1985

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Juanita Hunter

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LETTER FROM THE PRESIDENT

As we close the doors on the American Indian Alaska Native Nurses' Association let us leave with a feeling of a job well done. I know we have achieved our goals—improving health care for Indian people, providing scholarships for Indians and developing good communications between Indian Nurses. The five women who attended the first organizational meeting in 1972 were Maxine Chuculate, Lorene Farris, Janice Kekahbah, Loretta Throop and Rosemary Wood; the three who incorporated the association in 1972 were Martha Primeaux, Janice Kekahbah, and Rosemary Wood. These women who started the organization did so in a dignified, professional manner and we would like to end the same way.

Indian organizations all over the United States are closing and we are finally among them. We were able to function for three years on volunteer help and I think that alone shows the dedication of Indians throughout history. We will survive (as we always have) and come back stronger and certainly more knowledgeable than before. Many people, Indian and Non-Indian, professional and non-professional have given so much of themselves to AIANNA. A few of them who are no longer with us are: Susie Yellowtail, Crow Indian, Registered Nurse, married to a Medicine Man, who called all of us her daughters: Sololo, the Hopi Medicine Man who counseled with us and prayed for us during our critical and happy times: Wally Galluzzi, former President of Haskell Indian Junior College, who assisted us by allowing us to have our first two national conferences (1975 & 1976) on the campus of HIJC and by allowing us to assist him in developing a quality Associate Degree Nursing program at Haskell: Lou Cimino who quietly supported his wife, Angie, to return from retirement on two difference occasions to help the Indian people (our prayers and thoughts are with Angie, Lou and family during this difficult holiday period).

Others who were instrumental in helping the high standard of success were staff people like Jess Burris, Steven Pratt, Larry Frank, Emily McKenzie, Judy Anderson, George Beaty, Jerry Spivey, Herman Riesenberg, Jolene Craddock, Fredith Blanchard, Teresa Holladay and many others.

Also, the husbands who were at nearly every conference were Jim Primeaux, Richard Chuculate, Sam Kekahbah, Seth Irving and, again, Lou Cimino. Jim Primeaux provided strong constant support and consultation during the life of the association: Martha has held responsible positions on the Board of Directors during the entire life of the Association (Martha held the position of President for two terms).
A very special thanks to Tom Lucas, our attorney, who stood with us during our troubled times, even going to hearings without compensation.

We cannot forget John Murphy, Executive Director of the Allstate Foundation, who supported over 350 Indian people in their professional education and who we now consider a personal friend.

To the many speakers, presenters, students and members of AIANNA, a found farewell - 'til we meet again.

Rosemery, Janice and Seth, it has been an education and a pleasure to work with you.

Doksha (next time).

Elfride Irving
AIANNA President

Dissolution of the American Indian Alaska Native Nurses Association

The AIANNA letter to the membership August 27, 1984 discussed the results of the one year (August '83 - August '84) "trial to determine if it would be possible to turn the Association around from a relatively large organization with government contracts and grants to a small self supporting concern." As you recall, the results demonstrated the turn around was not possible.

The results of that one year study also demonstrated that when left on our own we are self sufficient, self supporting, take care of ourselves and take care of our own. However, we were not left on our own in that the Department of Labor continued to command, through force of power and size, an inordinate amount of our limited resources in the form of time, energy, attention, and actual costs incurred in communications, consultation, staff time, and attorney fees. Had the resources devoted to responding to Government demands for attention been directed toward Association business the Association would have been able to survive, and we believe, the Association would have been able to grow and develop. This, of course, was not the case.

Based on the results of the one year trial period ending August 1984 the Association began an orderly assessment of its financial assets and liabilities. Decisions were made concerning liquidating assets and paying debts. The Association has been

To pay all legitimate debts and to pay a small amount of the consultant fees to the professional staff. The Association is in good standing with the IRS, the Secretary of State, Accountants, Attorneys, landlords, the utility companies, etc. The Association's fiscal year has always ended December 31 and has always contracted for an end of the year financial accounting audit. This year is different only in the fact that there will be no more business post close-out of fiscal year '84.

It was hoped that some activities of the Association could be continued without incorporation and/or tax-exempt status. However, this is not feasible. Another time, another place perhaps...

You have been responsive, responsible, caring and giving members. Membership dues have been sent in in a timely fashion, requests for information for the Newsletters has been forthcoming, recruitment of new members has shown a steady upward incline, dissemination of scholarship information has gone into rule and urban communities. There was an outstanding response to the publication NETWORK. Many, many members contacted their Senators and Congressional Representative, some contacted the White House. There were Congressional inquiries and the Department of Labor did respond. We did learn through this process that the Department of Labor would have to eventually refer our case to the Department of Justice, this we did not know before. If we had the resources to continue and to present our case to someone outside the Department of Labor it is likely we could receive relief. We gave every thing in our power to survive. We exercised our rights as citizens and saw a brief glimpse of democracy in action. Democracy does not guarantee success but is does guarantee the right to try, to state our beliefs and ideas. This, as a group, we did and did well. We can and should take pride in our efforts.

Historical Overview

In 1970, as a young graduate student, Janice Kekahbah spent a summer's internship with the National Indian Youth Council. A portion of that time was in the headquarters office of Indian Health Service. This experience called forth, in the mind of the young Indian Nurse, several questions which would prove a spring board influencing her future and that of many other Indian Nurses. These, at first seemingly very simple, questions were: "How many Indian Nurses are there?"; "How come so few Indian Nurses work in Indian Health Service?"; "Where are they?"; Who are they?; Where do they work?". The graduate and the Department of Justice and the Department of Labor asked these questions to the powers-that-be in the Indian Health Service, American Nurses Association, National League for Nursing, Bureau of Indian Affairs. None of these groups knew many did no care: some asked her why she wondered, why she cared and what difference did it make.
That same summer of 1970 saw yet another graduate student, Rosemary Wood, wondering different thoughts as she studied suicide among Indian youth. "How come there is such a lack of information concerning health problems of American Indians in the literature?"; "Why is it that those providing health care to American Indians know so little about Indian people?"; "What is it about the providers that prompt them to behave in a way precedent by the consumers as uncaring?"; "How come INDIAN HEALTH resources are under the control of and primarily benefit those other than Indians?"

At the end of the summer of '70 these two graduate students "meet-up" at the Gallup Ceremonial in New Mexico. The questions of both were asked and began to develop into a paradigm of concern. On their return trip to their respective graduate programs, New York University and Rutgers's the State University of New Jersey, Janice Kekahbah reentered the Parklawn Building and introduced Wood to the Director of Indian Health Service and his immediate staff. The Indian Nurses and the bureaucrats asked each other questions, gave one-and-other suggestions, issued challenges. One of the many outcomes was a 1971 contract between Wood and Kekahbah and the Indian Health Service to study "The Relationship Patterns Between the Deliverers of Health Care Services and the Consumers of Health Care Services within the American Indian Community."

The contract afforded nothing in the way of salary. The two researchers spent many nights in sleeping bags in the mountains of Santa Fe, Taos, and Albuquerque: beans and chile were staples; two research assistants were paid with experience and Colorado Kool-Aide: a Ph.D. research consultant, Dr. Shirly Smoyak, was paid with "trade beads" and in-kind consultant work. However, the study did afford Wood and Kekahbah an opportunity to pursue their original questions concerning Indian Nurses and Indian Health Care: to gather information and experience in a variety of Indian communities. Before 1971 was over the two had an idea of how to address their questions.

Kekahbah and Wood sent the first INDIAN NURSE NEWSLETTER to every Indian Nurse either had ever known or had heard about. The NEWSLETTER was sent to Tribes, Tribal newspapers, Indian organizations, professional organizations. Responses came from Indian Nurses all over the country. Indian Nurses had identified themselves as a group, a community, a sisterhood and were expressing a desire to associate one with the other. This took no Government grants or contracts no large private donations. It did take the kind cooperation of the American Indian community to address envelopes, type and copy, to receive the word and pass it on: to say "Good idea, keep going."

At the beginning of 1972 the second INDIAN NURSE NEWSLETTER went back to those responding to the first calling for an organizational meeting at the ANA Conference, held that year in Detroit, Michigan. Again the Nurses responded. Some said they could not make the trip but encouraged those who could; a few said they would try to make it and a few said definitely they would make the organizational meeting. Five Indian Nurses arrived: Maxine Chuculate from Oklahoma, Lorene Parris from Florida, Loretta Throops from Alaska, Janice Rekaahbah and Rosemary Wood in from New Mexico. They adopted the Constitution and Bylaws written earlier in Albuquerque by Wood, Kekahbah and Emo Marbut. The five meet with the Executive Director and President of the American Nurses' Association. In 1972 the fact of American Indian existence in modern America was not well publicized: the existence of American Indian Nurses was not unknown but was not thought about much: the concept of an American Indian Nurses' Association was brand new. The leadership of ANA greeted the representatives of the newly formed AINA professionally and courteously, they were critical in the purest most helpful meaning of the word. They were NOT paternalistic nor nor were they patronizing. They were, in fact, what we as professional nurses would expect nurse leaders to be. In 1972 the President of the American Nurses' Association was Rosamond C. Gabrielson, the Executive Director was Eileen Jacobi. Among others representing AINA at the meeting was Jim Hudson and Margaret Carroll. Margaret Carroll maintained an active interest in the AINA and attended several AINA conferences.

In 1972 Wood, Kekahbah and Martha Primeaux incorporated the association in Oklahoma as the American Indian Nurses Association. Official meetings of the association were held each month during the remainder of that year. The usual attendance consisted of four or five members (Wood, Kekahbah, Primeaux, Chuculate and Jim Kastell). Also in 1972, AINA received a small grant from the Association of American Indian Affairs. The endowment provided the funds necessary to establish and maintain a national communication network for Indian/Native Nurses.

In October of 1973 the ALLSTATE FOUNDATION sponsored a seminar in Northbrook, Ill "to bring together experts in the filed of nursing to discuss ways of retaining disadvantaged student candidates for nursing careers." As president of AINA, Rosemary Wood was invited. This seminar provided, among other things, an opportunity for the Foundation and the Association to become more familiar with mutual goals and aspirations. In 1974 AINA "received a little help from our friends". Unknown to one and other, but knowing that The Allstate Foundation was looking for Indian Nursing Students for scholarships and that The American Indian Nurses' Association was looking for scholarships for Indian Nursing Students, Dr. Shirley Smoyak and Dr. Elizabeth Carnegie separately arranged for Rosemary Wood and Janice Rekaahbah (AINA) to meet with John Murphy and Jack Nelson of The Allstate Foundation. In July 1974 AINA submitted to the Allstate Foundation a proposal to initiate AINA/ALLSTATE SCHOLARSHIPS FOR AMERICAN INDIAN NURSING STUDENTS. In November of 1974 The Allstate Foundation sent a draft in the amount of $25,000.00 to the Indian Nurses' Association for the nursing scholarship program. Thus began the most successful, consistent, long lasting scholarship program for American Indian Nursing
Students to have been initiated up to this point in time.

Also in 1974, AIANA negotiated a contract with the Indian Health Service for the purpose of recruiting nurses into the IHS. President and Martha Primeaux was the President-Elect. In 1975 Rosemary Wood was Executive Director, Janice Kekahbah was the Associate Director and Martha Primeaux was the President. It was also in 1975 that AINA negotiated a contract with the U.S. Department of Labor.

In 1975 the Department of Labor was providing CETA grants to American Indian Tribes and organizations for the purpose of training individuals to become employable. Although the guidelines and regulations did not prohibit funding ADN education the and, therefore, were not utilizing the funds for Nursing education. AINA entered into negotiations with CETA to provide, under contract, education to the agency and their grantees and thus assist them in their mission to train Indian people in employable fields. (The program was a success but the teacher died.)

In 1976 the American Indian Nurses' Association had contracts with the Indian Health Service and the Health Resources Administration. The contract with the Health Resources Administration was to determine the feasibility of developing a national nursing education program at Haskell Indian Junior College. The study produced hard data demonstrating that there was a need within the Indian community for the program; there was a large pool of qualified willing potential students; there was a ready market for the skills to be taught; and Haskell Indian Junior College had the resources and desire to initiate the program.

Janice Kekahbah assumed the position of Executive Director of the American Indian Nurses Association in 1977 after Rosemary Wood left the Association to assume the position of Chief, Nursing Branch Director. Throughout the life of the Association, January 1977 to October 1981, Kekahbah managed over a million dollars in contracts, purchase orders and grants representing a tremendously variety of programs each of which were involved and complex. Throughout these years Kekahbah recruited, developed and supervised a large cadre of staff, employees and consultants for the Indian Nurses but not overdirect staff was her gift to the membership at large. The Indian Health Service was not very interested in Indian health concerns for the 1970's were ten with the Indian Health Service, two with the Department of Labor, two with Haskell Indian Junior College.

There were no more contracts after 1981. Although IHS has lent contracts to non-Indian and non-Nursing groups for Indian Nursing concerns the Service would not? could not? did not contract with the Indian Nurses. Kekahbah went off salary in '81; helped her staff terminate; liquidated what she had to of AIANNA assets; saved and store what she could; paid Association debts; completed mountains of paper work. She gathered around her Martha Primeaux (Primeaux's husband, Primeaux's brother), Rosemary Wood, Jerry Spivey, Bob Smith, Larry Frank, Seth Irving and Elfreida Irving. They rented and borrowed pickup truck, dollies and trailers. They moved papers, furniture, books, paper, typewriters, papers, business machines and papers. Kekahbah and friends moved the remnants of AIANNA from the fourth floor of Peters and Main in Norman, Oklahoma to the U-Hall Storage Co. and there, in a storage bin, Kekahbah conducted Association business. Kekahbah and friends (Rosemary Wood, Seth Irving and Elfreida Irving) then borrowed and rented and moved AIANNA to the Irving home 2108 Maple Lane Lawrence, Ks. and there, in an extra bedroom, Kekahbah conducted Association business. Her staff was Rosemary Wood, Seth Irving and Jerry Spivey. Kekahbah and 'staf went to the Third Annual Conference, books, papers, furniture, books, paper, typewriters, papers, business machines and papers. Kekahbah and friends moved the remnants of AIANNA to the walk-up office at 7th and New Hampshire in Lawrence, Kansas and there, Kekahbah conducted Association business.

AIAA began making a come-back. The Scholarship Programs began to come to life again; money was made from a conference; books began to sell again; a calendar was developed and sold, membership dues increased and the number of members also increased, Kekahbah contracted with Kansas School of Religion to assist them with their conference. But all a long the Department of Labor was demanding time, attention, resources. Frightening, threatening, demanding. THIS BRINGS US TO DECEMBER 1984.

REFLECTIONS

Rosemary Wood

During these past years the Association related with other professional nursing organizations, colleges and universities, health delivery agencies, legislators, American Indian Tribes, American Indian Urban groups, Alaska Native Corporations, students of nursing and other health careers. The Association has served as advocates for consumers and for conferences, biannual meetings of the Board of Directors, the AIANNA/ALLSTATE Scholarship Program, Indian Nurse Registry, School of Nursing Surveys, Membership Files, Communications and Liaison Center; Publication of Life Cycle of the American Indian Family, Alternative on American Indian Aging, Counselors Handbook etc. Among the major contracts, purchase orders and grants managed by Kekahbah were the 1974-76 contract with the Indian Health Service, two with the Department of Labor, two with Haskell Indian Junior College.
deliverers of health care serves: the Association has served as counselor, mother confessor, change agent.

Reflecting back, it seems that many things have changed during these past ten to fourteen years. Society has changed. Nursing has changed and the American Indian Community has changed. The Association and each of us have been part and parcel of that change. Like a catalyst, we entered into the American society, the American Indian society, and the society of American Nurses to help facilitate a change; but, unlike a catalyst, we ourselves were changed in the process. How have we, the society of American Indian Nurses, changed? We have changed in that we are no longer single individuals, atypical intents in a larger group within which we continually fall away from the norm, in one way or the other. We, as American Indian Nurses, have come together many times, in many varied ways throughout the years now. We are familiar with one-and-the-other; we know each other's names, faces, families, Tribes. We are a group, a reference group, a group of colleagues, an association of like people. The Association (with a big "A") facilitated the development of this group. Conferences and Newsletter provided vehicles for communicating within the group. However, the falling away of the Association (with a big "A") is not synonymous with the falling away of the association (with a little "a"). Forces beyond our control caused the falling away of the Association, the Incorporation. No one can cause the falling away of our association one-with-the-other unless we cooperate with them to do so. Freedom of association, after all, guaranteed by the Constitution of the United States. Lets choose to exercise that right.

How else have we changed? In the earlier years, "THEY" were all non-Indians and "WE" were all Indians. Now, "WE" are Indians and some of "US" are non-Indians. In the earlier years, we wanted an Indian in this position or that position of authority. And like what happens sometimes, we got what we asked for and, it was not what we needed. The appointment of persons to positions of power and influence who are biologically American Indian has not, in many cases, proven at all helpful; and, in some cases, has called forth feelings which are less hopeful. Many Indian Nurses were elated at the appointment of an American Indian to the position of President of Haskell Indian Junior College only to have this appointment result in the destruction of one of our most precious achievements—the Associate Degree Nursing Program. Similarly, many Indian Nurses were very pleased at the appointment of an American Indian to the position of Director, Indian Health Service. The first year an Indian sat in that Chair in the Parklawn Building was the first time in eight years IBS failed to contract with AIANNA. A parallel to this phenomena can be seen in the following words of Gloria Steinem, "The generation gap is not an age gap at all but a generation gap. It is not in the life years but in the years of culture and experience. It is not a question of biology and seeing a woman per se." She continues:

"There is no evidence, for instance, that Prime Minister Margaret Thatcher, who came to power mostly as a representative of party and class interests, has a special or deeper appeal for women voters. Indeed, she is actively opposed by feminist groups in..." 

As there are many men who are feminists and women who promote patriarchy there are, I suppose, American Indians who promote the status quo of society and government in Indian affairs. Although this is not pleasant to discuss, or even to think about, it might prove helpful to know. It is also helpful and hopeful to realize that many non-Indians promote Indian Self Determination and wish to relate with American Indians as friends and colleagues. Twenty five per cent of AIANNA's 1984 membership was made up of non-Indian Nurses many of whom had paid dues since 1973 and many of whom had attended nearly every conference. Now we know, sisterhood is not so much a function of biology, or even culture, but of the mind and spirit.

I will say this, AIANNA the incorporation is the corporal being of AIANNA. AIANNA, the association of Indian, Native and Non-Indian Nurses, is the spiritual being of AIANNA. People in high places have never understood that the destruction of the corporal nature of a being often results in freeing that being's spiritual nature even further.
A FEW REMARKS AND REMEMBERANCES

All of the people I know have changed in the last twelve years. The Association's activities and its very existence has changed many people. "It" is responsible for the betterment of many peoples view of themselves therefore allowing them to further their education, look for a more rewarding job, create a more enriching environment for family and community. "It" has helped many of us on a very personal level such as demanding that one learn to use parts of oneself that possibly would never have been developed and used; how to speak in public; how to formulate ideas and concepts in a way to make them presentable and sensible to the public; how to trust ones own feelings enough to validate them with others without any fear; to know that ones colleagues and friends have the same concerns, fears and bizarre thoughts.

A personal example of change—remember the stark fear of many of us when we first had to speak in public at one of the conferences. Wasn't it terrible? Makes me nervous to think about it. Then ten years later, for some of us, the moderator had to threaten with the "ole" Coo Stick to get us to stop talking and sit down. Anything but stoic, huh? At the First AINA Conference at Haskell I vaguely remember presenting a paper on research in the Indian community and opening my mouth at one point in the presentation and nothing came out. Martha P. was the President and moderator. She turned and looked like "Oh my God! She is catatonic." Thank goodness I was able to let go of the podium and Martha took over. I will miss sitting around "telling stories" and sharing memories with everyone. However, I do believe that We'll meet up again sometime to work and to laugh.

The AIANNA has had a group of gifted women for Presidents. Rosemary Wood, Martha Primeaux, Maxine Chuculate, Lorene Farris and Elfrieda Irving. I learned from them all and appreciate each ones courage and commitment.

Someone who deserves special mention is Seth Irving who for the last three years has paid all the bills, worried with the bank statements, communicated with those who owed AIANNA money and those to whom AIANNA owed money. He has moved at least two tons of paper to and from one storage place to another. Thanks Seth.

Well, I could go on and on. See you.

JANICE KEKAHBAH
P. O. Box 113
Lecompton, KS 66050

Cathryne A. Welch, Ed.D., RN
Executive Director

NEW YORK STATE NURSES ASSOCIATION
2113 Western Avenue, Guilderside, N.Y. 12084, (518) 456-5371

October 30, 1984

Judith A. Ryan, Ph.D., R.N.
Executive Director
American Nurses' Association
2420 Pershing Road
Kansas City, MO 64108

Constance Holleran, M.S.N., R.N.
Executive Director
International Council of Nurses
3, rue Ancien-Port
CH-1201 Geneva
SWITZERLAND

Dear Dr. Ryan and Ms. Holleran:

Enclosed is a copy of the Resolution re the Need for Fair and Humane Treatment of Nurses Recruited from Other Countries to Work in New York State approved by the 1984 NYSSNA Voting Body on October 18, 1984.

This resolution was presented to the Voting Body by registered nurses employed by the City of New York, Health and Hospitals Corporation, who have been deeply concerned about, and involved in assisting to resolve, the difficulties and problems encountered by nurses from other lands upon employment in New York City. During discussion of the resolution questions were raised regarding whether NYSSNA should communicate directly with nurses associations in other countries or whether NYSSNA should request ANA to communicate NYSSNA's concerns to ICN. It was the consensus that nurses from other countries seeking employment in New York State confront specific local issues and problems that neither ANA nor ICN can be reasonably expected to know about, monitor and systematically influence. It was also the consensus that NYSSNA should keep ANA and ICN aprised of its efforts to implement this resolution and that ANA and ICN may wish or need to become involved in our communications with other nurses associations. NYSSNA anticipates that our Committee on Human Rights will have substantial oversight of implementation of this resolution and we expect the ANA Cabinet on Human Rights will have some interest in it.
We are now collecting data essential to full understanding of the problems cited in the resolution. Upon completion of this assessment we will develop a plan for the communication called for in the resolution. That plan will be shared with both ANA and ICN.

We will appreciate any comment or advice you wish to offer regarding implementation of the resolution. We will continue to keep you apprised of our activities in relation to this.

Thank you,

Cordially,

Martha L. Orr
Executive Director-Designate

Cathryne A. Welch
Executive Director

THE NEW YORK STATE NURSES ASSOCIATION

RESOLUTION RE THE NEED FOR FAIR AND HUMAN TREATMENT OF NURSES RECRUITED FROM OTHER COUNTRIES TO WORK IN NEW YORK STATE

Approved by the 1984 NYSNA Voting Body

WHEREAS, the Articles of Incorporation state that two purposes of the Association are to promote and protect the health and welfare of nurses and to promote cordial relations and cooperation among New York State nurses and between such nurses and nurses (individually or in association with one another) throughout the world;

WHEREAS, the infringement on any nurse's human or professional rights compromises the integrity of all nurses' rights;

WHEREAS, nurses from other countries are not receiving the benefit of making informed decisions about employment conditions in New York State;

WHEREAS, the full implications of visa status are not being made known in the recruitment of nurses;

WHEREAS, the time and expense involved in the recruitment, training and the living arrangements for nurses from other countries are costly;

WHEREAS, there is a growing need for collaboration with other nursing organizations representing nurses also represented by NYSNA; Therefore be it

RESOLVED, that this Voting Body recommend to the NYSNA Board of Directors that dialogue be initiated with professional nursing organizations in countries where nurses are being recruited in large numbers to work in New York State for the purpose of resolving these problems, and be it further

RESOLVED, that the results of this dialogue be reported to the 1985 Voting Body.

cc: Cecilia F. Mulvey, President
Ellen M. Burns, President-elect
Kathleen Sward, Chairman, Committee on Human Rights
Jane Fielding, Deputy Director, Program
All of the people I know have changed in the last twelve years. The Association's activities and its very existence has changed many people. "It" is responsible for the betterment of many peoples view of themselves therefore allowing them to further their education, look for a more rewarding job, create a more enriching environment for family and community. "It" has helped many of us on a very personal level such as demanding that one learn to use parts of oneself that possibly would never be developed and used; how to speak in public; how to formulate ideas and concepts in a way to make them presentable and sensible to the public; how to trust ones own feelings enough to validate them with others without any fear; to know that one colleagues and friends have the same concerns, fears and bizarre thoughts.

A personal example of change—remember the stark fear of many of us when we first had to speak in public at one of the conferences. Wasn't it terrible? Makes me nervous to think about it. Then ten years later, for some of us, the moderator had to threaten with the "ole" Coo Stick to get us to stop talking and sit down. Anything but stoic, huh? At the first AINA Conference at Haskell I vaguely remember presenting a paper on research in the Indian community and opening my mouth at one point in the presentation and nothing came out. Martha P. was the President and moderator. She turned and looked like "Oh my God! She is catatonic". Thank goodness I was able to let go of the podium and Martha took over. I will miss sitting around "telling stories" and sharing memories with everyone. However, I do believe that We'll meet up again sometime...to work and to laugh.

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Well, I could go on and on. See you.

JANICE KAAHBAH
P. O. Box 113
Lecompton, KS 66050
We are now collecting data essential to full understanding of the problems cited in the resolution. Upon completion of this assessment we will develop a plan for the communication called for in the resolution. That plan will be shared with both ANA and ICN.

We will appreciate any comment or advice you wish to offer regarding implementation of the resolution. We will continue to keep you apprised of our activities in relation to this.

Thank you.

Cordially,

[Signature]

[Name]

Executive Director-Designate

[Signature]

[Name]

Executive Director

[Enclosure]

[Additional information]

cc: Cecilia F. Mulvey, President
    Ellen M. Burns, President-elect
    Kathleen Sward, Chairman, Committee on Human Rights
    Jane Fielding, Deputy Director, Program

[Resolution text]

RESOLUTION BE THE NEED FOR FAIR AND HUMAN TREATMENT OF NURSES RECRUITED FROM OTHER COUNTRIES TO WORK IN NEW YORK STATE

Approved by the 1984 NYSA Voting Body

WHEREAS, the Articles of Incorporation state that two purposes of the Association are to promote and protect the health and welfare of nurses and to promote cordial relations and cooperation among New York State nurses and between such nurses and nurses (individually or in association with one another) throughout the world;

WHEREAS, the infringement on any nurse's human or professional rights compromises the integrity of all nurses' rights;

WHEREAS, nurses from other countries are not receiving the benefit of making informed decisions about employment conditions in New York State;

WHEREAS, the full implications of visa status are not being made known in the recruitment of nurses;

WHEREAS, the time and expense involved in the recruitment, training and the living arrangements for nurses from other countries are costly;

WHEREAS, there is a growing need for collaboration with other nursing organizations representing nurses also represented by NYSA: Therefore be it

RESOLVED, that this Voting Body recommend to the NYSA Board of Directors that dialogue be initiated with professional nursing organizations in countries where nurses are being recruited in large numbers to work in New York State for the purpose of resolving these problems, and be it further

RESOLVED, that the results of this dialogue be reported to the 1985 Voting Body.
An Analysis of Nursing: A Social Policy Statement
Cabinet on Human Rights

The task force believes that the present title of the document is misleading and may possibly be viewed by some nurses as a title "contrived" in an effort to make the publication more palatable to the nursing profession. It can be assumed that a document entitled, Nursing: A Social Policy Statement, would probably attract less interest for the majority of nurses than a document entitled, "the scope of nursing practice."

The task force recommends that consideration be given to titling this document, "the scope of nursing practice," or some other more descriptive title. Within the framework of the scope of nursing practice, it is appropriate to address the social context in which nursing practice takes place, and nursing's responsibility for effecting social policy. We think that the preliminary statement in this section should be broadened to clarify and address the responsibilities of nurses to effect those social policy changes. This expansion should include, describe and expound in greater detail the relationship of nursing to different modalities of health care delivery, including health maintenance, disease prevention, and promotion of wellness. This section provides an excellent opportunity in which to document the importance of nursing to the American public and to the health and well being of communities throughout the world.

There is a need to address more specifically in this section the health needs of those populations other than middle-class whites, who more often seek care for very acute health care problems. Some of those groups include the elderly, handicapped, the poor, high-risk populations, medically indigent, unemployed, and women and children.

The "directions in health care" which are described on page 3 seem to place unreasonable expectations on the patient. Large segments of society are not as responsible regarding their health as this section in the document implies. The task force believes that this document should spell out the particular health needs of those "minority" groups nursing's social responsibility in meeting those needs; and to speculate on how nursing and these clients can effect positive changes in health policy. This task force recommends that a sixth statement be added to directions in health care to address the above, and include a ".

This could be stated as, "development of new knowledge and technology about special health care needs of minorities," (i.e., poor, rural, elderly, etc.) We also believe a statement is needed to address "access" to preventive care for the poor, elderly and children regarding the resources which are, and will be available to them as society becomes more prevention oriented.

The task force recommends that the last sentence on page 8 be changed to read: This legal authority to practice stems from the social contract between society and the profession; legislation derives from the social contract. It would also be appropriate to include, on the same page, a statement which addresses the need to include content related to cultural diversity in the nursing curricula to help ensure humanitarian nursing care. An additional statement should be added reflecting the accountability on the part of teaching/learning institutions for assuring culturally relevant experiences.
The Role of the Generalist

This task force is concerned about the paucity of information and recognition of the nurse generalist in this document. While the task force understands the charge to the TNSCN, "to describe a characteristic of specialization in nursing," it seems to us that this does not preclude establishing in a more equitable manner, the role of the nurse generalist. Since this is the largest group of nurses practitioners and it delivers most of the nursing care to the people of this country, it would be most appropriate to address in some depth the nurse generalist.

We believe a separate section should be developed to focus on this group of nurses, a group who constitute the majority of the practicing nurses, and the majority of the membership of the American Nurses Association. This document, by not sufficiently discussing nurse generalists, minimizes their importance in delivery of nursing care today and in the future. If ANA fails to recognize the significance of the nurse generalists, a role so basic to the nursing profession, and to explicate this significance to all nurses, in the health community and public, the worth of all nursing will never be fully appreciated by the health community and the general public.

We further believe an expanded section on the nurse generalist will provide greater linkage to the section on specialization, and will help to clarify the role of the nurse specialist in meeting society's health care today and in the future.

This task force believes that the idea of certification evolved to recognize specialization for their skills in nursing practice; however, specialization in this document seems to imply that the worth of certification for generalists is negated or not recognized. More elaboration around this issue should be included to clarify the issue.

Specialization in Nursing

This task force believes that specialization in nursing practice is an integral part of the scope of nursing practice. Specialization as presented in this document has one-third of the content devoted to it, and as a result it appears to be separate and apart from the scope of nursing practice. We recommend that specialization be featured in this document in a manner that demonstrates how it evolves as one part of the scope of nursing practice. In this context, it would be beneficial to describe the interlocking and complementary nature of the practice of the generalist and specialist. An elaboration on this relationship would ensure that all practitioners feel a part of the "evolution" of nursing and serve as an incentive for generalists to seek and make opportunities for career progress through career ladders, etc., therefore fulfilling the ultimate goal of improving patient care.
The task force suggests that TPNSRAH look at the generalist and specialization sections and outline how they interlock; then develop enabling mechanisms to keep nurses in the system.  

We believe it is crucial that the practicing nurse view this document as one pertaining to her practice. If NPN cannot achieve consensus by the majority of the practicing nurses, half the battle is lost. Without the combined support and efforts of all nurses, the evolutionary process of the Social Policy Statement is hampered before it begins. If we look at the nursing profession today and accept the direction of this document for the future, then the logical next step is to carefully consider and mobilize all of those individuals who will be affected by the movement. Those individuals who will be affected must view this evolutionary process as a positive one and must feel a part of that movement.

This task force believes that a request for feedback from the nursing community should be emphasized in the introduction. If the intent is to receive feedback, the responses to the document need to be closely monitored. We fear many practitioners will believe this social policy statement is a fait accompli from which they have been excluded. If there is lack of a mechanism for input this fear will only be reinforced. The task force recommends that the following strategies be considered in an effort to achieve the above:

1. Include in the document a request for feedback from practitioners, and develop some mechanism for synthesizing those responses to be used for consideration in the revision.
2. Use The American Nurse as a vehicle for receiving responses and utilize the Delphi Process to collate concerns, identify key issues and to achieve consensus.
3. Provide opportunities at the state level for providing information and seeking feedback through such mechanisms as forums, regional meetings, etc.
4. Request a review and solicit feedback from specific groups, i.e., Community Health Nursing Division of the American Public Health Association.
5. Expand representation on the task force to be more inclusive of B.A. graduates, ethnic minorities and culturally diverse practitioners.

We believe accommodations similar to those listed above are necessary to make the nursing community aware that each nurse has been considered within the scope of nursing practice, and a sincere attempt has been made to include her/him in the evolution of this document which describes the scope of nursing practice.

NATURE AND SCOPE OF NURSING PRACTICE

The task force believes that this section is primarily a process statement and in order to effectively explicate what nursing practice is, information needs to be added which addresses the content of nursing practice.

Nursing is more than a practice discipline, it is also an "intellectual" discipline and this should be emphasized in the document. The nature of the nursing profession mandates that nurses attend to the philosophical well being of patients and provide "holistic" care. If nurses accept "holism" and operationalize it into their practice, they will recognize and address those differences which exist among clients. Nurses also have a right to have knowledge about different cultural groups. Furthermore, the concept of holism legitimizes human rights concerns. Stratification does not alter the concept of holism. The statement should articulate what positive actions nursing can take to ensure holistic and collaborative efforts between clients and professionals. Several statements which recognize the multicultural nature of society should be included. We recommend that an additional statement be added to the list on page 10 such as 11. "Human responses to non-supporting environments (i.e., economic, social, cultural, political, physical)." A glossary would be useful.

SPECIFIC

We recommend the following specific changes in Sections II and III as identified below:

p. 8 Legislation derives from the social contract
p. 14 MIXED

- Change /Data Collection/ to Collection of Data About Health Status Phenomena
- brackets which indicate feedback in the social should be more defined (i.e., there should be a loop from evaluation of data collection)
- diagram should reflect "holism" and social context in which client functions; as pictured here, the client is viewed as a static object
- diagram should reflect interaction of nurses with other professionals

p. 17

- (Expand title of figure 2 to read "Characteristics of the Scope of Nursing Practice as it Relates to Nursing Practice")
An Analysis of Nursing: A Social Policy Statement, Cabinet on Human Rights

p. 18 Paragraph 3
- Delete "altered" and add "specifically addresses" frame this statement in the positive
- Define scope of nursing practice

p. 19
- Lack of a mechanism for stratification process which is multi-dimensional based upon clients/care need

p. 22
- If there is a need for specialization this should be highlighted, i.e., social needs
- If nurses have social responsibility that responsibility should also include fellow nurses

p. 23 Paragraph 3
- Are competencies of graduate nurses really spelled out?

p. 23 Paragraph 4
- The term "gatekeeper" has an "exclusion" connotation, especially for minority people. This word choice does not enhance the real purpose of the document
- There should be adequate assessment of social context

p. 27 Paragraph 4
- "Professional organizations do not initiate trends" is contrary to the purpose of a social policy statement—this statement negates nursing's responsibility to effect change

p. 28
- This might be better phrased to indicate that nursing faculty have responsibility for planning, dictated by society's need
- This entire section puts too much emphasis on universities

p. 30
- The conclusion should include a synthesis of those ideas included in the Social Policy Statement
- The statement should include strategies to recognize the multicultural nature of society and should operationalize the concept of "holism."

An Analysis of Nursing: A Social Policy Statement, Cabinet on Human Rights

DEFINITION OF "MINORITY"

The word "minority," as used in this paper, is based upon the definition developed and adopted by the Cabinet on Human Rights in September 1980, "those persons who are unable to take advantage of existing social, cultural, and economic opportunities because of systematic discrimination, exclusion, and abridgement of rights whether covert or overt on the basis of race, creed, color, sex, lifestyle, physical disability or age."

The task force recognizes the serious limitations and disadvantages to using this term; however, it is used here in lieu of a better word. The task force would choose another word, if it exists, or invent one because of the following reasons: (1) This definition implies that the onus is on the recipients of society's injustices, rather than the impact of these injustices on those individuals; (2) The task force is concerned about the less than equal connotation that the traditional definition of the word "minority" carries; (3) The task force also believes the word is a misnomer when used to define the aggregate of those groups embodied in the above definition; (4) "Minority" over the past two decades has been a word used to refer to people of color, universally, while the reality is that these groups comprise 80 percent of the world population.

Rev.: 10/18/83

8/29/83

LAI: Rlnh 33
TO: Jean Steel, M.S., R.N.C.
Chairperson, Cabinet on Nursing Practice

FROM: Mary Long, President, Georgia Nurses Association

DATE: June 12, 1984


The GNA Board of Directors has asked me to convey their concerns regarding "The Report of the Task Force on Nursing: A Social Policy Statement," that was sent to SNA's for consideration.

I am attaching two letters of concern from the unit of Nurse Practitioners and two members of the Association.

The GNA Board asks that the Cabinet on Nursing Practice consider all of the concerns that are addressed in these letters.

Within the next month, additional concerns will be addressed by various units on nursing of the GNA and these will be forwarded to the Cabinet.

3. The Task Force recommends that "the reimbursement objective should not be payment for nursing performance of medical acts." This seems inconsistent with The Social Policy Statement which acknowledges (p.16) that there are "meeting points at which nursing extends its practice into the domains of other professions" and that "all of the health care professions interact... and in some degree overlap in their activities." The implication of the Task Force report is that nursing and medical activities are always separate and distinguishable. On the contrary, The Social Policy Statement asserts that "A statement of the scope of nursing ought not to limit the boundary or fix the intersections of nursing with other professions, but should allow for expansion and flexibility." Restriction of reimbursement to those activities found in a taxonomy of nursing diagnoses does not promote expansion and flexibility in nursing practice and does a disservice to nursing specialists at the growing edge of the profession. In order for consumers to have maximal access to nursing care, all aspects of care delivered by nurses, including "tasks and activities" should be reimbursed. Further, the Task Force report states:

"It is understood that in emergency situations, in some practice settings, and in some urban and rural areas underserved by the health care system, some nurses prepared to do so carry out selected conventionally medical tasks with appropriate medical and nursing policy sanctions, support and controls."

This implies that the only segments of the population which should benefit from the services of nurse whose expanded roles may include "conventionally medical tasks" are the emergency client and the underserved.

4. Finally, we have some difficulty with implementation strategy #4. The wording should imply that short-term continuing education programs for nurse practitioners be phased out gradually, rather than discontinued, to allow time for such programs to be incorporated into graduate level curricula.
June 1, 1984

Jean Steel, MS, RN, C, Chairperson
Cabinet on Nursing Practice
American Nurses Association
2420 Pershing Road
Kansas City, MO 64108

Dear Ms. Steel:

The Nurse Practitioner Conference Group of the Georgia Nurses Association has received and reviewed the report of the Task Force on Nursing: A Social Policy Statement, dated March 20, 1984. We found the report not as helpful as expected for ANA structural units for two reasons:

1. Most of the strategies refer to a very small premise in The Social Policy Statement.
2. Some of the assumptions and strategies are not consistent with The Social Policy Statement.

To elaborate:

1. The reference point for Goal 2, p.6, "Promotion of unity in nursing in a basic and common approach to practice" is unclear. There is a statement in The Social Policy Statement on page 7, describing working relationships in health care, which states, "Nursing must recognize and assess...relationships within nursing..." This premise is not further elaborated, and we feel that the promotion of Goal 2 as the major source of implementation strategies for The Social Policy Statement is misguided.

2. Comparing the "sometimes contentious groups in nursing" to tribes within a species is neither appropriate nor helpful. Diversity in nursing in Georgia has been and continues to be a positive force. Through the collective efforts of diverse groups, sometimes with differing opinions, we have effected progressive health legislation and broadened the scope of nursing practice in our state. Improved health care options for consumers has been one of the visible results of this alliance. Any problems caused by this diversity are far outweighed by

(Over)

In conclusion, while we recognize the work which has gone into the preparation of this report, it is of limited value to us because of its narrow scope. Our hope is that it could be expanded to reflect the major premises of The Social Policy Statement, with consideration given to the points of disagreement which we have outlined.

Sincerely,

Susan McConnell, MS, RN, C
Chairperson
Nurse Practitioner Conference Group

cc: GNA Commission Chairs
ANA Board of Directors
SNA Presidents
SNA Nurse Practitioner Specialty Group Chairs
May 24, 1984

Dear Colleague,

This letter is to draw your attention to "The Report of the Task Force on Nursing: A Social Policy Statement", distributed from Jean Steele, Chairperson of the Cabinet on Nursing Practice. It is our hope that the House of Delegates will closely examine this Social Policy Statement at its June meeting in New Orleans and as a consequence of that examination send it to a new committee for massive revision.

We believe that in its current form the Social Policy Statement will serve to further divide nursing, decrease its effectiveness as a cohesive body, and, if implemented, cause nursing to turn its back on a social mandate of the people of the United States. We further believe that it has the potential for stymieing the natural evolution of nursing as indicated by historical perspective.

Many parts of the Social Policy Statement are good and can be effective in meeting the state's worthy objectives of serving to unify nursing around a shared, common, guiding framework for practice. However, aspects of this policy pursue one goal and ignore the potential damage its recommendations do to other equally worthy goals.

Goal two of the Social Policy Statement, "Promotion of Unity in Nursing and a Basic and Common Approach to Practice", though worthy on the surface, has, in the way it has been interpreted and in its instrumentation, become a weapon with a potentially destructive force. The definition of a "Basic and Common Approach to Practice" is the crux of the problem. Used as it is in this policy it is restrictive, exclusionary, and judgmental. All disciplines and professions that thrive and grow are enriched by their ability to support and sustain diversity among their subcultural groups. This cross-fertilization enables the discipline to evolve. Narrowness, rigidity, and limitation of membership in the group decrease creativity and innovation.

This Social Policy Statement, its rationale, and its prescription for implementation would effectively remove from our midst nurse midwives, nurse practitioners, and nursing anesthetists. We do not wish this to happen. Quite the contrary, we wish for nursing a structure which enables us to support those whose roles are blurred with others—for out of this very role-blurring develops new roles for nurses and keeps the profession thriving and growing. Had it not been for this kind of role-blurring, nurses would still not use such tools as the thermometer, the sphygmomanometer, and the stethoscope. The functions in which these tools are used were once solely physician functions. There was a time when nurses never used a monitor, never pretended to be able to read an EKG, could not
start IV's, and did not suction patients. Because the legitimate lines between and among health care providers blur due to our common purposes, "to increase the level of health of people", a major focus for each group can be adopted. But strict lines of demarcation will stop the natural evolution of the discipline.

In order to adopt a basic and common approach to practice one would need to adopt a basic and unifying theory of nursing. The dangers in this are self-evident and all major nursing theorists have advised against it. In the rationale for this goal, the Social Policy Committee develops a frank attack on our colleagues who are nurse practitioners. This committee seems to set itself up as judge and disciplinarian and states on page 7 of its report (to which we have supplied the emphasis):

"Up to a point, diversity is a constructive response to social change and increased professional capabilities. The sometimes contentious groups within nursing can be compared to tribes within a species. Tribes that deny the species do so at their own peril: the denial impairs the evolution of the species."

They continue with a quote from Gardner to further chastise our colleagues by saying:

"Just as excessive individual pride must tempered by the larger context in which our strivings occur, so a compulsive sense of purpose must be curbed... There is a time to seize and a time to loosen one’s grasp, a time for effort and a time for repose... Purpose is a consequence of biological vitality, but purposefulness without limits can destroy. The moment comes when the striving must let up, when wisdom says 'Be Quiet'."

This statement may or may not be true. But it assumes that the diversity in nursing:

(1) is not constructive;
(2) is built on an ignorance of our common mission, roots, and responsibilities;
(3) is contentious; and
(4) denies the species; and
(5) will impair the evolution of the species.

All these assumptions lack documentation and are at odds with our perception of reality and the perception of many of our colleagues.

We have not seen the tribes within our midst denying the species. In fact, quite the converse is true. We see these tribes as active, committed nurses, bent on the preservation of the species and the development of that species to its highest potential. Sometimes it is these very tribes that lead the whole species forward.

Gardner was obviously chosen to bolster a position already taken. We would prefer a quote from Margaretta Styles' On Nursing: Toward a New Endowment, one of the finest thought-provoking books by a nurse on nursing of the '80's.

Styles states at pp. 231-233 (emphasis again being provided):

"NURSING'S UNIQUENESS IS less that we hold exclusive territory and not that we are immune from functional redundancy, but THAT NURSING, and nursing alone among the health fields, IS INCLUSIVE.

And patients need inclusivity, perhaps above all else, in our fragmented, mechanistic, superspecialized world.

If we believe in our name and the moral commitment that accompanies it, then we must preserve these broad dimensions: this requires a recommitment to our Nightingale origins. We must not retreat from hospitals and extended care facilities into the community. We must not relinquish technology for sociology and anthropology. We must not abdicate management responsibilities for a narrow individualistic definition of nursing. We must not abandon 24-hour, 365-day nursing for personal convenience and a misguided view of professional prerogative.

On the contrary, we must enlarge our authority in health policy and administration. Where health care is public, we must have a strong hand in governance; where health care is private, we must have a strong hand in ownership—in both instances striving for the best care at reasonable social and personal cost.

Moreover, our clinical hand must be strengthened. New and "expanding" roles, such as those of nurse practitioner and clinical specialist, undoubtedly represent a response to the need for additional nursing knowledge and skills and indicate in a true sense the need for an expanded education, research, and power base for professional practice."

The committee's quotation of a part of Dr. Styles' book (pp. 138-142) to support condemnation of "expanded roles" seems out of context and not at all within the intent of her main point that it is "axiomatic" that nursing must maintain one all-embracing professional society. And, as a major expression of our sense of collectivity, we are called to join and participate in that society as well as in other organizations that may appeal to and reflect our special interest (p. 140). It takes real imagination to perceive Dr. Styles as supporting exclusivity, as not supporting diversity of roles, and as supporting the
Nursing is regulated by state law, and no state nursing practice act with which we are familiar removes nursing practice from some measure of a dependent relationship with physicians. As always, as with medical assistance in death, the future is uncertain. But, as is true of most oppressed groups, nurses find it easier to turn their anger inward and to attack themselves. By doing so we merely delay facing the problem that is the issue: The fight for autonomy for nursing is a good fight—the fight for autonomy is a necessary fight. We can best accomplish autonomy by focusing on the system that prohibits nurse autonomy, not on elements in nursing that are the victims of legal curtailment.

On page 8, the task force states:

"In regard to reimbursement for nursing, the objectives should be payment for nursing diagnosis and treatment. This entails continued refinement of nursing diagnosis in relation to human responses, and their incorporation into a taxonomy(ies) as warranted by experience.

The reimbursement objective should not be payment for nursing performance of medical acts. Identification of medical acts within nurse practice acts jeopardizes nursing’s ability to regulate itself as it must do to remain a profession. Such identification also subjects nursing practice to medical authority and nurses to the risk of medical as well as nursing malpractice or negligence allocations. Further, it tends to perpetrate the outdated task-and-activity orientation of nursing practice."

The task force obviously perceives the reimbursement for nursing as an either/or proposition; either it is done for nursing diagnosis and treatment or it is done for medically related diagnosis and treatment. It seems to our advantage to be able to have payment and reimbursement for nursing and practice whether there be medically related aspects or not. Why must we, of all groups, support a self-imposed, restrictive perception of..."
reimbursable nursing practice? Especially when one of our goals must obviously be recognition of nursing to the extent that its role and functions are reimbursable through third party payments.

Page 8 continues with a statement of exceptions that are "understood", such as in emergency situations, in some practice settings, and in underserved health care systems. Why those exceptions? If it is good for emergency situations and for urban and rural underserved areas, does this mean that the middle-class, wealthy, non-emergency situation person does not deserve the benefit of our services? Research has proved that client, once exposed to nurse practitioners and midwives, often request and prefer them for health problems that are not acute. It leaves us puzzled why our Social Policy Statement would make exceptions for certain people only.

We wish to draw attention to the fact that this whole area of the Social Policy Statement is written on the assumption that nurse practice acts must use a task-and-activity orientation of nursing practice in order to cover those blurred areas of medical-nursing practice most encountered by nurse practitioners, nurse midwives, and nurse anesthetists. This is simply not a valid assumption. Again, we believe our energy is misplaced: Why not develop a new nurse practice act that does not perpetrate the outmoded task-and-activity orientation of nursing practice and yet incorporates all our colleagues in nursing?

We particularly direct your attention to the remark that such identification "of medical acts within nurse practice acts, subjects nursing practice to medical authority and nurses to the risk of medical as well as nursing malpractice or negligence." That statement still assumes that the identification of medical acts with nurse practice acts by task-and-activity orientation is the model that will be used. If we base our practice decisions and professional growth decisions on fear of malpractice and negligence suits, we will be timid and hesitant in the adoption of new roles.

In conclusion, federal funding patterns, which usually set the tone for the direction of nursing, indicate that nurse practitioners and nurse midwives are a bona fide aspect of the health care delivery system. These nurses have the support of the American people through their duly elected representatives in the Congress, and they are a major wedge in the fight of the American people against medical monopoly. If we do not remain attentive to the social needs that cause new areas of nursing to come into being, and if we do not work to support, regulate, direct, and guide the development of these new groups without curtailing their growth or excommunicating them from the mainstream of nursing, we will plant the seeds for our own destruction.

On this basis, and with the intent of pursuing both unity and autonomy for nursing, we respectfully request that you help to defeat goal 2, including rationale and implementation plan of the Social Policy Statement of January 1984, and that the task of formulating a social policy statement be remanded to a different committee for major revisions that will focus on unity through support of or subcultural groups and alteration of our health care system.

Sincerely,

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BIBLIOGRAPHY

