characteristics

The survey was administered from March through May, 1997. Five hundred questionnaires were distributed and 350 (70%) were returned. Table counts may vary due to missing data points for some of the variables. Respondents ranged in age from 18 to 49. Table 1 describes the characteristics of the respondents. The majority of the students were between the ages of 20 to 23 (65%). Most of the respondents were female (63%, n=216). Seniors (53%, n=181) were the largest educational level represented in the sample. Twenty percent (n=70) of the sample participated in fraternities or sororities. Sixty-eight percent (n=261) of students were Caucasian. This sample was somewhat reflective of the greater student population at this public university. Similarities were found for race. While actual percentages were not reflective of the university population regarding educational level, the trend, which was smallest for freshman and greatest for seniors, was consistent with the university as a whole. Seniors were overrepresented in this study, as were females.

Design

A descriptive correlational study was used to examine the relationship between use of dating violence and selected demographic characteristics. The Conflict Tactic Scale (CTS) (Straus, 1979) measured dating violence. Scores were computed on the CTS by summing the responses for each of the six summative scales (reasoning, verbal aggression, minor violence, severe violence, very severe violence, and sexual aggression).

Frequencies were used to describe the sample population. T-tests for independent samples were used to examine differences between the groups, and Pearson's correlation statistic was used to describe the relationship of the demographic variables and type of violence as measured by the CTS scale.

Survey Instruments

The data collection tools used in this study consisted of a demographic data survey and the CTS (form R, RC) developed by Murray

Table 1. Characteristics of the Sample*

Personal Characteristics	% Females (n=216)	% Males (n=129)
<i>Ages</i>		
18-19 years	21 (43)	26 (33)
20-23 years	61 (130)	71 (91)
24-32 years	9 (18)	2 (3)
33-49 years	10 (22)	2 (2)
<i>Educational level</i>		
Freshman	11 (23)	17 (22)
Sophomore	18 (38)	16 (20)
Junior	17 (36)	19 (24)
Senior	55 (118)	49 (63)
<i>Race/Ethnicity</i>		
Caucasian	70 (151)	58 (75)
Asian	8 (17)	12 (15)
African-American	9 (19)	10 (13)
Latino	7 (16)	11 (14)
Biracial/ other	6 (12)	9 (11)
<i>Sorority/Fraternity</i>		
Yes	20 (43)	21 (27)
No	80 (170)	70 (102)
<i>Previous History of Violence in Family of Origin</i>		
Yes	24 (51)	18 (23)
No	76 (165)	82 (107)

*The sample size may change due to missing data.

Table 2. Conflict Tactic Scales Definitions

Reasoning	The use of rational discussion, argument, and reasoning — an intellectual approach to the dispute. Scores range from 0 to 18.
Verbal Aggression	The use of verbal and nonverbal acts which symbolically hurt the other, or the use of threats to hurt the other. Consists of using insulting words, sulking, stomping, spitefulness, threaten to hit, and hit an inanimate object. Scores range from 0 to 36.
Physical Aggression	The use of physical force against another person as a means of resolving conflict. It includes minor violence, severe violence, very severe violence, and sexual aggression.
Minor violence	Consists of hitting, slapping, pushing, grabbing, or throwing something at his/her dating partner. Scores range from 0-18.
Severe violence	Consists of hitting or trying to hit his/her dating partner with an object other than his/her hand. Scores range from 0-6.
Very severe violence	Consists of kicking, biting, hitting with a fist, choking, threatening with a knife or gun, or using a knife or firing a gun. Scores range from 0-18.
Sexual Aggression	Using some form of sexual conflict with his/her partner. Scores range from 0-12.

A. Straus (1979). The demographic data form was developed by the researchers specifically for this study. It included questions regarding the students' age, educational level, race or ethnicity, sex, religion, marital status, year in college, personal and family income levels, number of siblings, parents' marital status, sexual preference, fraternity or sorority membership, history of violence, type of violence experienced, age that violence started, who was responsible for the violence, use of violence toward others, and whether or not they had ever participated in organized sports.

The CTS was chosen because it specifically measured the tactics (reasoning, verbal aggression, and physical violence) used by individuals to resolve conflict. It was developed originally to assess the conflict situations within families and has been used as the basis for two national family violence surveys (Straus, Gelles, & Steinmetz, 1980; Gelles & Straus, 1988). The alpha reliability coefficients for the conflict tactic scale were found to be .48 for reasoning, .83 for verbal aggression, and .82 for physical aggression (Straus, 1990).

The CTS is a 7-point, 19-item questionnaire, which lists various tactics that might be used to resolve conflicts. Form R is more specific to the conflict resolution that occurs within dating relationships. The original questionnaire was designed to elicit both the subject's participation in conflict resolution, and the subject's perception of his or her

partner's participation. However, in this study only the subject's participation was analyzed.

The conflict tactics on the questionnaire are arranged in order of increasing coerciveness and social disapproval (Table 2). It starts with tactics that most respondents positively value (such as, "discussed an issue calmly") and progresses to more socially disapproved of tactics (such as "beat him or her up"). The conflict tactics on the questionnaire fell into one of three categories, which form the three basic summative scales of the CTS. The categories/scales are; reasoning tactics, verbal aggression tactics, and violence/physical aggression tactics. Within the violence category, there are three subsets, which address minor violence, severe violence, and very severe violence. Because this questionnaire was used with university students, a fourth category that addresses sexual aggression was added. This section, not part of the original questionnaire, was developed and used previously by Mertin (1992) who added them to the CTS.

When administering the conflict tactic scale, individuals are instructed to indicate how many times they have used any of the conflict tactics listed in the past twelve months using the following response categories: 0=never, 1=once, 2=twice, 3=three-five times, 4=six-ten times, 5=eleven-twenty times, and 6=more than twenty times.

Results

Use of Violence

The prevalence rate for students' indicating a previous history of violence in their family of origin was 22% (n=87). Of these respondents, 3% (n=12) were abused sexually; 13% (n=50) were abused physically; and 20% (n=78) were abused emotionally. These numbers and percentages do not add up to 22% or n=87 because respondents could select more than one type of abuse. The prevalence rate for use of violence in a dating relationship in the past 12 months was 37% (n=143).

Conflict Tactic Scale

Reasoning

Reasoning is the only category used in the conflict tactic scale that is a positive way of managing conflict in dating relationships. Ninety-eight percent (n=366) of the sample used some type of reasoning to avoid conflict in a dating situation. The majority of the students (95%, n=371) stated that they had discussed an issue calmly. Eighty-one percent (n=317) of the students located information to back up their side of things, while less than half (45% n=176) brought in or tried to bring in someone to help settle things.

Verbal Aggression

The verbal aggression category is operationalized in a manner that includes physical acts of violence directed toward inanimate objects. Ninety-four percent (n=367) of the sample stated they had used some type of verbal aggression in a dating relationship. Seventy-two percent (n=281) stated they had insulted or sworn at their partner; 71% (n=279) stated that they sulked or refused to talk about an issue. More than half of the respondents (59%, n=231) had stomped out of the room, house, or yard. Seventy percent (n=274) stated that they had either done or said something to spite a partner. Fourteen percent (n=55) stated they had threatened to hit or throw something at their partner; 30% (n=119) stated they had thrown, smashed, hit, or kicked something.

Minor Violence

Twenty-two percent (n=87) of the sample stated they had used some type of minor aggression against their partner. Ten percent (n=39) stated they had thrown something at their date; 18% (n=69) stated they had pushed, grabbed, or shoved their partner; and 8% (n=33) stated they had slapped him or her.

Table 3. Difference in Use of Conflict Tactics by Gender*

Dependent Variables	Males (n=124) Mean	Females (n=209) Mean	t test
Reasoning	9.57	9.51	.15
Verbal Aggression	9.72	10.51	-.92
Minor Violence	1.07	.81	.87
Severe Violence	.24	.009	1.54
Very Severe Violence	.82	.13	2.37**
Sexual Violence	1.34	.69	2.49**

**p<.01

*The sample size may change due to missing data.

Severe Violence

An individual who hits or tries to hit her or his date with something participates in severe violence. In the category of using severe violence, 5% (n=18) of the sample stated they had used some type of severe violence against their partner.

Very Severe Violence

Six percent (n=25) of the sample stated they had used very severe forms of aggression against a date. Six percent (n=25) stated they had kicked, bit, or hit with a fist; 3% (n=10) stated they had beat him or her up; and 2% (n=8) stated they had choked him or her. Two findings of great concern were that 1% (n=6) of the students stated they had threatened their date with a knife or gun; and 2% (n=7) stated they had used a knife or fired a gun.

Sexual Violence

Twenty percent (n=78) of the sample stated they had used some form of sexual aggression against a partner. Eighteen percent (n=72) stated they wanted sex when their date did not; and 5% (n=21) stated they had awoken their date in the night and demanded sex.

Gender Differences

There were significant gender differences in the use of very severe violence and sexual violence. Table 3 shows that male students were more likely to engage in behavior labeled as very severe violence than female students were (t=2.37, p<.01). In addition, male students were more likely to participate in sexual aggression than female students (t=2.49, p<.01).

Fraternity/Sorority Membership

This study found no significant differences in the behaviors of students who were members of sororities and fraternities and their undergraduate student counterparts (see Table 4). However, prior research indicates that members of fraternities and sororities are more likely to participate in behaviors that could be described as violent.

Prior History of Violence

There were significant differences between students who experienced violence in their family of origin and those who did not. Students with a prior history of violence were more likely to engage in verbal aggression than their counterparts (t=2.23, p<.05). Table 5 shows that students who experience violence in their family of origin were

**Table 4. Difference in Use of Conflict Tactics by Sorority/
Fraternity Membership***

Dependent Variables	Yes (n=68) Mean	No (n=263) Mean	t test
Reasoning	9.17	9.63	-.86
Verbal Aggression	11.27	9.91	1.31
Minor Violence	1.15	.82	.80
Severe Violence	.15	.13	.24
Very Severe Violence	.66	.28	1.04
Sexual Violence	.58	1.04	-1.87

* The sample size may change due to missing data.

also more likely to engage in sexual violence than students who did not experience violence in their family of origin ($t=2.06, p<.05$).

Educational Level

Freshman and sophomores were grouped as one category and juniors and seniors were grouped into another category. There were significant differences between educational level and use of violent tactics. Table 6 shows that lower classmen were more likely to engage in minor violence activities than upper classmen ($t=2.00, p<.05$). Freshmen and sophomores were also more likely to participate in behaviors of very severe violence than their junior and senior classmates ($t=2.05, p<.05$).

Discussion

The prevalence rate in this study was found to be as high as 90% when verbal abuse was included as a form of dating violence. This percentage is higher than the prevalence rates quoted in the literature, and may be due to the fact that dating violence is not consistently defined across studies as being inclusive of verbal aggression. In this study, physical and sexual violence occurred equally in 13% of the dating relationships. A greater number of male respondents indicated use of very severe violence and sexual violence than did female respondents. This finding falls within the range reported by past studies (Stets & Pierog-Good, 1989; Lloyd, 1991; Barnes, Greenwood, & Sommer, 1991).

The investigators were intrigued by the data that demonstrated no significant relationships between gender and reasoning, and verbal aggression. Based on the research that has demonstrated the increased verbal skills in women, one might have expected to find a gender difference in the use of reasoning and verbal aggression.

There were significant differences found between educational level and both minor violence and very severe violence. Overall, freshmen and sophomore students were more likely to engage in these behaviors than junior and senior students were. Prior research has identified the relationship between violence and the use of alcohol. Based on this information, programs for beginning college students should address the hazards of excessive drinking and violence.

Students who experienced a prior history of violence were more likely to participate in verbal aggression and very severe violence than their counterparts. This finding is partially supported by the work of Gallagher, Harmon, & Lingenfelter (1994), who found that

conflict tactics are often learned within the family of origin, which can predispose individuals to becoming a victim or perpetrator of campus violence.

Several limitations were identified in this study. The first is that the sample was a convenience sample of university students attending a public upstate New York university, and therefore, cannot be generalized to all college students. While random selection of subjects is the preferred method of data collection, on sensitive topics individuals tend to self-select. Therefore, targeting particular groups often counters the effect of self-selection. While the study results can not be generalized, the findings are supported by previous research (Ensign, 1997; Wiederman, 1997).

The second limitation dealt with the problem of self-report. Self-report of violent and abusive experiences and current use of violence may not reflect participants' actual experiences and behavior. However, the results of this study are similar to findings in the research literature on use of violence in dating situations (Hohmna & LeCroy, 1996; Kinsman, Romer, Furstenberg, & Schwartz, 1998).

Implications for Intervention

Implications for intervention will be discussed as they relate to primary, secondary and tertiary prevention of dating violence and sexual assault. Primary prevention is aimed at intervention before abuse has occurred. It includes both general health promotion and specific protection. The campus health service, residential life, Panhellenic councils, and physical education departments on college campuses must work collaboratively to address the issue of dating violence with incoming freshman, and sorority and fraternity members. Freshman orientation should include sessions that address conflict resolution skills as they relate to interpersonal relations. Discussions with student groups (both freshman and upperclassmen) should be offered in dorms, in fraternity and sorority houses, and in open student forums to discuss how to prevent dating violence and to practice conflict resolution skills.

Campus student life administration should make it clear in all printed materials that dating violence is not tolerated on the campus. In addition, social skills, assertiveness training, sexual decision making, stress management, conflict resolution, and self-defense can easily be introduced in dormitory meetings. The campus environment should also be supportive of prevention programs through the provision of campus lighting, escort services, adequate security measures, and personnel and protocols for rapid response.

Table 5. Difference in Use of Conflict Tactics by Previous History of Violence in Family of Origin*

Dependent Variables	Yes (n=71) Mean	No (n=264) Mean	t test
Reasoning	9.76	9.47	.54
Verbal Aggression	12.04	9.79	2.23**
Minor Violence	1.35	.81	1.45
Severe Violence	.27	.11	1.24
Very Severe Violence	.64	.32	1.07
Sexual Violence	1.49	.80	2.06**

** $p<.05$
* The sample size may change due to missing data.

Table 6. Difference in Use of Conflict Tactics by Educational Level

Dependent Variables	Freshman-Sophomore Students (n=98) mean	Junior-Senior Students (n=239) mean	t test
Reasoning	9.53	9.50	.06
Verbal Aggression	10.43	10.17	.29
Minor Violence	1.42	.72	2.00*
Severe Violence	.30	.008	1.84
Very Severe Violence	.87	.18	2.05*
Sexual Violence	.90	.99	-.31

* $p<.05$

Secondary prevention intervention seeks to identify dating violence and sexual abuse early and to deal with it promptly. Healthcare providers (whether on campus or in the community) should ask all students screening question about violence in their intimate relationships. Nurses practicing in college health services should be particularly sensitive to question, diagnose, and refer students of both sexes who present with unexplained injuries. Because of the frequent use of less severe forms of physical violence, students' presenting behaviors will be less apparent. It is only through insightful and supportive inquiry during history taking that the student in either the college/university health service or in the primary care setting is likely to disclose dating violence. Because of the growing prevalence of dating violence in the college setting, the nurse should routinely explore exposure to dating violence for both male and female students. Screening for sexual aggression is particularly critical for college and university students. Any student presenting in the college/university health service for gynecological examination should be screened for possible sexual abuse. In addition, students should be made to feel comfortable in disclosing injuries due to homosexual as well as heterosexual relationships. When dating violence is identified, students should be referred to on-campus and community resources for counseling to assist them. Students should be encouraged to report and identify the perpetrators of the abuse. Campus administration should

deal directly with perpetrators to make it clear that this type of behavior is not acceptable on the campus. Consistent and rigorous endorsement of rules regarding dating violence and sexual assault must be upheld. Campus security must develop partnerships and linkages with community police and social agencies. Campus security must be prepared to refer to local police agencies when crimes occur.

Tertiary prevention requires limitation of disability and rehabilitation for those individuals who have already experienced assaults. Nursing care of sexual assault victims to prevent venereal disease and pregnancy is necessary in college health services. Referrals should be made to campus counseling and community counseling services for dating violence and sexual assault victims, their roommates, and friends. Services must also be offered to perpetrators of dating violence and sexual assault, as they are also in need of counseling services.

If dating violence is not addressed, these behaviors continue to be used as students leave the college environment and enter cohabiting and marital relationships. Therefore, it is imperative that universities and colleges: provide an atmosphere where violence is not tolerated; provide educational prevention programs to all students; provide counseling for students who are both victims and perpetrators; and prosecute perpetrators of violence. When colleges and universities provide these interventions, they help young adults develop the skills necessary to sustain healthy interpersonal relationships.

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Disseminating Nursing Research to the Consumer

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ABSTRACT

Nurses can serve the public, enhance the image of nursing, and influence public policy by disseminating nursing research findings to a lay audience. This article explores the benefits of publishing for the health care consumer and provides strategies for translating scientific data into useful consumer information.

Introduction

Every nurse is accountable for the scientific basis of the nursing profession and to the public who are the consumers of healthcare (ANA, 1995). As consumers take more responsibility for their own health and wellness, helping them put health related discoveries into perspective becomes an increasingly important aspect of nursing professionalism. Nurses are in a unique position to disseminate research findings as the foundation for safe and effective practice to the general public. Doing so demonstrates nurses' caring, commitment, and implementation of the American Nurses Association's social policy statement. Publishing for the health consumer is an opportunity that extends patient teaching beyond the boundaries of direct patient

care, enhances the image of nursing, and points out that nurses are community resources for health care information. The purpose of this paper is to delineate the benefits of publishing for the health consumer, discuss the political implications of bringing nursing research to the public, and suggest strategies for translating scientific data into meaningful and useful consumer information.

Benefits of Publishing for the Consumer

Empowering patients to become partners in their care

Nursing is a nurturing and caring discipline in which effective communication is a central theme. Nurses see the outcomes of

caring as restoration and empowerment of patients (Benner, 1984). Communicating research findings to the public is not only an aspect of caring and empowerment but also an ethical responsibility (Copp, 1990). Self care, consumer involvement, partnership, and responsibility for health and wellness are now part of the vocabulary of professional nurses. Implicit in these terms is the need for a current and accurate knowledge base. Knowledge enables the individual to effectively manage minor health problems not requiring the care of a health care provider. In addition, a knowledgeable consumer is better able to navigate the complexities of the healthcare system (Shirreffs, 1978). However, the public is unaware of the scope of nursing research being conducted and how it can benefit them.

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“Nurses need to demonstrate that nursing research is important to the health of the public.”

Gordon and Buresh (1996) stated that such ignorance has a significant impact on the health of the public. Consumers cannot take advantage of “nursing innovations or advanced levels of nursing expertise if they do not know about them” (p. 62).

Enhancing the image of nursing

The image of nursing is an issue that has concerned the profession for decades. Each nurse is responsible for enhancing the collective image of professional nursing. “It is the responsibility of every nurse to take pride in nursing research, to use it and articulate it to patients and their families” (Dreher, 1997, p. 6). Imagine how the image of nursing would be enhanced if nurses explained to their patients and families that their care is based on current scientific studies conducted by nurses.

Consumers know very little about what today’s nurses actually do. They are only beginning to realize that nurses provide evidenced-based care and conduct scientific research. Therefore, it is understandable that they do not fully appreciate the importance of nursing research to their health.

Nurses need to demonstrate that nursing research is important to the health of the public. Just as medical research contributes to improving health, nursing research also impacts individuals’ health and health care. Effective dissemination and application of nursing research results can show the public the intellectual challenges and scientific breakthroughs that are part of nursing. To get the attention they deserve, nurses must be willing to compete for the attention of the media (Gordon & Buresh, 1996).

Evidence of the media’s response to increased public interest in health and wellness abounds. Health articles and columns in newspapers and popular publications, television and radio programming, and the growing numbers of Internet sites attest to consumer interest in health information. These venues have been underutilized by the nursing profession (Bezyack, 1999). Media reach audiences in far greater numbers than do nurses

in clinical practice. The public’s interest in health information is rising exponentially as demonstrated by the proliferation of magazines targeted at health-seeking men and women of all ages and lifestyles (Jimenez, 1991). Nurses are potential contributors to articles addressing health issues. Nurse researchers will be able to disseminate important healthcare research to the consumer by publishing their research results in the popular press as well as in professional journals.

Influencing Public Policy

The tremendous lobbying power of the American Medical Association (AMA) is one example of the political impact that organized and planned communication can have on the public view of healthcare professionals. The positive image of nurses as professionals has been cultivated by Sigma Theta Tau International as well as by the New York State Nurses Association, the American Nurses Association, and multiple specialty nursing organizations. However, nursing has not made much headway in getting its message across. Research has shown that nurses are not perceived as a source of health information by a majority of consumers. Politicians are increasingly relying on public opinion polls to shape public policy. Jimenez (1991) reports that in a public survey, nurses were identified as a source of health information by only 37% of the respondents. This was far less than other perceived sources (magazines, 78%; television, 76%; and physicians, 74%). Nurses in all aspects of professional practice possess the power to educate our political representatives, as well as the public, by utilizing the media to tell stories of the nursing profession. Such stories document how nurses make a difference in patients’ outcomes. It is only through the dissemination of our stories and research to the public that we will be able to influence public opinion about the role of nursing in health care and thus positively affect public policy.

Strategies to Consider when Publishing for the Public

Writing for the public is one aspect of patient education. Because nurses are continu-

ally engaged in patient education, writing for a lay audience may be easier than some of us think. The following are some tips that can guide nurses when writing for the consumer. The first four tips address translating research findings into information for the public. The others are tips on how to write research results for a consumer magazine.

Tip #1: Use non-technical terminology

When writing professionally, we use appropriate technical and medical terms and approved abbreviations, which are recognizable to other professionals. We use similar language when we communicate verbally. Just listen to two nurses exchanging reports at change of a shift, and you will hear a series of abbreviations and short hand phrases that would never be found in any dictionary. Yet, with few exceptions, we have little difficulty understanding each other. These terms, however, will seem like a foreign language to the public. Thus, tip one is to eliminate all technical terminology and other shortcut phrases. Use simple language that will be understandable to virtually anyone reading the piece. Following are portions of scholarly works published in professional journals and examples of how the information can be expressed in simple language.

Example 1:

Using Technical Language

King, Rowe, Kimble, & Zerwic (1998) examined the relationships among dispositional optimism, coping strategies, and psychological and functional outcomes in women during the year following coronary artery bypass grafting surgery. They reported: “Optimism was significantly related to positive mood and life satisfaction within each time {1, 6 & 12 months after surgery}, and was inversely related to negative mood at 1 and 12 months after surgery. Optimism was clearly and consistently related to positive psychological outcomes {in women who underwent coronary artery bypass surgery}. It was inversely related to negative psychological outcomes, although this relationship is not as consis-

tent, nor as strong as the relationship to positive psychological outcomes. Others have reported similar relationships between optimism and psychological outcomes in individuals dealing with illness or a major health event. Thus it appears that those who are optimistic feel better.”

Using Simple Language

After bypass surgery, women who viewed themselves as optimists reported higher levels of positive moods and were more satisfied with their lives than women who did not view themselves as optimists.

Example 2

Using Technical Language

Watson, Wells, and Cox (1998) studied the use of rocking chairs to improve the psychological well-being and balance of nursing home residents with dementia. They reported, “Rocking time was negatively correlated with a reduction in depression and anxiety ($r=.39$). The research suggests that those who rocked 80+ minutes daily seemed to experience improvement Rocking time was also negatively correlated with doses of PRN pain medication ($r=.64$).”

Using Simple Language

Rocking for at least 80 minutes a day led to a reduction in depression and anxiety among nursing home residents with dementia. It also led to a reduction in their request for pain medication.

Tip # 2: Write at a sixth-grade reading level

Glazer-Waldman, Hall, and Weiner (1985) studied the reading ability of patients admitted to a hospital over a six-month period according to age, race, and sex. Fifty percent of the subjects were drawn from the outpatient clinics and 50% from the hospitalized patients. Results revealed only 40% of the subjects could read at the 6th-grade level. Therefore, attention should be given to the reading level of the written word to enable consumers to take advantage of nursing innovations. Usually the level of reading ability is based on the number of syllables in each word. The fewer the syllables, the lower the reading levels. Therefore, it is recommended that simple, short words of one or two syllables be used whenever possible. Several word processors contain functions that will evaluate the reading level of the written word. For example, Microsoft Word has a readability function that is part of its spelling and grammar tools. It will produce a “readability statistic” in the form of the Flesch-Kincaid Grade Level statistic.

One easy way to substitute words is through the use of a thesaurus. Most word processing programs now have one. If not, then the old-fashioned book kind works just as well. Simply look up the words that are too complex and find substitute words that will be more appropriate to the reading level.

Tip # 3: Write a press release on the findings of nursing research

A press release distributes information to the media in a concise, direct manner. This information enables the public to make informed choices and decisions. It is often helpful to work with the public relations staff in your organization. They have the expertise to help write an effective press release. They also have contacts in the media and know how to get their attention.

Every press release on research findings should include the names and credentials of the investigators, the institution(s) with which they are affiliated, the location of the research study, and its time frame. If

the study has been published in a research journal, the name and publication date of the journal should be mentioned.

Editors and reporters often have questions about the material in a press release. If the researchers are available for an interview and willing to supply additional information or answer a reporter’s questions, that information should be included, along with a contact phone number or e-mail address.

After a press release is sent, it is perfectly appropriate to call the publication to make sure it has been received by the reporter or editor who handles health issues.

Here is an example of research findings as published in a professional journal, followed by an example of how to put those findings in a writing style suitable for a press release.

Professional Journal

“In this randomized, controlled trial of methylprednisone, naloxane, or placebo in the treatment of acute spinal-cord injury, we observed a significant improvement in motor function and the sensations of pinprick and touch six weeks and six months after injury in the patients treated with methylprednisone. The beneficial effect of methylprednisone was limited to the patients treated within eight hours of injury, supporting the hypothesis that early treatment is more effective.” (Bracken, et al., 1990).

Press Release Style

A clinical research study demonstrated that early treatment of spinal cord injury patients with steroids results in better patient outcomes.

Tip # 4: Translate research findings for everyday application

A major challenge in publishing nursing research is to translate the findings in such a way that they can be used by the average person. The recent emergence of journals such as *Applied Nursing Research* and *Clinical Nursing Research* represents an important but insufficient step in this direction. An implication section with suggestions for clinical practice is a standard feature of research reports published in these two journals. However, these journals are not read by the average consumer.

The previously mentioned study by Watson, Wells, and Cox (1998) has implications for everyday use. In writing for the lay public, the writer might say for example, that care givers of Alzheimer patients can place their loved ones in a rocking chair for 80 minutes a day. This may help to soothe them and reduce their anxiety and depression.

Tip # 5: Pick topics of interest to the public

While all research may have some significance to the general public, certain topics will be more timely than others. For example, current research in the areas of breast cancer, asthma, and HIV/AIDS is of great interest to the public. A study on the use of companion animals in health care might also be of interest. In contrast, reports on the redesign of a hospital care delivery system would probably be less appealing.

It can be argued that any current nursing research topic may have some interest to the public, so that while being discriminating is important, it also may be possible to slant any research in such a way as to make it relevant to a general audience. For example, although hospitals’ revamping of its care delivery may appear to have less relevance than a study of breast cancer, the public is aware of the difficulties hospitals are facing due to reductions in their reimbursement from managed care, and government programs like Medicare and Medicaid.

These cuts have had great impact on the services being delivered in our current health care systems. An article discussing how delivery systems are redesigned to respond to these reimbursement changes may greatly interest the public.

The most important factor to consider is which elements of the research are most relevant to the audience for whom the article is being written.

Tip # 6: Conduct consumer review

If you can, ask several people who are not in health care to read your article. Ask them if they understand it, and if you could make any changes to make it clearer. Ask them if the topic is relevant to them, if it is something they want to read about, and if the way it is presented captures their attention.

Tip # 7: Use the active voice rather than the passive voice

The active voice of a verb in the English language denotes that the subject takes action. In the passive voice of a verb, the subject is acted upon. The use of active voice empowers the recipient and the provider of health care.

Example:

Passive voice: “Despite an increased incidence of intra cerebral hemorrhage, an improvement in clinical outcomes at three months was

found in patients treated with intravenous t-PA within three hours of the onset of an acute ischemic stroke.” (The National Institute of Neurological Disorders and Stroke rt-PA Stroke Study Group, 1995).

Active voice: The National Institute of Neurological Disorders and Stroke found that treating stroke patients within three hours of the attack produces better results.

Conclusion

Publishing the results of research conducted by nurses in media outlets targeted for the consumer has many advantages. First and foremost, it gives consumers useful information that can affect their health and well-being. Second, it increases the public’s understanding and appreciation of nursing and what nurses contribute to health care. Heightened awareness of what nursing offers can influence public policy, funding for nursing research, participation by nurses in multi disciplinary review teams, and recruitment into the profession. This would increase the likelihood that nurses will be called upon as health care experts when journalists prepare their materials for release, thereby increasing consumer access to a broader range of credible health care information. It would simultaneously enhance the credibility of the nursing profession.

In summary, disseminating nursing research findings is in the best interest of consumers and nurses alike. It’s a win-win opportunity!

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INFORMATION FOR AUTHORS

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WHAT'S NEW IN THE

Clinical Practice

Dickerson, S. S., Flaig, D., & Kennedy, M. (2000). Therapeutic connection: Help seeking on the Internet for persons with implantable defibrillators. *Heart & Lung, 29*(4), 248-255.

This study describes how persons with implantable cardiac defibrillators use Internet bulletin board as a type of support group to seek practical information and support in coping with daily anxieties of living with an ICD. The Internet provides a therapeutic connection similar to a face-to-face support group that is free of time and space barriers. Lurkers are also able to benefit from reading the messages without feeling the need to participate.

Whittmore, R. (2000). Strategies to facilitate lifestyle change associated with diabetes mellitus. *Journal of Nursing Scholarship, 32*(3), 225-232.

For adults with diabetes strict adherence to regimes that foster glycemic control have been found to substantially reduce the many possible complications associated with this disease. But this degree of glycemic control requires sometimes drastic lifestyle change. The author describes a review and critique of published literature from 1985 to 1999 about strategies to facilitate lifestyle change. It was found that diabetes education programs that focus on self management and behavioral strategies, and that provide culturally relevant information, had the most positive results. A substantial bibliography is provided.

Creason, N., & Sparks, D. (2000). Fecal impaction: A review. *Nursing Diagnosis: The International Journal of Nursing Language and Classification, 11*(1), 13-23.

Creason and Sparks review the published literature on fecal impaction with specific foci on its definition, diagnosis, etiology, signs and symptoms, and treatment. The authors point out that although this concept appears as a defining characteristic of bowel incontinence, fecal impaction is not on the current list of accepted nursing diagnoses. Yet, the terms "constipation/impaction management" are listed in the Nursing Interventions Classification taxonomy (McCloskey & Bulechek, 1966). Although the authors initially intended to review only research literature, the paucity of such literature led them to conduct a wider review. One important gap the authors noted is that "...there is no clear indication when the change from the diagnosis of constipation to fecal impaction occurs." Finding only two studies related to its treatment, the authors also note that the treatment of fecal impaction lacks a research base.

Lipman, T.H., Hench, K., Logan, J.D., DiFazio, D.A., Hale, P.M., & Singer-Granick, C. (2000). Assessment of growth by primary healthcare providers. *Pediatric Health Care, 14*(4), 166-171.

Growth is the single most important indicator of health in children, and precise measurements are critical for accurate growth assessment. American Academy of Pediatrics guidelines state that children should be measured every 2 months until 6 months, every 3 months from 6-18 months, and then yearly until age 18. Children from birth to 2 years should be measured lying down and the results plotted on a length chart. Children between 24-36 months can be measured either lying or standing, but the results must be plotted on the appropriate chart: *length* for lying and *height* for standing. Many children are referred to endocrine practices in error because height is obtained but plotted on length growth charts, giving the impression that growth has decelerated. This is because a child's height is less than his length. In an attempt to determine the accuracy of growth assessment in primary care practices, the investigators instituted a telephone survey to gather information about how often children are measured and the techniques that are used to conduct the measurements. In the Philadelphia area, 24 family and 26 pediatric practices were randomly surveyed with 5-10 minute interviews. The results showed that 58% of these practices had incorrect policies regarding obtaining length versus height. Correct techniques were significantly more likely to occur in pediatric practices, but 38% of these offices still made errors regarding length versus height. Inaccurate equipment was used in the majority of practices, particularly when obtaining length. Of most concern was the finding that in 24% of practices children were measured only at well-child visits, which compromises poor children who are more likely to receive health care only when ill.

Healthcare Delivery

Oermann, M., & Templin, T. (2000) Important attributes of quality health care: Consumer perspective. *Journal of Nursing Scholarship, 32*(2), 167-172.

This study describes the importance that consumers place on high quality nursing care. The most important indicators were nurses who are well informed, able to communicate and spend time with patients. Patient education was an essential component especially in individuals with chronic illnesses, low income levels and less education.

NURSING LITERATURE

Environmental Health

Green, P. (2000). Taking environmental health education seriously. *Nursing and Health Care Perspectives*, 21(5) 234-239.

Faculty and nurses sensitive to environmental problems will be interested in this article. Chemical hazards are but one of many environmental health risks people face today. The author of this article points out that “nurses must broaden their view of the environment to include the intricate interplay of human life with physical, chemical, biological, and social forces. Increasing students’ awareness and knowledge about the basic principles and concepts of environmental health can be achieved through minor expansion of curricular content” (p. 234). The author describes a course developed at Howard University for senior nursing students in which they pursued a variety of environmental issues in the community and in partnership with a coalition of 20 community, professional, and academic organizations. Content about many of these issues was also incorporated into other courses in the curriculum.

Nursing Education

McCloskey, J.C., & Bulechek, G.M. (Eds.) (1996). *Nursing interventions classification (NIC) (2nd ed.)*. St. Louis: Mosby.

Elfrink, V.L., Davis, L. S., Fitzwater E., Castleman, J., Burley, J., Gorney-Moreno, M.J., Sullivan, J., Nichols, B., Hall, D., Queen, K., Johnson, S., & Martin, A. (May/June 2000). A comparison of teaching strategies for integrating information technology into clinical nursing education. *Nurse Educator*, 25, (3), 136-144.

The Nightingale Tracker (NT), a project undertaken by FITNE and partially funded by the Helene Fuld Health Trust Fund, resulted in a computer-based electronic communication system designed to assist the supervision of students in community-based clinical education. A description and comparison of students’ attitudes and teaching strategies used to help students learn about the use of the NT during field tests in five sites are given. Tables provide the reader with summary information about the field tests. These include: a listing of the types of programs involved; the number of students participating; teaching approaches; students’ scores on an attitude test at one and six weeks during the training sessions; students’ reactions; and recommendations for teaching. Instructional strategies for integrating information technology into clinical nursing education are addressed.

Community Health

Hendricks, C. (2000). Fostering Healthy Communities @ Hair Care Centers. *The ABNF Journal*, 11 (3), 69-70.

The Chi Eta Phi, Inc. chapters (N=7) in South Carolina are implementing an innovative health education project designed to educate African Americans at the community level. Funded (\$1,500) by the South Carolina Nurses Association, Chi Eta Phi developed a health education outreach program to target patrons at barbershops and beauty salons (Hair Care Centers) in African American communities across South Carolina. Based on the Healthy Communities Initiative, the project is called Fostering Healthy Communities @ Hair Care Centers or Project F-HC. The major goal of the project is to provide self help and health education information via health promotion and disease prevention materials. The information will be provided in places (hair care centers) people use on a regular basis. Health topics will be presented based on the monthly national health awareness themes as well as resident area needs. Chi Eta Phi, Inc. is an international nursing organization comprising registered nurses and nursing students primarily of African descent. Founded in 1932, the organization has been involved in national and international initiatives focusing on health promotion, disease prevention, and early detection of disease within the African American Community.

Health Policy

Gebbie, K. M., Wakefield, M., & Kerfoot, K. (2000). Nursing and health policy. *Journal of Nursing Scholarship*, 32(3), 307-314.

The purpose of this qualitative research project was to describe ways nurses are and are not effective in developing health policy in the U.S., and to provide useful information for those interested in making nursing a more vital part of the policy arena. A sample composed of 27 American nurses currently active in health policy at the national, state, local, and organizational level was interviewed using a semi-structured format. The questions focused on career paths, contributing resources, and strengths and weaknesses of currently available information for policy work. The results revealed that policy involvement meant to the nurses speaking for patients who have a limited voice and advocating for reallocation of limited resources. Strong belief in the capacity and importance of people caring for themselves distinguished nurses in their policy roles, and policy makers responded to the experiences of the nurses. However, the nurses did not use nursing research in a significant way to inform policy making. The investigators recommended that a system be developed to connect nurse policy makers with nurse scholars.

Professional Associations: Ethics, Duty, and Power

Marilyn L. Dollinger, FNP, MS, RN, CS

ABSTRACT

The traditional role of professional associations to establish a contract with society on behalf of the individual members of a profession is more important today than ever. As healthcare professionals struggle to advocate for patients while facing the realities of practice, professional associations provide a supportive and collegial forum to discuss and develop standards, share experiences and gather peer support to work for effective change. Individuals must use the platform provided by professional associations to speak to the public and exert political influence on policy. Professional association membership is not optional in today's healthcare environment. It is the duty, responsibility, and privilege of all professionals to participate in professional associations to influence the future of an accessible, equitable, and high quality healthcare system.

Introduction

A traditional role of professional associations is to establish a contract with society on behalf of its individual members. This function of professional associations is more important today than ever before. In health care, recent efforts at reform, driven by cost control measures, are giving third party payers unprecedented power and authority over physicians and nurses, the two largest groups of healthcare professionals. Insurance companies can determine standards of practice, reimbursement rates, control access to treatments, and even dictate which medications will be "available" under different insurance plans. These dynamics are threatening the role of physicians as gatekeepers, primary decision-makers, and sources of referrals. Nurses, in contrast, have struggled over the latter part of this century to have their pro-

fession and its contributions recognized as distinct from medicine. In this context, nurses need to see the current shifts and redistribution in power and control as an opportunity to better define their role in health care and utilize the potential of their professional associations to achieve that goal.

Professions and Professional Associations

Historically, professional associations evolved in the traditions of the four classic professions: law, medicine, academia, and theology. With increased knowledge and specialization, many groups affiliated with these traditional professions, including nurses, sought and adopted the status of a profession and as part of the process, organized professional associations. Many authorities have reviewed the criteria that must be met

for any "occupation" to qualify as a profession. For years debate ensued about whether, in fact, nursing met these criteria. In 1933, Carr-Saunders and Wilson described professions as bodies of experts who were organized with their own elaborate system of education, entry by exam, a code of ethics, and self-monitoring of members of the profession. More recently, Wilensky (1964) described several "firsts" for American professions: a national professional association; government-sponsored licensing and regulation; professional examinations; separate and distinct professional schools; university-based professional education; a national-level journal; and accreditation of schools or processes. Bayles (1981) wrote that, as a minimum, members of a profession require extensive training involving a "significant intellectual component," which provides an important ser-

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vice to society. The intellectual training and judgment required to attain professional status also requires a significant level of autonomy. Although professional nurses have long met these criteria, the recognition of nurses as professionals who along with many other professionals comprise a healthcare team has been an important step in the process of gaining a place at the policy table.

As professional nursing associations have evolved, they have filled the traditional role of professional associations in developing a social contract on behalf of individual members. This requires that the members of a profession use the association to balance the protection of the public's interests with protection of the welfare of the members of the profession. In the interest of protecting the public, professional associations set educational criteria for admission into the profession, articulate standards for practice, develop a code of ethics, and provide a collegial forum for professional discussion, debate, and peer review. The articles of incorporation for the American Nurses Association (ANA) in 1896 articulate these objectives:

The object of the Association shall be: to establish and maintain a code of ethics, to the end that the standard of nursing education be elevated; the usefulness, honor and interests of the nursing profession be promoted; public opinion in regard to duties, responsibilities, and requirements of nurses be enlightened; emulation and concert of action in the profession be stimulated; professional loyalty be fostered, and friendly intercourse between nurses be facilitated. (Associated Alumnae of Training Schools of the United States and Canada [now known as the ANA] in Fowler, 1993, p.17).

In all professions, the relationship between the professional and the client includes an element of trust (Bayles, 1981). In relationships between healthcare providers and patients, the success of an intervention (therapeutic effect) may at times depend, in large measure, on the trust in the provider and the patient's belief that a positive outcome will result (placebo effect). Professional associations have a dual role in this process. Associations articulate the values and standards of the profession to the public. The creation of public credibility supports not only the association's members, but also all members of the profession in their relationships with patients (Fowler, 1993). Patients have the benefit of enhanced trust in their professional provider even if their particular provider does not belong to the professional association.

Professional associations also provide a valuable link to members within the professions, giving tangible evidence of the norms, values, and standards which otherwise may not be visible, meaningful, or relevant, to individuals practicing in the field (Smoyak, 1989). Because a professional association provides public credibility and peer reinforcement, all professionals should be encouraged to join and participate in their professional organization.

Changes in the Role of Professional Associations

Changes in the method of delivering healthcare are changing the role and importance of professional associations. As a result of Congress' failure to articulate a comprehensive national healthcare policy in the United States, healthcare reform is occurring in a piecemeal fashion. Health care professionals are shaping the debate and influencing policy through their collective power in professional associations. Several important trends that impact the role of professional associations have developed.

The introduction of health maintenance organizations (HMOs) and managed care has disrupted the continuity of the healthcare provider-patient relationship. First, for example, some programs in Medicaid allow patients who depend on government assistance to access health care to change their enrollment in HMOs on a monthly basis. By exercising their autonomy and frequently changing providers, many patients give up the opportunity to develop a personal and enduring relationship with a primary healthcare provider. It is unclear whether the government, in permitting frequent changes of provider, does not understand the value of continuity in the patient-provider relationship or if the government was simply seeking to give consumers wide choices to provide access to healthcare. However, it is clear that continuity of care and patients' trust in their providers are jeopardized under the open and frequently changing enrollment in Medicaid.

Second, in private healthcare plans, individuals and families are often unable to continue with their providers of choice because the providers are not included on the HMO's provider panel. In these cases, many patients have expressed concern about the disruption of an ongoing relationship with their professional provider. This lack of continuity between providers and patients has a negative impact on the quality of care, over time. In both these situations involving Medicaid and private health plans, the continuity of care necessary to establish trust between patient and professional is eroded.

A second trend impacts the patient-professional relationship. Under managed care, third-party payers are controlling decisions traditionally left to providers. In an effort to control costs, HMOs may offer providers incentives to restrict the number of diagnostic tests done or the treatment alternatives offered. The providers must balance their advocacy for high quality patient care with both personal financial incentives and the legitimate need to contain healthcare costs. The public's awareness of the imposition of these incentives on physicians and other providers has further eroded the public's trust in their healthcare provider.

Because of these changes, the need for active professional associations is more important today than ever before. Professional associations reinforce with the public the nature of the values, rights and duties between patients and providers. Professional associations also give the providers a forum to discuss and develop standards, share experiences, gather peer support and develop a platform from which to strengthen public confidence in the profession.

In addition to cultivating the public's trust in their healthcare providers, professional associations are a powerful means by which healthcare professionals influence healthcare policy. Associations have legislative departments and professional lobbyists to track issues at both the state and federal level. State governments control the profession, through licensure, certification or registration. Federal regulations determine reimbursement criteria for healthcare providers, mandate special services to underserved or rural areas, and finance educational programs for healthcare professionals (Weissert, Knott, & Stieber, 1994).

In the legislative arena, members working together through an association have much greater political clout than they have as individuals. Associations have greater numbers, lobbying impact, skills, and resources including political action committees. Nurses are working actively through their professional associations to achieve whistleblower protection in the workplace, protection of patients' rights in HMOs under managed care plans, and changes in current and past regulations to allow all healthcare providers to be eligible to provide

and be reimbursed for services based on their scope of practice and not title. Equally important, nurses are supporting legislation for workplace safety using needleless systems or other devices, protection against mandatory overtime and dangerous staffing levels. In advocating for both themselves and consumers, professional associations must balance the healthcare provider's role as patient advocate in issues related to cost, access and quality with the profession's need for equitable pay, safe working conditions, and autonomy in practice.

Third, professional associations in both medicine and nursing have assumed the role of collective bargaining representative. The ANA has bargained for its members since 1946. The AMA changed its longstanding opposition to collective bargaining in 1999, in an effort to reestablish professional authority in negotiations with HMOs. The role of collective bargaining agent highlights the competing interests between patient advocacy and professional welfare. Balancing the ethical principles of autonomy, justice, beneficence and non-maleficence will require thoughtful reflection. A professional association provides a forum for that discussion among its members and between professionals and the public.

Fourth, professional associations have enhanced importance as its members move into advance practice roles. As more patient care is moved from acute care settings into the community, nurses with advance practice skills are gaining autonomy in their practice. As they gain autonomy, these nurses become more vulnerable to the effects of public policy, particularly legislation that may limit their scope of practice and curtail their reimbursement for services. Advance practice nurses, who seek legislative changes to promote their practices, have an added incentive to participate in professional associations.

In sum, nurses have taken longer than physicians to join and promote professional associations, organize politically, and develop a power base. The lag in promoting nursing through a professional organization has limited nurses' power in the legislative process. Although nurses have traditionally had high levels of trust with patients, the general public has not recognized the nurses' expertise and role in health care. In contrast, physicians, whose role, expertise, and professional association are well known, have seen an erosion of the public's trust in the changing healthcare environment described above. In order to achieve an independent and equal voice in both the political process and the public debate over healthcare, nurses need to strengthen their ties to professional organizations.

Ethics and Professional Associations

Ethical issues of politics, policy, and professional associations involve "decisions about our conduct with each other; whether our conduct is right or good; identification of our duties and obligations; and, what we ought to do when ethical values conflict with each other or with other values, such as economic or cultural values" (Aroskar, 1998).

Professional associations can assist practitioners in resolving complicated ethical issues. Three areas of concern are particularly pertinent for nurses when considering how professional associations influence the ethics of healthcare. First, nurses increasingly fear that the loss of continuity in the provider-patient relationship, triggered by HMOs, will undermine the therapeutic nature of the relationship. Professional associations may be able to bridge this gap with their public campaigns to define the nurse-patient relationship. The New York State Nurses Association (NYSNA) campaign to alert consumers to demand a "Real Nurse" is an example of these campaigns. However, when faced with an increasingly consumer-oriented and dissatisfied public, nurses may find it difficult to promote public confidence in nurses and distinguish their performance from others in the healthcare system including physicians and HMOs.

Second, members of professional associations determine the ethical code of the profession. The professional association provides leadership and resources for members to analyze and resolve direct care issues and determine when unethical conduct occurs. Because every nurse has a vital stake in this ethical decision-making process, it is important that professionals join the associations in significant numbers. Only if a majority of nurses belong will the ideas, issues, concerns, and participation be broad enough to truly do justice to the profession as a whole. From the public's perspective, the professional association is presumed to be speaking for each nurse regardless of whether the individual belongs.

Third, professional associations have substantial impact on the broader ethical issues that face health care. Nurses, acting through their professional association, can assist the public in formulating policies to promote comprehensive, equitable, accessible and high quality healthcare. In this debate, the costs of health care are balanced against the principles of broad access to quality services. This process of setting a nationwide ethical standard for healthcare is not the responsibility of any single group. Achieving access to quality healthcare at a reasonable cost will require cooperative and collaborative efforts among all groups who are involved in health care delivery, financing, evaluation, research, policy analysis, and policy formation. Nurses, through their professional association, can influence that debate.

In conclusion, professionals have a duty, through participation in professional associations, to protect the interests of the public, advocate for their own welfare, represent to the public the true nature of the professional role and relationship, and, improve healthcare through policy. When joining a professional association, individuals acquire greater participation in critical decisions that affect not only nurses but their patients as well. Finally, nurses, acting through their professional association, will set their own ethical standards and influence the national debate over the ethics of access to health care for everyone.

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