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Juanita Hunter

Historical Resolutions 38

Albany State College

Albany, Georgia 31705

A Unit of the University System of Georgia

Nursing

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July 24, 1984

Dr. Juanita K. Hunter, Ed.D., R.N.
Chairperson
Cabinet on Human Rights
American Nurses' Association, Inc.
2420 Pershing Road
Kansas City, MO 64108

Dear Dr. Hunter:

Thank you very much for your letter and the attached Certificate of Honor of June 26, 1984, received July 18, 1984.

I am grateful to the American Nurses' Association for this recognition.

It is regretable that I could not receive this tribute at the convention. I understand that the awards activity was quite impressive.

Again, thank you very much.

Sincerely,

Lucille B. Wilson

Lucille B. Wilson, R.N., Ed.D.
Chairperson and Professor

LBW/bb

An Equal Opportunity/Affirmative Action Institution - M/F/V/H

WASHINGTON, DC
AFRO-AMERICAN
Capitol Edition
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MAR 16 1985
BUBBLES

Reed's top nurse honored as 'Nurse of the Year'

By Angela Tillman

Clara Adams-Ender, chief of the Walter Reed Army Medical Center's (WRAMC) Department of Nursing, was saluted as the Black Nurse of the Year on Feb. 16 by the Black Nurses Association of the Greater Washington area.

It all started during the turn of the century when black nurses managed to educate themselves to the health care needs of their people.

As black nurses, they saw the purpose and need for an organization that would meet regularly to define the health care concerns of blacks and; therefore, formed the National Colored Graduate Nurses Association.

However, the National Colored Graduate Nurses Association was disbanded in 1952. Black nurses then merged with the American Nurses Association, which at the time was mostly a white organization.

In 1970, during an ANA convention, several black nurses founded a chapter of the National Nurses Association.

This chapter was formed because black nurses felt the need again to pay special attention to the health care needs of blacks.

And so, 80 years later, the Black Nurses Association of the Greater Washington area, an offshoot of the original organization, is honoring a Walter Reed nurse for her contributions to the nursing community.

Originally "black nurses met to discuss what their practice was about, to become better acquainted with one another, and to provide communion and fellowship," Col. Adams-Ender said.

The stated purpose of the association was to provide a forum for collective action among black nurses. In that way the nurses as a group could affect change in the health care system, causing it to be more responsive to the needs of disadvantaged populations across the country.

The metropolitan chapter was officially charted in 1975. The NBNA has 28 local chapters throughout the country.

CLARA ADAMS—ENDER

Initially, most black nurses attended black schools such as Tuskegee Institute (the oldest black nursing institute in the United States), Meharry Medical College, Nashville, Tennessee, and Harlem Hospital School in New York.

"Most nurses went to hospital schools of nursing because they were owned by hospitals and were less expensive," Col. Adams-Ender said. Nursing students were also a source of cheap labor for hospitals during this period.

The Civil Rights Act of 1964 changed the careers for black nurses. This time, they could attend any school in the country and get accepted by law. Personal relationships with white student and teachers were slower to develop.

"When they started going to other schools, blacks found themselves isolated and in the minority where they were the majority at black schools. They also found social isolation from the black group with which they had grown up," Col. Adams-Ender explained.

"I think what made the difference between that period and the present day, is that now the association is much more sophisticated and is chartered to identify the special health care and nursing needs of black people in the United States," she continued.

Both men and women now belong to the association. It is basically a civilian organization, but there are some military members.

"It is no longer a black association because anyone can join," she said. "Whenever you get a perspective from history, it helps one to understand what makes people what they are today."

The association has identified three major health concerns of blacks: hypertension, alcohol and drug abuse, and sickle cell anemia.

It also strives to educate blacks about health care problems, prevention, treatment, and what they can do to help themselves.

The association also provides a continuing education program for nurses, participates in health care fairs, lobbying legislatures for nurses, and collects information concerning job opportunities especially when the organization in looking for black employees.

It serves as a network for nonprofit professional organizations and recently, opened its membership to nursing students and licensed practical nurses (who are not considered registered (nurses).

"We try to look at the general membership meeting as a time to discuss organizational business and topics of interest to the nursing community," said Ethel Holland, president of the Black Nurses Association of the greater Washington area.

A lot of blacks work in institutions where there are not many blacks. This is a way of coming together as a network to discuss health concerns, job opportunities, and job counseling," she said.

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Resolution on Baccalaureate Scholarship Program

WHEREAS, Education for those licensed to practice nursing should take place in institutions of higher education; and

WHEREAS, Minimum preparation for beginning professional nursing practice at present should be the baccalaureate in nursing; and

WHEREAS, The vast majority of registered nurses have been prepared below the baccalaureate level for nursing practice; and

WHEREAS, A cutback of funds for nursing education, student loans, and scholarships would reduce and severely handicap the access of students to baccalaureate nursing programs; therefore, be it

Resolved, That ANA support the Commission on Human Rights in its efforts to create a scholarship fund to support baccalaureate education for registered nurses; and be it

Resolved, That the criteria for selection of scholarship recipients reflect national priorities for increasing access to nursing care in underserved areas of our population.

The last action of the House of Delegates in connection with the report of the Commission on Human Rights was the adoption, during the final business session, of the following motion: "That ANA encourage members not to attend national meetings of any organization that are held in states that have not endorsed the Equal Rights Amendment."

Adopted by the 1978 House of Delegates

MINORITY REPRESENTATION IN NURSING EDUCATION

WHEREAS, There continues to be minimal representation of minority groups in nursing and nursing education, particularly at the baccalaureate and higher degree levels; and

WHEREAS, This minimal representation reflects the need for increased efforts focused on recruitment, retention, and graduation of minority persons at the baccalaureate and higher degree levels; and

WHEREAS, Proposed changes in educational requirements for nurses may have significant impact upon minority representation in nursing, especially at the baccalaureate and higher degree levels; therefore, be it

Resolved, That the American Nurses' Association and its constituents give major consideration to the effects that the proposed changes in educational requirements for nurses may have on minority representation in nursing; and be it

Resolved, That the American Nurses' Association establish liaison relationships with various groups representing minority nurses in order to facilitate collaboration regarding the educational needs of minorities; and be it

Resolved, That the American Nurses' Association and its constituents sustain their active role in the reaffirmation of their commitment to increase the numbers of blacks and other minorities in the nursing profession by introducing new legislation and vigorously supporting legislation that will increase recruitment, retention, and graduation of minority persons in baccalaureate and higher degree programs in nursing; and be it

Resolved, That the American Nurses' Association establish liaison relationships with various educational groups to facilitate the dissemination of information and provide support for recruitment of minority persons into baccalaureate programs in nursing; and be it

Resolved, That the American Nurses' Association support continued funding from multiple sources to assure institutionalization of programs in nursing education designed to increase minority representation in nursing, and exert its political power toward securing financial support for black and other minority institutions; and be it

Resolved, That the American Nurses' Association support the development of mechanisms for financial assistance for minority students in basic and graduate nursing education programs.

Adopted by the 1980 ANA House of Delegates

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REPORT OF THE CABINET ON NURSING EDUCATION

Report: A
(A-84)

SUBJECT: Implementation of the Baccalaureate

PRESENTED BY: Delight M. Tillotson, M.S.N., R.N.
Chair, Cabinet on Nursing Education

REFERRED TO: Reference Committee B
(Jo Ann Page, M.N., R.N., Chair)

The Cabinet on Nursing Education has had as its primary focus over the past biennium the development of strategies to facilitate implementation of a coherent system for nursing education and particularly the implementation of the baccalaureate as the educational preparation for professional nursing practice. Support of the cabinet for the concept of grandfathering continues as it has since 1978.

The work of the interdisciplinary National Task Force on Education for Nursing Practice culminated in publication of a major document Education for Nursing Practice in the Context of the 1980s, published in May 1983.

Past House Action

Resolution on Identification and Titling of Establishment of Two Categories of Nursing Practice (1978)
Resolution on Establishing a Mechanism for Deriving Competency Statements for the Two Categories of Nursing Practice (1978)
Resolution on Increasing Accessibility to Career Mobility Programs in Nursing (1978)
Resolution on Baccalaureate Scholarship Program (1978)
Motion: 78 Concept of Grandfathering
Motion: 78 Continuation of Services to all ANA Members
Resolution on Minority Representation in Nursing Education (1980)
Resolution on Baccalaureate Programs in Nursing for Registered Nurses (1980)
Motion: 82 Expedite Implementation of the Baccalaureate

At the same time and in response to the cabinet's request, the Board of Directors allocated funds to be used to fund one or more states to implement their plans for establishing the baccalaureate position. In addition, the board provided funds to the cabinet to convene a meeting of American Nurses' Association representatives and representatives of a number of state nurses' associations with plans for nursing education. The purpose of the meeting was to develop a coordinated strategy for achieving the association's educational goal.

The strategy meeting was held in Kansas City in July 1983. Significant outcomes of the meeting included consensus that 1) a continuous flow of information regarding SNAs' progress in implementation is required, and 2) the SNAs need financial assistance in their implementation of the ANA goal.

The cabinet planned for distribution of the funds by collaborating with the Center for Research in the issuance of a formal request for proposals from SNAs. Twelve states responded. From this group two states were selected to receive grants to support implementation of their plans.

The Board of Directors in approving its 1984 budget offered further support by committing additional funds over the next five years to assist in implementation. A total of four states were selected by the Cabinet on Nursing Education to receive funds for this first year to assist them in establishing congruence between baccalaureate preparation for professional nursing practice and rules, regulations and statutes governing nursing licensure. The board also committed funds to support a scholarship program for baccalaureate completion and graduate education for minority nurses.

During the last biennium other indications of important progress toward the ANA goal of baccalaureate education as the basis for professional nursing practice have been noted. Increasing numbers of SNAs are taking official positions of support.

A review of the past four years of the available nursing statistics (1977-78 to 1980-81) reveals that the number of state-approved basic baccalaureate nursing programs has increased by 12 percent, providing improved accessibility for R.N.'s pursuing the baccalaureate degree. Over the same period, the reported numbers of R.N.'s recognizing their need for baccalaureate preparation, returning to colleges and universities and graduating with the baccalaureate degree increased by 33 percent. Of these, the proportion studying part time increased by 12 percent.

The number of ethnic-minority students pursuing the baccalaureate degree is increasing also. The percentage of minority students pursuing baccalaureate preparation, as compared to other nursing programs, increased from 9.4 to 12.8 percent. In 1978, the highest percentage of minority nursing students were enrolled in associate degree nursing programs (10.7 percent). By 1981, the highest percentage of minority

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nursing students were enrolled in baccalaureate programs (12.8 percent). The percentage of minority nursing students as compared with total nursing enrollments also increased from 8.5 percent to 10.6 percent. Even though this is a positive trend, it is just a small beginning toward our long term goal of equal representation of all minorities within the nursing profession.

The Cabinet of Nursing Education and the Cabinet on Nursing Practice have been in communication with one another to assure that there is clarity around approaches to achieving congruence of licensure with baccalaureate preparation. On February 11, 1984, the Cabinet on Nursing Practice endorsed the main motion accompanying this report.

All of the other ANA cabinets have also been invited to submit recommendations for implementation strategy and their full support has been requested. All ANA cabinets were also asked to assess the impact and questions regarding this implementation strategy on the pursuit of other ANA goals such as those concerned with economic and general welfare, human rights, ethics, nursing research, and practice.

The Cabinet on Nursing Education plans to move forward to coordinate national planning and the use of resources for establishing baccalaureate education as preparation for professional nursing practice. Consistent with these efforts, the Cabinet on Nursing Education recommends:

That the American Nurses' Association establish the goal that the baccalaureate for professional nursing practice be implemented in

5% of the states by 1986
15% of the states by 1988
50% of the states by 1992 and
100% of the states by 1995

with the ultimate goal being congruence of professional nurse licensure with the educational base of the baccalaureate in nursing.

3/20/84
4/04/84

THIS I BELIEVE ABOUT NURSING

The history of nursing is replete with examples of courageous, assertive, and future oriented leaders. Those nurses have interwoven their talents not only in setting the course for nursing but for many of the enduring social revolutions of the nineteenth and twentieth centuries. As nurses, we should be proud of our heritage. Those positive changes initiated by nurses have occurred in spite of a systematic denial of the power potential and worth of nurses and nursing by the society as a whole.

The struggle for attainment of true professionalism by nurses is in many respects akin to the plight of minorities in America. Nothing less than a complete change in the economic, political and social system will be needed to achieve this goal. Differing viewpoints between and among nursing leaders and organizations continually reinforce to the nursing community and to the public at large that our house is divided. The continuing conflicts about standardization of nursing education, collective bargaining and credentialing are but a few of such examples.

I believe that if we are to survive as a profession or a semi-profession, we must recognize and support one voice which will speak for the nursing profession. Currently, we do not do this. Secondly, we must engage ourselves more actively in the actual political, social and economic systems which now control our being without our equal representation. Thirdly, we must keep pace with our illustrious past and accept the challenges of change which require increased knowledge and expertise.

As minority nurses, we have unique contributions which we can offer to the struggle. Our experiences of black nurses in a color conscious society afford us the opportunity to provide unique leadership abilities to our colleagues. I believe nursing has the potential to achieve professionalism, however we must look to ourselves for the action plan and the actors.

Juanita K. Hunter

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AMERICAN NURSES' ASSOCIATION
MIAMI BEACH, FLORIDA
May 6, 1960

Resolution Re Acceptance of All Professional Nurses as Members

Resolved, That the state be further encouraged in its efforts to provide membership in its state nurses association for all qualified professional nurses so that by at least the time of the next biennium all fifty states will have accepted all professional nurses as members.

Adopted by the 1960 ANA House of Delegates

AMERICAN NURSES' ASSOCIATION

RESOLUTION REGARDING ADVANCEMENT OF ANA CONCERN FOR INTERGROUP RELATIONS
(Submitted by the ANA Committee on Legislation)

WHEREAS, deprivation, discrimination and racial prejudice deny equality, justice, and economic opportunity to millions of Americans; and

WHEREAS, the American Nurses' Association has supported legislation and programs to promote and protect the physical, mental and social well-being of all citizens regardless of race, creed, color or national origin; and

WHEREAS, the course of recent events makes clear the challenge to all people for self-examination and determination to abolish racial prejudice, poverty and discrimination in our society; therefore, be it

RESOLVED, That nurses increase and intensify their participation in local, state and national action groups working to eliminate conditions of discrimination and deprivation; and be it further

RESOLVED, that whenever nurses are aware of discriminatory practices, both within and outside of the health field, they have an obligation to notify the proper authority, knowing that they will be supported by the American Nurses' Association on all levels; and be it further

RESOLVED, that the American Nurses' Association work at all levels to help obtain sufficient and substantial funds from national, state and local government for all programs which help to eliminate discrimination and poverty; and be it further

RESOLVED, that the American Nurses' Association make every effort to improve the educational system and the educational opportunities for all age groups without regard to race, creed, color, sex, national origin.

Adopted by the 1968 ANA House of Delegates

(APPROVED BY HOUSE OF DELEGATES 1968)

JLH:hb
7/3/68

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RESOLUTION ON HEALTH CAREER OPPORTUNITIES

(Submitted by the ANA Commission on Nursing Services)

WHEREAS, There is a known need for additional health service workers to meet the health care needs of our society; and

WHEREAS, The unemployment rate is greater among socio-economically disadvantaged groups; and

WHEREAS, Individuals with socio-economically disadvantaged backgrounds have demonstrated interest and capability in delivering health care services; therefore, be it

RESOLVED, That the American Nurses' Association reaffirm commitment to the expansion of employment and educational opportunities for the socio-economically disadvantaged in the health occupations including the field of nursing; and

RESOLVED, That the ANA encourage and assist SNAs and DNAs to initiate programs which facilitate success in education, employment and retention in the field of nursing for the socio-economically disadvantaged.

Adopted by the 1970 ANA House of Delegates

RESOLUTION ON NURSING EDUCATION

WHEREAS, There are too few members of minority groups in nursing; and

WHEREAS, Curriculums of many schools of nursing do not provide a practical approach to the problems of today's society; therefore be it

RESOLVED, That the ANA actively seek development of remedial programs which will prepare minority group men and women to enter schools of nursing; and

RESOLVED, That the ANA seek increased funds to provide schools of nursing with low cost loans and scholarship aid; and

RESOLVED, That the ANA urge schools of nursing including graduate programs, to develop programs of cultural studies of various ethnic groups; and be it further

RESOLVED, That the ANA seek ways to sponsor programs which will help nurses to work with community groups in defining, and obtaining services to meet their health care needs.

Adopted by the 1970 ANA House of Delegates

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RESOLUTION ON ANCILLARY PERSONNEL

(Amended by the House of Delegates)

WHEREAS, Ancillary nursing personnel in hospitals and other health agencies generally are poorly paid; and

WHEREAS, Hospitals and other health agencies generally have not provided programs, funds, or released time for education which will provide career advancement for ancillary personnel, and

WHEREAS, Ancillary nursing personnel play an important role in providing direct patient care; therefore, be it

RESOLVED, That the ANA develop a meaningful position supporting career advancement and improved economic and general welfare for ancillary personnel.

Adopted by the 1970 ANA House of Delegates

RESOLUTION ON NATIONAL PRIORITY

(Amended by the House of Delegates)

WHEREAS, The delivery of health care is not currently available to all citizens; and

WHEREAS, The current fiscal allowances in the federal budget do not permit adequate delivery of health care; therefore, be it

RESOLVED, That the ANA again emphasize its belief that quality care is a right for all persons, not a privilege for the few, and continue to visibly support all measures to obtain this end; and

RESOLVED, The ANA vigorously pressure the government to redefine its priorities so that health care for its citizens be a first priority.

Adopted by the 1970 ANA House of Delegates

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RESOLUTION ON PROFESSIONAL RIGHTS AND RESPONSIBILITIES

WHEREAS, Nursing practitioners generally do not have the means to define and implement their independent functioning within their practice setting; and

WHEREAS, Nurses frequently are prohibited from asserting their personal political views, and participating in activities which reflect these beliefs; therefore, be it

RESOLVED, That the ANA clearly define and support methods through which nurses will have a definite and effective voice in their practice reinforced by support of grievance processes; and

RESOLVED, That the ANA take a more active role in protecting individual nurses whose professional rights are infringed upon because of their socio-political convictions.

Adopted by the 1970 ANA House of Delegates

RESOLUTION ON THE UNIVERSAL DECLARATION OF HUMAN RIGHTS

(Submitted with endorsement of the ANA Board of Directors)

WHEREAS, The International Council of Nurses has endorsed the Universal Declaration of Human Rights and requested its member associations to take appropriate steps to support and implement the objectives as set out in the United Nations Declaration of Human Rights, and

WHEREAS, The United States actively supported and voted for approval of the Declaration of Human Rights in the General Assembly of the United Nations on December 10, 1948, and

WHEREAS, The President's Commission for Observance of Human Rights Year - 1968 measured the progress of the United States towards achievement of the standards embodied in the Declaration, and

WHEREAS, The United States has enacted many and fine laws dealing with cultural, civil, political and economic rights, and yet millions of its citizens are poor, too many are illiterate, malnourished and poorly housed, lacking health care, and minorities are still striving for basic rights and opportunities; be it therefore

RESOLVED, That the American Nurses' Association support all efforts to advance the unfinished business of achieving the common standard set forth in the U.N. Declaration of Human Rights - 1948 within the United States, including:

1. Amendment of the United States Constitution to provide that equality of rights under the law shall not be denied or abridged by the United States or by any state on account of sex.

2. Clear authority, moral support and adequate funding for agencies of government responsible for implementation of civil rights legislation so that there is equal protection of every individual's right to vote, to have food and shelter, health care, education, employment opportunities, and enjoy the benefits of public services.

3. Reform of the judicial and penal systems so that th dignity and rights of all persons are protected.

4. Self-government for the citizens of the District of Columbia with appropriate voting representation in the Congress of the United States.

5. Legislation to provide for federal regulation of the ownership and use of lethal weapons.

6. Protection in the law of the right of all working people to organize and bargain collectively, including employees in health services, agriculture and public service.

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7. A national policy and program for income maintenance with full attention to the dignity of the individual and to the integrity of the individual and the family.

8. A national health program that provides equal access to comprehensive health services of high quality with full attention to the dignity and integrity of the individual.

9. Continuing effort to improve the quality of teaching throughout the educational system, provision of equal opportunities for all pupils, abolition of racial isolation in schools and opportunities for students to interact with others of diverse racial and ethnic background.

10. Ratification by the United States Senate of the following conventions submitted by Presidents of the United States:

    Political Rights of Women (OAS and UN)
    Genocide (UN)
    Freedom of Association (ILO)
    Forced Labor (ILO)

11. Submission to the Senate and ratification of the following conventions signed by the United States:

    Consent to Marriage, Minimum Age of Marriage
    and Registration of Marriages
    Elimination of Racial Discrimination

Adopted by the 1972 ANA House of Delegates

RESOLUTION ON AFFIRMATIVE ACTION PROGRAM

(Submitted by ANA Commission on Nursing Research)

WHEREAS, in 1951 a merger of the National Association of Colored Graduate Nurses and the American Nurses' Association was effected which resulted in the dissolution of the National Association of Colored Graduate Nurses with a subsequent commitment by the American Nurses' Association that the participation of black nurses in the American Nurses' Association would receive major promotional efforts, and

WHEREAS, "It was recognized that if Negro nurses were to receive complete and adequate services within the American Nurses' Association, provision must be made by the ANA for staff and facilities which would enable Negro nurse members to participate effectively in the total program of the organization and ensure that the program would contribute to the welfare of all Negro nurses,"* and

WHEREAS, The Committee on Intergroup Relations, which was established as the vehicle to implement the Intergroup Relations Program, was dissolved by the ANA in 1962 before the objectives of the program were achieved, and

WHEREAS, In the 21 years since the merger of the National Association of Colored Graduate Nurses and the American Nurses' Association, black nurses have been noticeably excluded from elected office and appointed positions on committees, commissions and boards within the organization and the inclusion of black nurses on policy and decision-making bodies in nursing and related health care groups has remained limited, and

WHEREAS, Increasing numbers of black nurses are finding it necessary to organize in caucus groups and associations to meet the needs created by the failure of the American Nurses' Association to discharge its obligation; therefore be it

RESOLVED, That the American Nurses' Association honor its commitment by taking immediate steps to establish an Affirmative Action Program at the national level which will rectify this failure; and be it further

RESOLVED, That such steps shall include:

1. Appointment of a Task Force composed of nurses representative of minority groups (which shall also include white nurses) to develop and implement such a program, and

2. Appointment of a black nurse to the ANA staff to work with the Task Force developing and implementing the program, and

3. ANA shall actively seek greater numbers of minority group members in elected, appointed and staff positions within ANA and urge states and districts to do likewise; and be it further

RESOLVED, That the ANA encourage and promote Affirmative Action Programs on the state and local levels; and be it further

RESOLVED, That an ombudsman be appointed to the ANA staff.

*Staupers, Mabel K. No Time for Prejudice, New York: The Macmillan Co., 1961, p. 138.

Adopted by the 1972 ANA House of Delegates

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Resolution on Nursing Practice and Research Involving Human Subjects

(Submitted by ANA Commission on Nursing Research)

(Co-sponsored by ANA Commission on Nursing Services)

WHEREAS, nurses encounter in their practice patients who are illiterate or lack command of the English language, and

WHEREAS, some individuals, although literate and with command of the English language, do not understand the intent and implications of the information conveyed, and

WHEREAS, some individuals do not recognize their right to refuse participation without jeopardizing the quality of their care, and

WHEREAS, some individuals are unable, for various reasons, to comprehend instructions or directions, and

WHEREAS, nurses participate in implementation of research through obtaining consent for individuals to participate in research; therefore, be it

RESOLVED, that organized nursing services develop and enforce written guidelines and policies designed to protect the rights of human subjects, and, be it further

RESOLVED, that the American Nurses' Association prepare a model of such guidelines and policies for dissemination.

Adopted by the 1974 ANA House of Delegates

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Resolution on Nursing Practice and Violation of Human Rights in Research
(Submitted by ANA Commission on Nursing Research)(Co-sponsored by ANA Congress for Nursing Practice)

WHEREAS, nurses frequently do not participate in the development of the statement of principles governing research on human subjects, and

WHEREAS, nurses may be assigned to participate in research on human subjects when the risks are not clear, and

WHEREAS, the nurse may find that certain research activities are detrimental to an individual's well being and/or are in violation of his human rights; therefore, be it

RESOLVED, that the professional organization on the state level provide a mechanism whereby grievances of nurses may be reported and redressed when they have knowledge of violation of human rights and well being, and, be it further

RESOLVED, that nurses be made aware of the mechanism and of the availability of these resources.

Adopted by the 1974 ANA House of Delegates

Resolution on Representation of Nurses on Institutional Research Review Committees
(Submitted by ANA Commission on Nursing Research)

WHEREAS, nurses have a profound concern for safeguarding human rights and values, and

WHEREAS, nurses are active participants in the designing, implementing, conducting and evaluating of research, and

WHEREAS, policies, guidelines and definitions regarding the research process affect nurse researchers, and nurses participating in research, and

WHEREAS, research funding includes monies designated for nursing; therefore, be it

RESOLVED, that the American Nurses' Association support the inclusion of nurses as regular members of institutional committees for review of research, particularly those projects that involve human subjects.

Adopted by the 1974 ANA House of Delegates

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Resolution on Ratification of the Equal Rights Amendment

(Based on Resolutions submitted by the New York State Nurses' Association and the Utah Nurses' Association Committee on Resolutions)

WHEREAS, the Equal Rights Amendment provides that "equality of rights under the law shall not be denied or abridged by the United States or by any state on account of sex," and

WHEREAS, the nursing profession through the American Nurses' Association was instrumental in securing federal approval of this significant social legislation, and

WHEREAS, ratification of this measure is now being seriously jeopardized by resistance in many states which have not ratified the amendment and efforts to rescind the ratification in those that have; therefore, be it

RESOLVED, that the American Nurses' Association reaffirm its strong support of the Equal Rights Amendment, and, be it

RESOLVED, that the American Nurses' Association encourage the nursing community to take every possible measure, individually and collectively to interpret the intent of this amendment and to secure its enactment, and, be it

RESOLVED, that ANA establish a special ratification of the Equal Rights Amendment Fund to be made by voluntary contributions from individual members, districts, states and other sources compatible with ANA policies and objectives; and, be it further

RESOLVED, that the fund be established until such time as 38 states have ratified the amendment and any remaining funds be used toward the implementation of the amendment.

Adopted by the 1974 ANA House of Delegates

Resolution on Mental Implications for Women in Our Society

Whereas, the majority of the Council of Advanced Practitioners in Psychiatric and Mental Health Nursing are women, and

Whereas, this council is committed to fostering and supporting good mental health practices, and

Whereas, this council believes women do not have equal rights in our society, and

Whereas, this council believes that the practice of such inequality has grave implications for promoting poor mental health in women; therefore, be it

Resolved, that the American Nurses' Association support the total promise of women's rights and equality and passage of the Equal Rights Amendment as a progressive step to good mental health practices in the society; and, be it further

Resolved, that ANA initiate and collaborate in providing leadership with other groups and organizations for promoting more progress in women's issues.

Adopted by the 1976 House of Delegates

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Resolution Against the Sexual Exploitation of Children

WHEREAS, The magnitude of the problem of child pornography and prostitution is recognized nationwide; and

WHEREAS, Such exploitation consists of manipulative tactics of adults upon children without the consent of the children; and

WHEREAS, The spirits of the victims of child abuse are mutilated and the bodies of the victims are violated; and

WHEREAS, Child pornography and prostitution should be viewed as child abuse rather than included in the pornographic empire; and

WHEREAS, There is need for adequate federal and state legislation relating specifically to adults involved in child pornography and prostitution; therefore, be it

Resolved, That ANA support legislation prohibiting the use of children in films dealing with sexually explicit acts, and providing that any material produced in violation be confiscated; and be it

Resolved, That ANA promote the strengthening of child abuse and neglect laws to include any commercial sexual exploitation of children; and be it

Resolved, That ANA support the establishment of greater penalties under the obscenity laws if offending material involves persons under 16 years of age; and be it

Resolved, That ANA support legislation to provide that the diagnosis of venereal disease in children under 12 years of age justifies investigation of child abuse; and be it

Resolved, That all nurses at every level of practice, and especially school nurses, who come in daily contact with children, be made aware of the signs and symptoms of this form of child abuse, and act as the child's advocate.

Adopted by the 1978 House of Delegates

Resolution on Sexual Life-Style and Human Rights

WHEREAS, A commitment to basic human and civil rights is a historical legacy of the American Nurses' Association; and

WHEREAS, The American Nurses' Association has previously encouraged and adopted a supportive position on legislation to ensure equal and full civil rights for women and ethnic persons of color; and

WHEREAS, The American Nurses' Association believes that the liberation of any person from inequities contributes to the freedom of all persons; therefore, be it

Resolved, That the American Nurses' Association support the enactment of civil rights laws at the local, state, and federal levels that would provide the same protection to persons regardless of sexual and affectional preference as is currently guaranteed to others on the basis of sex, age, ethnicity, and color.

Adopted by the 1978 House of Delegates

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Resolution in Support of Antidiscrimination Efforts

During discussion of this resolution, a motion was introduced to amend the last statement to read, "That the American Nurses' Association Commission on Human Rights work in concert with N.U.R.S.E. Inc., to . . ." The motion was defeated on the grounds that the problem encompassed more than just human rights, i.e. economic and general welfare. The following resolution was adopted by the House of Delegates:

WHEREAS, Nurses are responsible and accountable to their patients and to the public to deliver professional lifesaving services; and

WHEREAS, Nurse training is increasingly complex, theoretical, technical, and analytical; and

WHEREAS, Nurses exercise the same or sometimes greater responsibility and accountability than many other health care professionals; and

WHEREAS, Nursing has for centuries been known as a "female" profession and as such has been segregated and limited in its opportunities for promotions; pay, and other terms and conditions of employment, all of which are recognized as target areas for change under Title VII of the Civil Rights Act of 1964; and

WHEREAS, Evidence presented by N.U.R.S.E. Inc., a nonprofit Denver nursing organization, in *Lemons et al.* v. *Denver et al.* demonstrates that nurses are paid less than scores of other, 100 percent male professions requiring similar or less education, supervisory responsibility, or experience, or having the same or less job worth, and this evidence demonstrates, further, that traditional organizational practices used in Denver and in a multitude of other cities have the effect of segregating nurses into pay groups with other women primarily because they are women, rather than organizing professionals with professionals irrespective of sex, and all of such evidence leads to the strong conclusion that nurses in Denver and elsewhere are the victims of sex-role stereotyping; therefore, be it

Resolved, That the American Nurses' Association find and declare that the work of N.U.R.S.E. Inc., in the Lemons litigation has been and will be of benefit to all nursing and that the association support, in whatever ways feasible, this effort to promote equitable compensation for nurses without regard to sex or traditional sex stereotyping; and be it

Resolved, That the American Nurses' Association support other well-reasoned court or legislative challenges to discriminatory practices in compensation for nursing; and be it

Resolved, That the American Nurses' Association establish a mechanism to work in concert with N.U.R.S.E. Inc., to promote public awareness of discriminatory pay practices, secure financial support for legal and legislative activities endorsed by the committee, seek legislative action to broaden the Civil Rights Act of 1964, disseminate information to nurses and the public concerning the unfairness inherent within present practices, and support efforts toward the establishment of fairer pay practices for professionals of comparable education, experience, and responsibility.

Adopted by the 1978 House of Delegates

Resolution on Safe Nursing Care for All People, Including Ethnic People of Color

The original resolution as presented to the House of Delegates was editorially modified during deliberation. The resolution as adopted follows:

WHEREAS, It is absolutely critical that nursing as a profession be dedicated to the care of all people, taking into account transcultural variability in physiological, developmental, cognitive, emotional, and sociocultural patterns; and

WHEREAS, The curricula of schools of nursing should reflect the transcultural and demographic characteristics of society at large; and

WHEREAS, Accreditation, certification, and licensure boards of nursing are responsible for providing credentialing mechanisms for all nurses with a minimum goal of ensuring safe care and profesional standards for all people; therefore, be it

Resolved, That the ANA House of Delegates direct the structural units of the association to reflect in all statements, policies, and publications, including those with reference to the accreditation process, certification, and licensure examinations, content pertaining to the safe nursing care of all people, including ethnic people of color.

Adopted by the 1978 House of Delegates

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MINORITY REPRESENTATION IN NURSING EDUCATION

WHEREAS, There continues to be minimal representation of minority groups in nursing and nursing education, particularly at the baccalaureate and higher degree levels; and

WHEREAS, This minimal representation reflects the need for increased efforts focused on recruitment, retention, and graduation of minority persons at the baccalaureate and higher degree levels; and

WHEREAS, Proposed changes in educational requirements for nurses may have significant impact upon minority representation in nursing, especially at the baccalaureate and higher degree levels; therefore, be it

Resolved, That the American Nurses' Association and its constituents give major consideration to the effects that the proposed changes in educational requirements for nurses may have on minority representation in nursing; and be it

Resolved, That the American Nurses' Association establish liaison relationships with various groups representing minority nurses in order to facilitate collaboration regarding the educational needs of minorities; and be it

Resolved, That the American Nurses' Association and its constituents sustain their active role in the reaffirmation of their commitment to increase the numbers of blacks and other minorities in the nursing profession by introducing new legislation and vigorously supporting legislation that will increase recruitment, retention, and graduation of minority persons in baccalaureate and higher degree programs in nursing; and be it

Resolved, That the American Nurses' Association establish liaison relationships with various educational groups to facilitate the dissemination of information and provide support for recruitment of minority persons into baccalaureate programs in nursing; and be it

Resolved, That the American Nurses' Association support continued funding from multiple sources to assure institutionalization of programs in nursing education designed to increase minority representation in nursing, and exert its political power toward securing financial support for black and other minority institutions; and be it

Resolved, That the American Nurses' Association support the development of mechanisms for financial assistance for minority students in basic and graduate nursing education programs.

Adopted by the 1980 ANA House of Delegates

EMERGENCY RESOLUTION

RESOLUTION ON EQUAL RIGHTS FOR WOMEN

(Submitted by the ANA Board of Directors)

WHEREAS The American Nurses' Association has been an advocate of equal rights for all persons irrespective of considerations of nationality, race, creed, life-style, color, sex, or age; and

WHEREAS The full equal rights afforded to women in the United States have not been constitutionally affirmed by passage of the Equal Rights Amendment; and

WHEREAS Efforts to ensure equal rights to all must continue unabated; therefore be it

RESOLVED That the American Nurses' Association continue its efforts to support equal rights for women and other groups not constitutionally protected; and be it

RESOLVED That the American Nurses' Association, by this public declaration, thank all whose efforts have helped raise the awareness of the public regarding equal rights; and be it further

RESOLVED That the American Nurses' Association do all in its power to move forward means, legal, and others, to ensure equal rights for women and all persons discriminated against in our society.

Adopted by the 1982 ANA House of Delegates

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ADOPTED BY THE 1982 ANA HOUSE OF DELEGATES

AMERICAN NURSES' ASSOCIATION

1982 House of Delegates

Report #11 Equal Opportunity and Human Rights

(Sponsored by the Commission on Human Rights)

The Commission on Human Rights recommends adoption of the following motion:

THAT THE AMERICAN NURSES' ASSOCIATION REAFFIRM ITS COMMITMENT TO EQUAL OPPORTUNITY AND HUMAN RIGHTS FOR THOSE PERSONS WHO ARE UNABLE TO TAKE ADVANTAGE OF EXISTING SOCIAL, CULTURAL AND ECONOMIC OPPORTUNITIES BECAUSE OF SYSTEMATIC DISCRIMINATION, EXCLUSION, AND ABRIDGEMENT OF RIGHTS ON THE BASIS OF NATIONALITY, RACE, PHYSICAL DISABILITY, CREED, COLOR, LIFESTYLE, SEX, OR AGE.

Report

Since its incorporation in 1901, the American Nurses' Association has promoted a variety of efforts to affirm its commitment to equal employment opportunity and civil rights. In 1946, the association launched a campaign to encourage all state and local associations to drop racial barriers to membership. In 1948, ANA adopted a policy that meetings be held only in integrated facilities and created a special category of direct membership in the four states practicing discrimination. In 1951, the National Association of Colored Graduate Nurses (NACGN) merged with ANA. The NACGN had been organized since 1908 to work against discrimination in the profession. The merger represented ANA's commitment to enable Negro nurse members to participate in the total program and to insure that the program would contribute to the welfare of all Negro nurses.

Before the Civil Rights Laws were enacted by Congress in 1965, ANA took efforts to implement affirmative action at the national level and in constituent associations. In 1960, ANA adopted a resolution, "Acceptance of all Professional Nurses as Members," (Attachment 1) and the 1968 House of Delegates adopted a resolution (Attachment 2) to eliminate discrimination.

In 1972, ANA adopted the Universal Declaration of Human Rights (Attachment 3) which included the equal protection of each individual's right to vote. The 1972 House of Delegates also adopted a Resolution on Affirmative Action (Attachment 4) which provided for systematic affirmative action programming by structural units at each level of the association.

A resolution supporting ratification of the Equal Rights Amendment (Attachment 5) was passed by the house in 1974. Resolutions on Sexual Lifestyle (Attachment 6) and In Support of Antidiscrimination Efforts (Attachment 7) were passed in 1978.

The Commission on Human Rights believes that ANA has a long and proud history of supporting human rights concerns. The commission senses that there is a strong move in this country to rescind and weaken much of the crucial legislation protecting an individual's personal freedoms. These are rights and privileges which women, ethnic minorities, and the culturally diverse had to fight lengthy battles to claim. These pieces of legislation which have now come under attach were enacted to redress years, and hundred of years of inequities to disenfranchised populations. These are freedoms which this association has consistently gone on record as supporting in the past.

This report highlights the siege on the Voting Rights Act, the Equal Rights Amendment and Affirmative Action as examples of the thrust to deprive segments of the population those very freedoms which this country was founded upon. While the scope of this report is limited to those issues above, assaults have also been made on legislation for the handicapped, lesbian and gay rights legislation, and the amendment guaranteeing the right to abortion.

EQUAL RIGHTS AMENDMENT

On March 22, 1972, the 92nd Congress passed the Equal Rights Amendment, and submitted it to state legislatures for ratification. A seven-year time period was imposed on the amendment, calling for its ratification by March 22, 1979. A ratification extension was granted this amendment, extending the ratification date until June 30, 1982. As this report is acted upon by ANA delegates, the Equal Rights Amendment might have become a moot issue.

In order for an amendment to become a part of the constitution, it must be ratified by 38 states, three-fourths of the union. Presently, 35 states, more than 70 percent of the United States population, have given this amendment a vote of confidence. Ratification by three more states prior to the June 30, 1982, deadline is needed to make this amendment become a reality. Unfortunately, ratification prospects do not look good. During the last year and a half, ERA efforts have been defeated in the legislatures of "key" states, Illinois, Florida, and Oklahoma. The opposition to the Equal Rights Amendment has even sought recision of the amendment in some states.

When the ERA was passed by the 92nd Congress, it enjoyed true bipartisan support. Since March 1972, both parties and the presidency have supported passage of the Equal Rights Amendment; however, that support has now ceased. The Reagan administration and the present Republican leadership have become major obstacles to ratification of the amendment.

The complete text of the Equal Rights Amendment is, "Equality of rights under the law shall not be denied or abridged by the United States or any state on account of sex. The Congress shall have the power to enforce, by appropriate legislation, the provisions of this article. This amendment shall take effect two years after the date of ratification."

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The Commission on Human Rights interprets this amendment to mean that women, 51 percent of the United States population, are protected by the United States Constitution and guaranteed equal pay, equal jobs, equal credit, and equal social security. The Equal Rights Amendment is needed because women historically, have not had access to equal jobs, equal pay, equal credit, and numerous other benefits that men have enjoyed in this country. More than 98 percent of the nurses in this country are women. The Commission on Human Rights believes that the future of nursing is linked to the future of women in this country.

VOTING RIGHTS ACT

Legislators in federal and state legislations have begun to argue for the termination and weakening of the 1965 Voting Rights Act. These legislators argue that the Voting Rights Act has been so successful in eliminating voter disenfranchisement that it is no longer needed. Another argument is that the act singles out specific areas of the country for pre-clearance (compliance) with the act, and that this is discriminatory.

The Commission on Human Rights believes that the Voting Rights Act is the single piece of federal legislation which enfranchised millions who had been excluded from the most basic process of democracy -- the right to vote. The commission cautions those who call for termination of the Voting Rights Act and reminds them that having the right to vote protected under the law since 1965 is a long overdue promise for a sixty-year-old Black person in the state of Alabama.

The primary issue over extension of the Voting Rights Act is whether voting rights violations can be proved by showing discriminatory effects or whether it is necessary to go further and prove that voting officials also intended to discriminate. The House passed a bill, H.R. 3112, and a majority of the Senate sponsored a bill, S1992, that includes an "effects test," while the Reagan administration is supporting an "intents test." Senator Kennedy comments, "Citizens may show that a particular election practice resulted in voter discrimination, without the requirement of a 'smoking gun' of direct evidence of intent. Otherwise, our minority citizens will face an impossible standard of proof in all but the most flagrant cases of discrimination."

Attorney General William French suggests that the effects test "could come down to where all of society had to have an actual quota system," despite the fact that the House incorporated language stating that unlawful discrimination cannot be established merely by the fact that minorities have not been elected in proportional representation in state and local offices."

The commission believes that there is sufficient evidence today to warrant the extension of the Voting Rights Act. In the state of Alabama, a series of voter reidentification bills has been introduced in the so-called "Black Belt" counties and passed in the state legislatures. These bills require individuals in Perry, Wilcox, Sumter, and Wilson counties to reidentify in person in the "beat" in which he is registered, or at the courthouse between 9:00 a.m.-5:00 p.m. on a given day. These restrictive clauses are guises to dilute the Black vote. In another instance,

two Black women, Julia Wilder, 69, and Maggie Bozeman, 51, were convicted by an all White jury of voting fraud and voting more than one time. Both women have been active for years in voter registration campaigns, but came to be noticed by the political establishment when they tried to use absentee ballots on behalf of the infirmed and elderly with whom they had been working. The circuit court judge ordered both women directly to prison from the court room despite the fact that neither had previous criminal records. The women's convictions were appealed to the Alabama Court of Appeals, which noted that the evidence was confusing, but refused to hear the case. The circuit court judge in the Wilder-Bozeman case had recently granted a suspended sentence to a White sheriff convicted of voter fraud.

These are but a few examples of infringements upon minority persons' right to the ballot. The Commission on Human Rights is in accord with those remarks made by President Johnson at the signing of the act on August 6, 1965:

> This Act flows from a clear and simple wrong. Its only purpose is to right that wrong. Millions of Americans are denied the right to vote because of their color. This law will ensure them the right to vote. The wrong is one which no American in his heart can justify. The right is one which no American, true to our principles, can deny...

AFFIRMATIVE ACTION

Two pieces of federal legislation dictate affirmative action in this country, Title VII of the 1964 Civil Rights Law which prohibits public and private employers with more than 15 employees from discriminating on the basis of race, color, religion, sex or national origin, and Executive Order 11246 which prohibits the use of federal funds by those who discriminate against women or minorities. These laws are enforced by two federal agencies, the Equal Employment Opportunity Commission, and the Office of Federal Contract Compliance Programs, EEOC and OFCCP respectively.

Historically in this country, white males have held all the positions of power. This is true in the federal government, in hospital and health care institutions, in university and educational settings, and in the corporate board rooms of this country. Statistics bear out that corporations, educational institutions, and unions did not hire women and ethnic minorities out of a sense of fairness. Implementation of affirmative action programs during the 1960s was an attempt to eliminate this favoritism afforded white males. This meant that white males were required by law to compete with women and ethnic minorities in the job market.

The results of affirmative action efforts over the past eighteen years have provided women and ethnic minorities with "some representation" in those places heretofore reserved for white males. Despite affirmative action gains, women in this country still earn considerably less ($.59 to $1.00) than men, the unemployment rate for ethnic minorities is twice that of the national average, and the disparity between black and white family incomes has actually increased.

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Given the paucity of gains achieved through affirmative action over the past two decades, the Reagan administration is promoting legislation which would change affirmative action laws to almost nonexistent. For example, currently companies with 50 or more employees and $50,000 in federal contracts must have written affirmative action plans. The present administration prooposes reducing this requirement to 250 employees and $1 million in contracts. The Department of Justice is seeking a Supreme Court reversal of the Weber Case. The Weber Case supports voluntary affirmative action plans by private employers that implement reasonable measures, including quotas, when they are necessary to eliminate discriminatory employment patterns and practices.

Title IX, the only comprehensive federal law prohibiting sex discrimination in education, is being threatened with amendments to weaken it. This regulation was instrumental in granting women access to schools of medicine and law or college campuses.

Affirmative action over the past two decades has made a mere dent in rectifying the inequities which have existed for women and ethnic minorities over the past several hundred years. The extent to which it can make America a more democratic society has not been realized.

CONCLUSION

Issues related to human and civil rights for all nurses and consumers of nursing services, as well as the general public, continue to need our focus as Americans with democratic ideals. Achieving equality of economic opportunity and social parity for women, ethnic minorities, and the culturally diverse has always been a concern of the nursing profession. True solutions will require a degree of sophistication and awareness on the part of all citizens which goes beyond the political capabilities of this association. It appears both timely and appropriate that the largest group of health care providers in the nation provide leadership in supporting a national climate conducive to the promotion of the rights and responsibilities of all segments of society. The American Nurses' Association has always assumed this leadership role. In 1982, when so many of the basic principles this country was founded upon are under siege, it is crucial that ANA reaffirm its commitment to equal opportunity and human rights for those persons who are unable to take advantage of existing social, cultural and economic opportunities because of systematic discrimination, exclusion, and abridgement of rights on the basis of race, physical disability, creed, color, lifestyle, sex, or age.

AMERICAN NURSES' ASSOCIATION

1982 House of Delegates

Resolution #9 Endorsement of the Concept of Comparable Worth

(Sponsored by the Commission on Economic and General Welfare, Commission on Nursing Services, and Commission on Nursing Education)

WHEREAS, Compensation for work that has been traditionally performed by women has been historically depressed in this male-dominated society; and

WHEREAS, Professional nurses have been predominantly female; and

WHEREAS, For these reasons, society has failed to recognize the valuable contribution that nurses make to the overall welfare of society, and to provide economic compensation in accordance with their contribution; and

WHEREAS, The concept of comparable worth recognizes the right of women to receive compensation based upon the inherent value or worth of the work performed; and

WHEREAS, It has now been proven by the pioneering and perservering efforts of NURSE, Inc., aided and assisted by the American Nurses' Association, that adequate legal remedies for obtaining economic justice are not available to women employees including nurses, when the jobs performed by them are substantially the same as, but not exactly equal to, the comparable, but higher paid jobs held by men;* and

WHEREAS, A wide acceptance and application of this concept has been viewed by women's groups as a major way of remedying the inequities resulting from the past discrimination against women in the matter of compensation; therefore be it

RESOLVED, That this House of Delegates of the American Nurses' Association endorses the concept of comparable worth that recognizes equal compensation for employees performing work of comparable worth or value regardless of their sex; and be it

RESOLVED, That this House of Delegates of the American Nurses' Association urges the ANA Board of Directors to take all measures deemed necessary for promoting and strengthening the growing movement for securing economic justice for women employees, including nurses, by supporting legislation, litigation, and research aimed at strengthening the movement; and be it further

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RESOLVED, That registered nurses in their employment situation be encouraged to challenge reliance upon current rates of compensation as a validating factor in determining salary structures because current rates are themselves a result of past economic discrimination.

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*See Lemons v. City and County of Denver, 620 F.2d 228 (10th Cir. 1980).

Adopted by the 1982 ANA House of Delegates

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AMERICAN NURSES' ASSOCIATION

1982 House of Delegates

Resolution #4 Social Responsibility for Health Care Services to At-Risk Populations

(Sponsored by ANA Committee of Chairpersons)

WHEREAS The federal government has historically assumed a role which includes the determination of basic benefit levels to provide comprehensive health service, establishment and maintenance of payment mechanisms and quality assurance procedures which facilitate access to quality care for all people; and

WHEREAS Emergent political and economic trends diminish the federal government's role and responsibility in providing access to basic health services, and in stimulating competition among health care professionals; and

WHEREAS These changes will particularly affect the poor and medically indigent, the aged, the unemployed, women and children, the physically disabled, and the chronically mentally disabled who are the at-risk populations and in the greatest need of access to comprehensive and cost-efficient health services including nursing services; and

WHEREAS The 1980 House of Delegates through its affirmation of the resolution, "Nurses, Nursing and the Government," formalized its social responsibility to intervene in the interests of securing humane health care services, designed and directed by qualified health professionals in which nurses are located in strategic positions to effect policy and service delivery; therefore be it

RESOLVED That the 1982 House of Delegates reaffirm the resolution on "Nurses, Nursing and Government" adopted in 1980; and be it further

RESOLVED That ANA include among its legislative/lobbying priorities for the 1982-1984 biennium efforts to assure that the federal government:

a) Continue its role in assuring financial access to high quality services for at-risk populations
b) Does not relinquish its responsibility to determine the nature of basic benefits and to establish and maintain payment mechanisms and quality assurance procedures

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c) Work in cooperation with state and local governments to assure access to comprehensive health care services, including nursing services, by providing a stable source of financing; and be it further

RESOLVED That ANA work with its constituents and with appropriate liaison organizations to monitor and help improve access to service for at-risk populations; and be it further

RESOLVED That ANA provide its constituents with information and assistance which will strengthen their role as effective policy shapers in assuring access to health services for all.

Adopted by the 1982 House of Delegates

AMERICAN NURSES' ASSOCIATION

CABINET ON HUMAN RIGHTS
OCTOBER 1-2, 1984
AGENDA ITEM 4.1.1
ATTACHMENT 2
TAB NO. 19

1982 House of Delegates

Resolution #4 Social Responsibility for Health Care Services to At-Risk Populations

(Sponsored by ANA Committee of Chairpersons)

WHEREAS, The Federal government has historically assumed a role which includes the determination of basic benefit levels to provide comprehensive health services, establishment and maintenance of payment mechanisms and quality assurance procedures which facilitate access to quality care for all people; and

WHEREAS, Emergent political and economic trends diminish the Federal government's role and responsibility in providing access to basic health services, and in stimulating competition among health care professionals; and

WHEREAS, These changes will particularly affect the poor and medically indigent, the aged, the unemployed, women and children, the physically disabled, and the chronically mentally disabled who are the at-risk populations and in the greatest need of access to comprehensive and cost efficient health services including nursing services; and

WHEREAS, The 1980 House of Delegates through its affirmation of the resolution "Nurses, Nursing and the Government" formalized its social responsibility to intervene in the interests of securing humane health care services, designed and directed by qualified health professionals in which nurses are located in strategic positions to effect policy and service delivery; therefore be it

RESOLVED, That the 1982 House of Delegates reaffirm the resolution on "Nurses, Nursing and the Government" adopted in 1980; and be it

RESOLVED, That ANA include among its legislative/lobbying priorities for the 1982-1984 biennium efforts to assure that the Federal government:

a. continue its role in assuring financial access to high quality serivces for at-risk populations,

b. does not relinquish its responsibility to determine the nature of basic benefits and to establish and maintain payment mechanisms and quality assurance procedures, and

c. work in cooperation with state and local governments to assure access to comprehensive health care services, including nursing services, by providing a stable source of financing; and be it

-over-

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RESOLVED, That ANA work with its constituents and with appropriate liaison organizations to monitor and help improve access to service for at-risk populations; and be it further

RESOLVED, That ANA provide its constituents with information and assistance which will strengthen their role as effective policy shapers in assuring access to health services for all.

Adopted by the 1982 ANA House of Delegates

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TO:

FROM:

DATE:

RE:

AMERICAN NURSES' ASSOCIATION

TO: Pauline Brimmer

FROM: Cheryl D. Thompson

DATE: August 17, 1982

RE: Analysis of letters received in Human Rights Unit

The attached grid shows letters which were received in this office from nurses who wanted to express a concern about a particular issue. I believe that these leters are but a small portion of those received in this office. My files are scanned periodically and most of these kinds of letters, those which are not likely to have further activity on them, are sent to Archival Services. I have received numerous letters (average 5-6 per month) from nurses who are opposed to ANA supporting the Equal Rights Amendment, and the 1985 Entry Into Practice position as it impacts on ethnic minorities. Many times these letters or notes are attached to the nurse's membership renewal notice and given as the individual's reason for not renewing her membership.

I do not believe that there are enough letters to get a real indication of what issues are most recurrent. My opinion is that the two issues above have been voiced the most often.

There is growing concern from state nurses' associations and male nurses regarding their ability to practice nursing in the OB/GYN area of the hospital. While state courts have denied them this privilege, I believe this is an issue that will continue to come to the forefront and may have to be ultimately settled by the Supreme Court.

The one case I would like to cite is that of Pamela Jones who was fired from her job of 12 years, ostensibly for writing an article in a local newspaper about a patient on life supporting machinery. Ms. Jones believes she was fired because she is a homosexual and that this incident was used as an excuse for her dismissal. At the Cabinet on Human Rights' suggestion, she contacted the American Civil Liberties and they agreed to take her case. The Commission on Human Rights is hopeful that justice will be exercised.

I believe that there is a need within the association to develop a more exact system for tracking correspondence which merits a response. My experience has been that I receive things which are forwarded to me for a response, a month or longer after they have been received at the ANA office.

CDT:ss:43

Attachment

	Name	State	Date	Concern
1.	Branch, Marie	California	January '79	Ethnic expertise was not used for the ethnic perspective portion of a publication
2.	Chiappetta, Lorraine	New York	November '80	Need to recognize cultural diversity in patient care
3.	Childs-Cowell	Washington	June '81	Pro ERA
4.	Christman, Luther	Illinois	July '81	No attempt to recruit men into nursing
5.	Culp, Bertha	Michigan	June '79	Concern for ethnic minorities and 1985 entry into practice
6.	Denny, Charlotte	Kentucky	March '79	Promoting ethnic nurses' involvement in state
7.	Ditchek, Sheila		April '79	Concern about entry into practice grandfathering clause for ethnic minorities
8.	Drens, Elizabeth	Delaware	August '82	Anti-gay rights and socialism
9.	Fontain, Andre F.	Oklahoma	March '82	Male nurse banned in delivery room
10.	Frease, Mike	North Carolina	November '81	Need for information on minorities in nursing
11.	Gantz, Jack	New York	January '81	Recruit male nurses to offset nursing shortage
12.	Garfield, Richard	New York	May '82	Human Rights in Central America
13.	Hardesty, Florence	Oregon	February '82	Support for lawsuit to combat discrimination in higher education
14.	Hesterly, Sandra	California	March '79	Resolution on health care for undocumented citizens
15.	Johnson, Mattiedna	Ohio	November '80	Need for cultural diversity in curricula
16.	Jones, Pamela	Texas	June '82	Suspended for writing article about patient on respirator

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Name	State	Date	Concern
17. Levine, Myra	Illinois	August '79	Discussion about South Africa at Fellowship Advisory Committee
18. Mackey, Florence	Minnesota	April 17, 1981	Opposed to ERA, gay rights, abortion
19. Moses, Margaret	Washington, D.C.	January '81	Against male only draft registration
20. Murillo-Rohde, Ildoura	Washington, D.C.	June 13, 1979	Retain director of affirmative action at University of North Mexico
21. Oertll, Thomas	California	May 5, 1982	Dearth of historical information on male nurses
22. Ohio Nurses Association		July 2, 1981	Backus vs. Baptist Medical Center
23. Overman, Rachel	California	February 11, 1981	Opposed to Black School of Nursing--G. Smith article
24. Pennsylvania Nurses Association		February '80	Studies to identify problems unique to minority nurses

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AUG 3 1984
PDSP

MRS. MABEL K. STAUPERS
3931 SOUTH DAKOTA AVENUE, N. E.
WASHINGTON, D.C. 20018

Dear Ms. Hunter,

I am getting a
friend to write this
letter for me of great
thanks to all members
thanking them for
presenting this

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certificate of honor.
You will never know how
said I was not being
able to come to New
Orleans. I am being taken
care of very well by
Howard University medical
staff and my eye doctor.
God Bless You All.
Please tell everyone hello and
come to see me when you can!
Sincerely, Ida B. Wells

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MARY ELIZA MAHONEY

(1845 - 1926)

Mary Eliza Mahoney was born April 16, 1845 in Boston, where she was a life-long resident. At age 34, she completed a rigorous 16-month nursing program at the New England Hospital for Women and Children Training School for Nurses in Boston. She was one of only three persons in her class to complete the program and became America's first black to graduate from a nursing school.

Throughout her career, patients gave glowing testimony of her expert and tender care. When she was 64, she gave the welcoming address at the first conference of the National Association of Colored Graduate Nurses (NACGN). She died January 4, 1926.

In recognition of her outstanding example of nurses, NACGN established the Mary Mahoney Award in 1936. Since the NACGN merged with the American Nurses' Association in 1951, ANA has presented the award at its biennial conventions. The award honors nurses for their efforts to broaden opportunities in nursing for minority group members.

In a jointly-sponsored project in 1973, ANA and Chi Eta Phi Sorority, Inc., an affiliate of the National Council of Negro Women, Inc., restored Ms. Mahoney's burial site and erected a monument in Everett, Massachusetts. In 1984, both organizations sponsored a 15-mile pilgrimage from Boston to the gravesite to keep Ms. Mahoney's legacy alive.

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AGENDA ITEM XI-B

AMERICAN NURSES' ASSOCIATION

COMMISSION ON HUMAN RIGHTS

FORWARD PLAN

In its continuing effort to establish the scope of the ANA's responsibility for addressing and responding to the equal opportunity and human rights concerns of nurses and health care recipients, with a major focus on ethnic people of color, the Commission on Human Rights evaluates national, social, economic, scientific, and education changes to determine their implication for the health and welfare of minority groups and consumers, to develop the means by which the association can systematically focus on human rights as an integral component of comprehensive care to all consumers and in educational and employment situations for all nurses.

The commission believes that, 1) a specific body of knowledge about ethnic people of color exist; 2) increased knowledge about, and sensitivity to ethnic people of color will dramatically affect the quality of nursing care delivered and; 3) the participation of consumers must be evident in the determination of the nursing and health care needs of ethnic people of color. The commission believes that affirmative action programming is a positive, continuing effort that is directed toward achieving results and specifically designed to transcent neutrality. Not merely non-discriminatory programming, it vigorously works to correct past inequities at all levels of an organization.

In order to facilitate its responsibilities, several kinds of programmatic activities have been developed by the commission. These activities are designed to identify the existing knowledge (data base), identify research directions for adding to that data base, assess the quality of care currently being delivered to ethnic people of color, identify the barriers which exist for ethnic people of color in obtaining safe quality care, develop human right standards and a model of care specifically related to delivering care to minority people, develop demonstration projects which adhere to the standards, and plan for the incorporation of such proven standards into all educational and practice settings through association policies, programs, and activities.

Specific programmatic activities designed to identify and increase the knowledge base include:

I. DATA BASE

WHAT	HOW	WHEN
1. Review of relevant literature		
A. Search and monitoring of proceedings from ANA & NLN conferences	Annotated bibliography ANA library staff to search?	On going
i.e. 1. Health care relevant to ethnic people of color		
2. Legislation		
B. Papers developed	Prepared for commission with specific focus	1977-1978
1. Presentation of papers 2. Publishing of papers 3. Taping of papers		
2. Human Rights Standards Existing Standards.	Reviewed	1976
3. ANA Minority Doctoral Fellowship Program	Maintain close linkage with director of program	Current and ongoing
4. Credentialing Study Bibliography	Search of literature by credentialing committee	1966 - January 1979
5. Regional Hearings	Consumers and providers to give testimony	Yearly Southwest - Native American 1979 Northeast - Industrial 1980 Detroit - Black 1981 South - Poor 1982
6. State of Minority Nurse	Obtain information on minority nurses from Dr. Audrey Burgess - Nashville Entry into practice statement as it affects ethnic people of color	1979 To be presented at 1979 Committee of Chairpersons Meeting

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WHAT	HOW	WHEN
7. Intraorganizational Linkage	Interface with commissions on education and research about areas of mutual concern	Ongoing
8. Extraorganizational Linkage	Interface with health related organizations. (National Institute of Mental Health, COSSMO)	Ongoing
	PROGRAMMATIC IMPLEMENTATION	
1.. Analysis of Literature	Director/Commission on Nursing Research Explore possibility of above writing proposal for funding through ANA in order to hire staff for this task	Immediately and through 1979
a. Papers prepared for commission b. Standards c. Minority fellow dissertation d. Credentialing	Review of literature	
2. Hearings (data base)	Collect testimonies which address legislative issues and education programs. Share results of hearings with Urban League and other groups.	Present through 1982, generate new information and disseminate
3. Analytic Integration of Total Data Base	Revision and dissemination of information. Future program planning with structural units and external organizations i.e. Council of Intercultural Nurses	Present through 1982.
4. Develop Human Rights Standards in Model of Care	Test what exist	
a. Review standards of ANA structural units		Ongoing

WHAT	HOW	WHEN
b. Demonstration project (High priority)	Collaborate with state or hospital unit in 4 - 5 cities Tie in credentialing	Start 1980
c. Testability		
d. Incorporate holistic proposed		
5. Baccalaureate Scholarship Program - Position Statement Concerning Commissions stand on Entry Into Practice	Subcommittee for B.S. Program	Early 1979 (1 - 2 Months)
6. Legislative Liaison With Washington Office Baake NIMH Money Veto Nurse Training Act	Commission to interface with Washington office	Ongoing

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Nursing Revisited

Mary Eliza Mahoney (1845-1926)

Mary Eliza Mahoney was "a small, very active, very lively [woman] who moved right along, skirts flying. She was a good aunt, plenty of caring."[1] This is how Miss Mahoney lives in the memory her great, great nephew, Frederick Saunders. Adah Thomas saw Miss Mahoney as a remarkable and inspiring person, who combined a gentle character with a great deal of charm.[2] The National Organization of Colored Graduate Nurses found her to be a true and sympathetic friend.[3]

These few verbal snapshots, taken in the last decades of Miss Mahoney's life, preserve the woman who was America's first black trained nurse. Much of the rest of Miss Mahoney's life are statistical facts. She was born in Dorchester, Massachusetts, May 7, 1845.[4] She lived most of her eighty years within a small circumference; her birthplace, and then in Boston's West and South Ends.[5] Yet her life of four scores exceeds geographical boundaries; indeed it exceeds time's constraints. For though she died more than fifty years ago, she continues as a living force within the profession. This tiny woman leaps over space and time to become a palpable presence for all nurses.

Miss Mahoney was born into interesting times. Her parents were among the inflex of migrants and immigrants that dramatically changed the character of Boston. Many had come from farms and rural areas seeking the higher wages of the industrializing cities. Others came from the old world fleeing persecu-

slave seeking Boston's promise of freedom, was returned to slave catchers in spite of Wendell Phillip's eloquent outrage. It is easy to imagine that this enactment of the Fugitive Slave Law was frightening enough to dissolve any reassurance that being a free negro may have had. The family legend that the Mahoneys left Boston for Touissant's free state of Haiti may have followed this terrible miscarriage of human freedom. As Miss Mahoney neared her sixteenth birthday Abraham Lincoln became president and shortly thereafter the first shots of the Civil War rang out from Fort Sumpter. A few weeks before her eighteenth birthday the Negro Massachusetts 54th Infantry marched along Boston's streets, led by Robert Gould Shaw. Twenty-four years later on May 31, 1897 these men would be immortalized by the St. Gaudens bas-relief across from the State House. How Miss Mahoney responded to all these events is lost to the shadows. Nor can it be said with certainty that she was in Boston during this period.

Preservation of the Union and freedom for the slave were among the issues of Miss Mahoney's coming of age. Another was the liberation of women; and, more is known how this affected her life. One of the concrete realizations in women's struggle against oppression was the founding of the New England Hospital for Women and Children. For a while social distinctions between rich and poor, lady and laborer, and colored and white were ignored. The hospital's organizers were social feminists, united against injustices towards

"only the best" were kept.[13] So it was that Mary Mahoney competed with 39 other women. Twenty-eight of them came from Massachusetts; others came from Rhode Island, Maine and New York, and one from Michigan. An idea of the physical labor awaiting them is suggested by the requirements. Applicants had to be well and strong and those with robust health were wanted.[14] Though diminutive in stature and under 100 pounds in weight, Miss Mahoney's long life attests to her physical health. That she completed the course without absence, an unusual occurence given the infectious diseases of that day, gives further testimony to her robustness. Young women whose attitudes and thinking were still malleable were preferred for it was thought that they would not be fixed in their opinions and judgments.[15] A few months shy of her 33rd birthday, Miss Mahoney exceed the upper age limit by two years. Later testimony suggests that Miss Mahoney was adaptable and open to new ideas and practices.

Mary E. Mahoney

Tradition has it that the Mahoneys came from North Carolina but there is some suggestion that at least part of the family came from Nova Scotia.[6] Migration patterns are difficult to trace, for many negroes travelled clandestinely; some on the underground railroad, others following the north star. The Mahoneys were free, but even they were not safe from slave catchers. Though Boston was famous for its abolitionists, it was still not openhearted about the negroes within its boundaries. How the Mahoneys managed this dichotomy between idea and practice is unknown. Unknown, too, are the ways they earned their living. Boston's mercantile economy offered little for the influx of unskilled laborers. For negroes, its opportunities were even narrower.[7] Reasons for the Mahoneys' migration are still to be discovered.

Other unknowns are Miss Mahoney's childhood and youth. How did Miss Mahoney respond to the circumstances swirling around her? She lived in a tumultuous time when liberty struggled for existence. When she was born, William Lloyd Garrison's abolition newspaper, published in Boston, was already 14 years old. Four years before her birth, Frederick Douglass, had escaped slavery and was living in New Bedford, Massachusetts. When Miss Mahoney was 3 years old, women were declaring their independence at Seneca Falls, New York. And when she was 6 years old, Sojourner Truth was in Akron, Ohio, making her stirring "And ain't I a woman?" speech. When she was 9 years old the gap between word and deed became a chasm. Anthony Burns, a fugitive

women doctors. For there is some suggestion that they, too, had their blindspots. A colored woman physician faced some initial difficulty in being accepted as an intern the same year that Miss Mahoney entered the nursing program.[8] It is easy to imagine that confrontation of the exclusion of the colored doctor would reveal the barrier to colored nurses as well. Mrs. Ednah Dow Cheney, secretary of the hospital, was an ardent abolitionist. She counted that female Moses, Harriet Tubman, and Booker T. Washington among her friends.[9] She was remembered for her decree that fitness was the only test for admission to the school.[10] She may have been the force correcting the racial injustice. Harder evidence is required to make these disparate events a cohesive whole. Until then, the dynamic which made Miss Mahoney's nursing career possible will remain a mystery. Miss Mahoney's education was not a one time event. Staupers reported that by 1899, Lavinia Holloway, Josephine Braxton, Kittie Tolliver, Ann Dillit, and Roxie Dentz Smith had trained at the New England Hospital.[11] It would be several more decades before the other Boston training schools integrated.

Susan Dimock, the young surgeon who had reorganized the program claimed that nursing was a high and noble work.[12] Many women seeking a way to earn their living apparently agreed. Such was the popularity of nursing and the training program at the hospital that there was no lack of applicants. And these were "women of high class in character, intelligence and kind feeling." These went through a winnowing process and

Delegates attending the National Convention in 1921, Miss Mahoney stands fourth from right in 1st row.

The ambiance of the little hospital must have had a tinge of sadness that March day as Miss Mahoney entered. The anniversary of the loss of Susan Dimock and Caroline Crane was nearing. Only three years before the young and talented surgeon, and the 1874 graduate of the training program had been lost at sea. The little hospital had hardly recovered from the financial blow of the Great Boston Fire of 1872 when this more irretrievable loss had occurred. So it was that the program, reorganized by Dr. Dimock, was administered by others. Some idea of its expectations survive. Early, the pupil nurses were placed in positions of responsibility under the "strict vigilance" of the woman doctors. Nursing at the hospital was done almost entirely by "our pupil nurses."[13] The program, then 16 months in length, extended the original medical, surgical and confinement nursing, with night nursing. Then and for many years after, the greater preponderance of cases was obstetrical, which limited the pupils' range of educational experience. Much of the training evidently was more service than education for each pupil nurse had the charge of a ward with 6 beds. Service demands shaped the education of these pioneers; as it did for the many nurses who followed them. Called wages by Dimock and allowances by her successors, pupils were given one dollar per week for the first 6 months; two dollars per week for the second 6 months and three dollars for the last 4 months. Supposedly it was a subsidy that underwrote the cost of the calico dress and felt slippers that served as a student uniform.[14] [15] From the perspective of the present day, the payment further emphasized the service nature of the training.

Given the use of pupil nurses for the labor of hospital care, few graduates were necessary. So it was that the doctors could report that most graduates left the hospital for the more lucrative private duty nursing.[16] And Miss Mahoney was no exception. She graduated August 1, 1879 and signed on with the Directory for Nurses at the Boston Medical Library. She joined the other 38,000 women workers in Boston. Most of these worked within three categories: personal service, trade and manufacturing. Their wages averaged respectively, $5.25, $4.81, and $5.22 per week.[20] Nurses fared better. Miss Mahoney, for example, charged $2.50 per day or $15.00 per week, as did her colleagues of similar training.[21] Higher wages and certainly lesser danger than in factory work made nursing an attractive way to earn a living. But nursing was not without its disadvantages for nurses had to wait for cases, and some of these could be as hazardous to health as the injuries of the factories.

cont. on page 8

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...ishing the difference between ...ss and servants the nurses refused to eat in the kitchen with the help, and demanded to eat with the families as peers. Miss Mahoney, however, stated that she would eat in the kitchen alone.[25] Her great, great nephew states that Miss Mahoney was a very social woman who also valued her solitude. And this may have been the reason behind her choice. Class and racial barriers may have been others.

Lavinia Dock, an articulate advocate for social justice, said, "Colored women make excellent nurses. To their natural gifts of tact and skillful [sic] handling are added soft melodious voices, sympathetic natures, and idealism."[26] Miss Mahoney's work validates this view. The doctors with whom she worked and the families of those she nursed testify to the value of her care. She had 13 cases over the 4 years she is listed with this directory. She received only positive evaluations. (Such was not the case for many other nurses who worked out of this directory.) Miss Mahoney had "good temper, discretion, and loyalty which were well tested in the case of a weak, nervous self-indulgent invalid," said one report. "High recommendation," said another, "No faults" said still another. "Excellent nurse" was the assessment of her four weeks with Mrs. C.A. Wheelock. "Would employ again" appeared often from the doctors and the families. Most of her cases were around Boston, Brookline and Roxbury, though she did travel as far as Woburn for one, and Concord for another.[27] It is only speculation, of course, but Miss Mahoney

their first convention in New York, Miss Wald gave a signal to the nursing profession. She hosted a reception at Henry Street in honor of the group. It is easy to see why she did. The NACGN's motto "Service to Humanity" was one Wald was putting into action in the slum tenements of New York City. Her work and the NACGN's motto only stated what a profession's reason for being is. But by this time the young profession had retreated from its obligation to serve society. So far had it retreated, that negroes suffered seven times as frequently as did non negroes of tuberculosis, a killer in those pre antibiotic days.[29] It was to ensure health care to their own, as much as to remove barriers, that the negro nurses founded the new organization. Their other objectives were to advance the standards and best interests of trained nurses to break down discrimination in the nursing profession, and to develop leadership within the ranks of negro nurses. Basic to eliminating double standards of education and practice based on race, the organization insisted that the negro nurse must meet the required standards for all nurses.[30] Miss Mahoney, a graduate of an approved school of nursing, and a member of her alumnae association met the requirements. Her sister, Ellen, did not.

The second convention was held in Boston. The nurses convened at the Twelfth Baptist Church on Shawmut Avenue. The Reverend Doctor M.A. Shaw gave the invocation. Then the diminutive Mary Eliza Mahoney welcomed the nurses. The meetings proceeded with papers on "The Ideal Nurse" and "Nursing in the West

too. Miss Mahoney arranged a special tour to the New England Hospital for Women and Children. The tour closed with tea served by the superintendent of nurses and the school's alumnae association.[33]

Reportedly Miss Mahoney found the training of 1909 less than what had been required of students of her time, 30 years before. Whether this was nostalgia for her youth or the actual state of affairs, there is no way of knowing. She was made a life member of the NACGN and continued to be its honored guest over the next 10 years. The last meeting she attended was in 1921 at Washington, D.C.'s Freedman's Hospital. Just one year into women's suffrage it seems fitting that these colored women nurses visited President Harding. They reminded him that there were 2000 trained negro nurses in America. Then they presented the President and Mrs. Harding with a basket of American Beauty roses.[34]

And so Miss Mahoney's long career came to an end. Then the metastisized breast cancer that would claim her life entered its final stages. She returned to the New England Hospital for Women and Children. There she died, January 4, 1926.[35]

Under the simple white marker lies all that could die of Mary Eliza Mahoney. She continues to live in the nurses honored by the National Association of Colored Graduate Nurses from 1936-1951, and by the American Nurses Association since that time. She continues to live in the inspiration she provided to Boston's colored nurses in the Mary Mahoney

14. NEH, year ending 9/30/1877.
15. NEH, year ending 9/30/1875.
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17. NEH, year ending 9/30/1874.
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29. Chayer, Mary Ella. *Nursing in Modern Society.* New York: G.P. Putnam's Sons. 1947, p. 188.
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32. "Visits to Hospitals Made." *The Boston Globe.* August 26, 1909.
33. Thoms, Op. Cit.
34. Ibid.
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Other Sources
Hazelle Ferguson
Helen Miller

The help of Ann Donovan of the Nursing Archives at Boston University is gratefully acknowledged.

—Mary Ellen Doona
MNA Historian

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The introductory data stated that Miss Mahoney had been nursing for more or less 14 years suggesting that she had worked as a nurse prior to her training. This was not so unusual. Nursing for hire had been a way of life long before the training schools came into existence. Women, negro and white, cared for their families and earned their living by using their nursing skills. Miss Mahaoney's first recorded ancestor was Ellen Freeman (Mumbet, Mum Bett) a Massachusetts woman who lived from c.1742-1829. She believed the words of the Bill of Rights and persuaded a young lawyer to argue for her freedom. The 1783 case freed Membet and established that slavery was abolished in Massachusetts. Would that her nursing career were as known as is her mark on Massachusetts legal history. All that remains is that she nursed her attorney's children for several years.

In 1845 when Miss Mahoney was born, the city directory listed more than 20 women under the category of nurse.[22] Women continued as nurses even after the training schools were established. Some of these, such as Miss Mahoney's sister Ellen, had been students in the training schools but left before graduation.[23,24] It was a time of change reflected in the kinds of women who called themselves NURSE. Untrained, partially trained and trained "nurses" competed for the private duty market. Some worked out of the directories, others free lanced, and many did both.

These nurses were one problem for the trained nurse; another was the patient they served. for the most part only individuals of financial standing were able to afford the cost of home nursing. Most of the nurses were not of this social class; yet, neither were they servants. Intent on

Mumbet

(Photo courtesy of the Massachusetts Historical Society)

may have worked out of several directories and with physicians, as did many nurses of that era.

During the several decades following her graduation, racial prejudice re-emerged in all its ugliness. "While the nursing community was small," said Dock, "it was free from this antisocial feeling, but as [nursing] grows, here and there barriers are put up, calling for pause and thought, that injustice shall not be done, at least, in the impersonal realm of education and state examination."[25] Dock and Lillian Wald, the founder of Henry Street, put this belief into action. In 1908, when the National Association of Colored Graduate Nurses held

Indies." Dr. John Hall of the Bay State Medical Society, in convention with his colleagues at Faneuil Hall, addressed the nurses on the need for the "Mutual Cooperation Between Nurses and Physicians." In the evenings the nurses joined the physicians, dentists and pharmacists at Horticultural Hall for entertainments arranged by the Ladies Auxilliary.[21]

The convention continued through three hot and humid August days. Visits were made to a home for aged, colored women in the West End where they, the nurses and the matron, Mary Townsend entertained each other with music and recitations.[22] Visits were made to hospitals,

Club of the 1940's. She continues to live in Helen Miller, and her sorority, Chi Eta Phi, which erected a proper headstone over Miss Mahoney. She continues to live in the Black Nurses Caucus and its ideas disseminated by Lorraine Baugh and the present organization, The New England Black Nurses Association. She continues to live in the more than 60,000 black nurses practicing in the United States today.[26]

Mary Eliza Mahoney lives in nursing's history as a reminder that the profession's enduring purpose is service to humanity.

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WICHE

POSITION PAPER:

THE PHRASE ETHNIC PEOPLE OF COLOR

This paper provides the historical development of the phrase "ethnic people of color," an explanation of what the phrase is meant to accomplish at this point in time and suggestions for future action.

Historical Perspective

Historically, there have been victims of oppression in this country. Many groups have suffered from such oppression. However, individuals who display a different skin pigmentation have been most subject to discriminatory practices, mainly the American Indians (including Alaskan Natives), Asians, Blacks, Chicanos and other Spanish-speaking people, and the Pacific Islanders.

Over the past decade, new heights have been reached in addressing problems nationally and locally, although discriminatory practices against the people mentioned above continues.

Explication of concepts basic to the development of strong individuals, families, and groups has led to a positive self-concept and self-esteem which in turn has heightened the awareness of minority groups to their potentials as human beings and as prospective professional people.

The term minority groups or disadvantaged minorities has long been used by groups, individuals and legislators. These terms connote an inferior status and do little to enhance a positive self-concept. Such phrases do not accurately define the oppressed groups to which major attention needs to be addressed.

In the evolutionary scheme of events, many minority nurses and other professionals felt a great need to develop a phrase which would more accurately and positively describe American Indians (including Alaskan Natives), Asians, Blacks, Chicanos and other Spanish-speaking people and the Pacific Islanders.

"Color" is the characteristic trait used by the dominant members of society to relegate particular members to an oppressed status. Color serves as the unifying concept included within a descriptive term. Color means a general concentration of melanin higher than that usually found in the Caucasian race. It usually marks a person for social and administrative discrimination not out of his own choice but rather through the practices and policies of those in positions of power.

Phrase - Ethnic People of Color

In the early 1970's the phrase ethnic people of color was introduced into WCHEN activities. It was believed that this phrase more accurately described the groups which have been discriminated against to the fullest extent. The phrase includes all groups whose skin pigmentation contain color, such as the Asians, Blacks, Native Americans and Spanish speaking peoples. This phrase ethnic people of color has received wide acceptance by individuals who are of color and is therefore in accordance with the right of self-determination.

The phrase has been adopted within all aspects of WCHEN programming. It is used in all WCHEN grants and is used by all the WCHEN steering committees. At the June 1976 American Nurses' Association convention, this phrase was also approved for inclusion in the description of the Commission on Human Rights. Because the phrase is serving the need for which it was developed, there is no valid reason to discontinue the use of the phrase at present.

Future Action

The Minority Issues Steering Committee proposes that the problems which need attention are more important than the semantics of the phrase used to describe the group. To concentrate efforts on developing or changing terms diverts energies from the pressing problems which desperately need attention now and impedes progress toward achieving WICHE/WCHEN goals.

The Minority Issues Steering Committee recognizes that there are developing and untested theories from the social sciences which relate to culture, health care and nursing. We of the Minority Issues Steering Committee foster and encourage theory building, testing and problem solving in all areas which will foster the development of nursing sciences. It is the hope of this committee that relevant, tested theories will further nursing progress by eliminating institutionalized discriminatory practices in the health delivery system and in the nursing educational system. It is proposed that appropriate forums for open discussion and opportunities for research be provided for the sharing of differing points of views and the development and testing of new theories. WCHEN as a parent organization is large enough to accommodate differing points of view and to foster the exchange of these views among its membership.

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The following persons contributed to the drafting of this position paper:

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6/22/76
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FILED JUN 28 1976

AMERICAN NURSES' ASSOCIATION

TO: Eileen M. Jacobi, Ed.D., R.N.
Executive Director

FROM: Pearl Dunkley, Ed.D., R.N.
Deputy Executive Director
Program Activities

DATE: May 31, 1976

1976 marks the 25th anniversary since the functions of the National Association of Colored Graduate Nurses were absorbed by ANA.

At the January 1947 meeting of the National Association of Colored Graduate Nurses a recommendation was sent to the ANA Board of Directors that the ANA Board take the necessary steps to absorb the functions of NACGN if there were no legal barriers within ANA that would hinder this absorbtion.

This recommendation was further reinforced by the Joint Committee on the Structure of the Six National Nursing Organizations which from its inception in 1946 had included NACGN.

In 1948 there was further advancement towards full membership status when the ANA House of Delegates voted individual membership to all negro nurses excluded from any state association. In that same year, the first negro nurse was appointed to the professional staff of ANA.

In 1950 the intergroup relations program was developed and in 1951 the Board of Directors of NACGN voted to recommend its dissolution, having worked for some 6 years to insure that its functions would be absorbed by ANA to the end that the "participation of black nurses in ANA would receive promotional efforts". The dissolution occurred at the national level in 1951.

It is timely for all structural units of the ANA to engage in self assessment in terms of to what extent the goals and promises of the "merger" were achieved based on the model affirmative plan developed by the Affirmative Action Task Force.

It is therefore proposed that in 1977, the 25th anniversary of the 1952 structure change, a significant program be sponsored by the ANA Board of Directors with every structural unit of the Association involved in assessment and forward planning.

All structural units could be charged to begin planning for such a conference at their orientation in the summer and include budgeting requests in the 1977 budget proposal in line with Priority #4.

The ANA Board of Directors should be asked to respond to the idea of sponsoring such a program and to authorize reallocation of resources within the 1976 budget to begin the work on planning and collection of data on the extent of participation of these minorities in ANA at all levels in 1976.

PD:bem

FILED JUN 28 1976

AMERICAN NURSES' ASSOCIATION

TO: Eileen M. Jacobi, Ed.D., R.N.
Executive Director

FROM: Pearl Dunkley, Ed.D., R.N.
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PD:bem

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AGENDA ITEM VI

AMERICAN NURSES' ASSOCIATION

Commission on Human Rights

INTRODUCTION

The quality of health care provided to ethnic minorities and other disadvantaged and underserved populations was the focus of a consumer hearing sponsored by the American Nurses' Association Commission on Human Rights. The hearing was held in Baltimore, Maryland, November 6, 1981. Baltimore was chosen for this hearing because of its size and its large ethnic population—factors which could provide insight into the effectiveness of health care to specific groups. For according to the 1980 census, Baltimore is the tenth largest city in the United States and has a population which is 55.5 percent black.

The Commission on Human Rights solicited testimony through extensive mailings to hospitals and schools of nursing, health and human services agencies, and consumer advocate groups. Witnesses were required to be either consumers from an underserved, disadvantaged, or ethnic minority population in the Baltimore area, or providers to these populations. Each was asked to: (1) identify general and specific health care needs and problems of his population in terms of such issues as access to care, accountability, home health services, payment mechanisms, mental health, quality assurance, and utilization patterns; (2) give specific details, examples, and data to concretize these issues; (3) give suggestions, recommendations, and strategies for addressing these issues; and (4) comment on positive health care experiences relative to

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these issues. Oral testimony of each witness was limited to a ten-minute presentation followed by a five-minute question and answer period. Written testimony of any length was invited for inclusion in the report.

Seven witnesses from Baltimore, Maryland, and Washington, D.C., testified at the hearing. They addressed their attention to groups they consider "high risk": the elderly, blacks, the chronically mentally ill, and inmates of correctional institutions. Since they referred almost exclusively to adults, little information on the health needs of chidren was garnered. The verbal and written testimony gave the nine-member commission firsthand information on the prevalent health needs and health care problems affecting ethnic minorities, the disadvantaged, and the underserved. Witnesses related personal experiences and provided data on such topics as the availability, accessibility, and quality of health care provided the underserved. In addition to their positive and negative assessments of the current system, the witnesses made recommendations for improvements in the delivery of health care.

The commission anticipates using the numerous suggestions for improvement offered in a future plan to establish a demonstration project which will address needs for a change in our health care system.

THE ETHNIC MINORITY

Research indicates that members of the disadvantaged ethnic minority are afflicted with more chronic conditions than others, that their health problems are generally more severe, and that they are also hospitalized more often.

During the War on Poverty and Great Society years, from 1965 to 1975, poor people's access to medical care increased. Services were usually free or greatly reduced in cost. However, in the last few years, medical facilities have been charging for services which were once free. Health providers say this was done to collect third-party payments for which the poor might be eligible. Still, many hospitals end up absorbing these medical costs.

In most U.S. cities, city and county hospitals carry the largest burden of inpatient care for the disadvantaged ethnic minority. Baltimore is no exception. Two witnesses representing hospitals with predominantly poor black populations testified: Jean Phaire, clinical educator for Lutheran Hospital in Baltimore, and Dr. Oakley Saunders of Provident Hospital in West Baltimore.

Lutheran is an urban hospital with a patient population which is predominantly black and elderly. Sixty percent of the patients are 65 years or older and live on fixed incomes. Most of Lutheran's patients reside in the immediate area.

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Ms. Phaire pointed out that the disadvantaged often use the hospital emergency room as their primary source of health care. Because of concern for enough money for the bare necessities of life, the community is crisis oriented, postponing health care until symptoms become unbearable or life threatening. Thus conditions which could have been treated in a clinic, end up requiring hospitalization.

Once persons are hospitalized, their care is influenced by economics. Approximately 60 percent of the patient population at Lutheran Hospital are covered by Medicare and Medicaid and 10 percent by medical assistance. In addition, 20 percent have Blue Cross and Blue Shield and 10 percent have various other insurance policies. If a patient is on medical assistance, when benefits are cut-off after 20 days, the hospital must absorb any further costs. Sometimes patients are sent home early, in which case someone must follow up to make sure there is no relapse.

A problem that Lutheran Hospital is doing something about is the difficulty some nurses find in dealing with patients from a socioeconomic area that is different from theirs and who have different needs. Sensing a need to help schools of nursing identify their particular needs, Lutheran Hospital is currently working with the Community College of Baltimore and Hall Community College. Ms. Phaire now sees greater concern among their graduates to understand patients and their specific needs in addition to acquiring clinical skills.

Provident Hospital, a 271-bed full-service facility has a population not unlike Lutheran's and hence similar problems. Medical referrals by its predominantly black medical staff and its black identity account for a mostly black patient population. Patients from several neighborhoods in Baltimore come there, mostly by public transportation.

Economics is seen to be one major problem. Patients do not have the money for proper health care, and since Provident is committed to serve them, it has a high bad-debt ratio. But bias by state and local officials compounds the problem. For example, without input from Provident, the city excluded it from the contract for a highly successful demonstration project for the coordinated health care of high-risk mothers. This underlines what Dr. Saunders sees is a lack of accountability by policy-making bodies to the ethnic minority. He cited as another example a much needed alcoholism program that was turned down after approval by hospital psychiatrists and city and state planning agencies. Such cases lead him to believe that the problem is not so much a monetary one as one of morality and ethics.

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THE ELDERLY

Older adults represent about 11 percent of the population today, and they account for over 29 percent of all medical health care costs in this country. Although they comprise a small portion of the U.S. population, studies show older adults have more illnesses, see more private physicians, and request more health care services than any other group.

Dr. Lois Evans gave extensive testimony on health care for the aged. She represented the District of Columbia Nurses' Asssociation and the Department of Nursing Practice of the Greater Southeast Community Center for the Aging.

The elderly population is one of the fastest growing groups in the nation. In the last decade it grew about 20 percent, while the general population increased only 8 percent. The 1980 census counted 103,655 persons over 60 years of age in Washington, D.C., and 109,151 over 65 in Baltimore. The latter constituted 13.8 percent of the city's population.

Historically, health care providers have focused their attention primarily on sick older adults, including the frail elderly, who are at risk for institutionalization, and the already institutionalized, but the frail elderly account for only 12 to 20 percent of the older population. They have some functional disabilities, probably one or more chronic illnesses, and require a

great deal of support service. They find it difficult to get to ambulatory care, and the current fragmentation of health care services exacerbates the problem. Dr. Evans believes it is possible to reduce this fragmentation so that a person entering the system has access to all the kinds of services he needs at that time.

Only five percent of older adults are in nursing homes or similar institutions at a given time, but an estimated 20 percent will spend some time in a nursing home. Dr. Evans stressed the need for nursing homes for people who need to be watched constantly or who need constant care.

Our ability to maintain a persons's life almost indefinitely in institutions raises difficult bioethical questions. Dr. Evans' center is cooperating with Georgetown University's Bioethics Department to examine these issues. The long-term institutionalization of persons who have little autonomy and perhaps no awareness causes us to reexamine the way we view people and human life. This is especially true in light of the strain such a situation imposes on family systems and the effect on the nation's already strained economy. She cited the case of an 84-year-old man, apparently coerced into accepting renal dialysis, who has been confused all along and is now so combative that he must be sedated. Such a case needs help from bioethics.

Although they comprise about 70 percent of the age group, the well elderly have been overlooked. Little has been done to help them remain healthy, to stay at home and ambulant, to enjoy their lives. Studies show that older

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people can learn more about health and that they do modify their self-care and health practices accordingly.

Dr. Evans has interviewed many older adults to discover their concept of health. Most seem to consider themselves healthy if they can still function and can still meet some of their interpersonal needs. Health promotion programs for senior citizens are needed, since they effectively teach the aging how to stay healthy as long as possible. Also needed are physicians and nurses who can help the aging address their health problems.

HOME HEALTH SERVICES

Medicaid and Medicare, both government funded health programs, were enacted in 1965. Medicaid, because of its expenditures and the number of people it covers, is the largest health care program for the poor. It offers myriad medical services to those on public assistance, and to the medical needy as well. Medicare, on the other hand, helps pay for medical care of the elderly. As a result of Medicare, high costs of hospital and medical care for older people have been substantially reduced.

However, according to testimony by Michael K. Milton, deputy director for special projects for the Visiting Nurses' Association in Baltimore, if it was not for the skilled care regulation in Medicare, many elderly could receive home health services. Approximately 20,000 people currently receive home health care in Maryland, while in fiscal 1980 Medicaid supported 15,481 persons in nursing homes. The General Accounting Office estimates that nationwide, 25 to 40 percent of the persons in nursing homes do not need that level of care. Applying these figures to Maryland means that it is possible that more than 6,000 persons in Maryland don't need to be there.

The chief reason for the overuse of nursing homes seems to be the Medicaid requirement that a patient must need the services of a registered nurse, a physical therapist, or a speech pathologist in order to qualify for aid. A

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physician must certify the patient for home health care. Mr. Milton suggests that a nurse is able to make that judgment. Further, Mr. Milton believes that giving less in Medicare and Medicaid coverage to a person cared for in a relative's home, than is given to a nursing home resident is inequitable and restricts freedom of choice.

THE CHRONICALLY MENTALLY ILL

Until the National Health Act of 1946, states' mental health hospitals were the mainstays of America's publicly funded mental health services system. That law, which established the National Institute of Mental Health, led to reform of state laws, increased public concern, and better financing for both care and training.

The centers set up under the Community Mental Health Centers Act of 1963 have virtually supplanted mental hospitals. Centers in catchment areas of 75,000 to 200,000 people provided inpatient and outpatient care, emergency day treatment, consultation and educational services, regardless of ability to pay.

However, the Mental Health System Act of 1979 has resulted in serious problems, according to Diahanne B. Anderson, B.S.N., of Baltimore. Actions to reduce the number of hospitalizations of the mentally ill have returned to the community large numbers of the chronically mentally ill, sometimes after many years of institutionalization. Ms. Anderson believes that community mental health centers are uniquely equipped to care for the health and welfare of these patients. In her opinion, the alternatives which have been tried have not worked, throwing persons who have been dependent for years, or who need a certain amount of supervision on to their own resources with little

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preparation. Many are barely surviving on welfare payments in poorly maintained housing, either in the midst of ghettos or on the edge of catchment areas. Ms. Anderson emphasized that some chronic mental patients cannot adjust to community living and would fare better in a state mental hospital, if such were restructured to provide domiciliary care in on-campus cottages. Set up on a Canadian model, different cottages would provide different levels of supervision, with the patient moving to a less structured environment as his functional level improves.

Ms. Anderson cited her experiences as coordinator of the Comprehensive Community Support Program, which was designed to provide deinstitutionalization for 50 chronic mental patients. It was found that patients of this type do need domiciliary care, because they are unsafe to themselves or others in the community. Originally they projected three months as the time needed to teach basic survival skills, but one year was found to be more realistic. With recent cutbacks in food stamps and medical assistance, deinstitutionalized patients are now living at subpoverty levels.

PRISONERS

Perhaps one of the most underserved minorities, in terms of health care in the nation, are persons in correctional institutions, the commission heard.

According to the Department of Justice, the nation's prison population reached a new high as of December 1979, with more than 314,000 prisoners. Historically, U.S. prisons have been beset by overcrowding and deterioration. Since the 1970s, due to increasing court scrutiny, U.S. prisons have been the object of large numbers of lawsuits and class actions directed at relieving poor conditions, including inadequate medical care. But the public seems to feel that prisoners don't deserve good health care, according to Vernard Purdie, a former inmate of the Maryland Penal System, and now an investigator for the Prisoner Assistance Project in Maryland. He noted that the population of the Maryland Division of Corrections was 8,500 persons, of whom 66 percent were black and 97 percent were male. Nearly 4,000 of these prisoners are released each year.

Lyada D. Johnson, a registered nurse and former associate director of health services for the Maryland Division of Corrections, noted that studies show that the incarcerated population has greater health needs and utilization of health services than comparable street populations. This is attributed to their socioeconomic class, their lifestyle, and their general underutilization

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of the health care system prior to incarceration. In addition, sociological studies of the prison environment have demonstrated that the environment itself increases symptom development. But further studies show that a coherent health care system decreases the number of sick calls and reduces the percentage of psychosomatic complaints.

Maryland has seven major institutions. Two prerelease centers have no onsite health care providers, but the three major institutions have infirmaries with 24-hour, 7 days a week nursing staff. However, infirmary service is not available to women. Ms. Johnson said that primary care, limited dental services, and referral to specialty clinics are uniformly available.

Problems that the witnesses touched upon included:

1) Lack of an organized system of health education

2) Problems with the corrections staff, ranging from job related stress, with its attendant alcohol and drug abuse, to unwillingness to use their first-aid and CPR training

3) Lack of a quality assurance program

4) Indifference of some health care personnel due to malingering by patients or burn-out of health care providers

5) Poor accountability of delivery of medications by correctional officers

6) Lack of a system of transferring health records when a prisoner changes jurisdiction

7) Inconsistent and delayed access to health care services, because the system relies heavily on the judgment of correctional officers.

Mental health care in prison is a particular problem. Inmates and staff agree that when persons with mental problems are mixed with the general prison population, there is danger to these inmates, to other prisoners, and to staff. And the lack of adequate programming and activities in these institutions leads to an increase of physical and mental health symptoms, taking up valuable staff time.

Money is a persistent problem. Maryland spends only $700 per year, per inmate, for health care. By state law, inmates are ineligible for Medicaid. So even these meager funds are not always available to pay suppliers of care.

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RECOMMENDATIONS FOR CHANGE

Access to health care is obviously better than it was 25 years ago for the ethnic minority, the disadvantaged and underserved, witnesses testified before the commission. However, they added that much more still needs to be done.

The health problems of these groups tend to be more numerous and more complex than others. Reports indicate that poor nutrition, substandard housing, and inadequate sanitation, accompanied by physical and psychological stresses of unemployment and deprivation, all interact to intensify these groups' health problems.

Witnesses called for more health promotion programs and specific training of health care professionals in the problems specific to these groups. Nursing schools need to work with hospitals in preparing nurses from different socioeconomic backgrounds to communicate effectively with the ethnic patient. Networks and coalitions including health professionals can seek to assure representation of minority concerns on city and state policy makers. Proper collection and use of health data can help effect changes.

Older adults, too, are plagued by lack of financial resources. While health professionals need to be aware of their responsibility to serve the sick

elderly, health education for the well elderly population is even more important. The frail elderly would be aided in access to health care services by the establishment on a single community organization to correct the effects of the fragmentation of health care. Nursing homes would become more effective if specially trained nurses were available to plan and assess care, and they would be less crowded if there were a way to provide more equitable funding for home health care for the elderly who can remain at home.

Representatives of community mental health centers believe that the standards of care and accountability they must meet should be required of boardinghomes, foster care homes, and group living placements for the chronic mentally ill. Chronic patients in crisis could be cared for more effectively with home health care, rather than by hospitalization, if such a program were funded.

Testimony indicated that while progress has been made in health care at Maryland's penal institutions, much more needs to be done. It was suggested that ANA develop standards for nursing care in corrections and cooperate with the American Medical Association on strategies for improved care. Services to inmates' families and for inmates as part of discharge planning are especially desirable.

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POSITIVE SIGNS IN HEALTH CARE

Witnesses cited a number of promising programs and services in the Baltimore area which could function as models elsewhere.

The Greater Southeast Community Center for the Aging, in Washington, D.C., provides a broad spectrum of community care for the elderly. In addition to community outreach programs, like telephone assurance and a Friendly Visitor's Program, there is a health day care program for the frail elderly, who receive rehabilitation, nursing, and health promotion services at the center. An extended care facility is being built which will provide skilled and intermediate care.

In 1979, Provident Hospital opened its community mental health facility which was designed to address the expanding mental health needs of persons living in an increasing complex and stressful socioeconomic environment. The facility's programs include chemical detoxification and psychodrama therapy.

In cooperation with the community, the hospital implemented the country's first church-based, nurse-coordinated community hypertension program. The hospital also organized the first specialized stroke program in Baltimore City, and established a Patient Advocate Program in Maryland.

Provident developed Lifeline, an electrically transmitted emergency home-to-hospital communications system.

It also has developed a network of educational affiliations within and outside the state of Maryland. These affiliations, which range from medical and public health schools to colleges and governmental scientific institutes, provide students in health professions with ongoing continuing education and training for the hospital's own staff.

As mentioned earlier, the Comprehensive Community Support Program, Baltimore City, provided 50 mental patients with deinstitutionalized services. The program found that patients did not need state hospitalization, but needed a type of domiciliary care situation. The program provided chronic mental patients with psychological treatment, living skills, and crisis intervention services. Patients were also provided housing, advocacy, and vocational training through subcontractural services with another agency.

A health education course has been offered to inmates in a Jessup institution through a local community college. The coordinator was a nurse. The course is being formally evaluated along with comparable community courses.

A major shift in delivery of health care to inmates in Maryland was brought about after the report of a task force jointly appointed by the Secretary of Correction and Health in 1980. Health care improvements included provision of sick call three times a week in the segregated and protective custody areas,

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onsite provision of primary care from 8 a.m. to 9 p.m., an increase in the quality of nursing care provided in the medical-surgical infirmary unit, and the opening of a psychiatric inpatient unit in April 1980.

Other positive improvements for inmates in Maryland have included the establishment of a subcommittee of the Maryland Nurses Association Council on Practice to develop standards for correctional nursing in Maryland; cooperation with sections of the Department of Mental Health and Hygiene in opening their resources to the division, particularly staff development; and the hiring of one person in each region to do administrative tasks in the health area, thus relieving clinical personnel to provide direct care.

In conclusion, many concerned health care providers are working to initiate or update existing health care programs and services based on the needs of their patient populations. Practitioners are learning new skills, gaining new information from research, community interest and patient advocacy on what is needed to serve the disadvantaged and underserved groups. The impact of their efforts will surely benefit these groups.

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10/26/82

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AGENDA ITEM X-A

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President

Myrtle K. Aydelotte, Ph.D., R.N., F.A.A.N.
Executive Director

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May 4, 1982

JUN 01 1982

Ernest D. Mason, Ph.D.
Helen Miller, M.S.N., R.N.
Nursing Research Department
North Carolina Central University
Durham, North Carolina

Dear Dr. Mason and Ms. Miller:

This letter shall serve to confirm the agreement between you and the Commission on Human Rights of the American Nurses' Association.

You shall prepare the manuscript for a publication, Contemporary Minority Leaders in Nursing: Afro American, Hispanic and Native American Perspectives based upon the attached publication proposal and supporting materials for the Commission on Human Rights. ANA shall underwrite your secretarial services and telephone costs, totaling $1,000. The manuscript prepared by you and the final publication shall become the property of ANA.

The final draft of the manuscript shall be submitted to ANA by you no later than July 31, 1982. Upon signing this letter of agreement and returning it, you will receive a check for $500 to underwrite the above expenses. Another check for an equal amount will be forthcoming at your request.

If the foregoing agreement is satisfactory to you, please signify your agreement by signing a copy of this letter in the space provided below and returning the copy to the undersigned.

Sincerely,

Cheryl D. Thompson
Staff Specialist, Human Rights
Research and Policy Analysis Department

CDT:ss:02

I agree to prepare a manuscript on behalf of the Commission on Human Rights for a publication entitled Contemporary Minority Leaders in Nursing: Afro American, Hispanic and Native American Perspectives.

on the terms and conditions as set forth above.
with the exception of the submission date,
July 31, which we request be extended to
Oct. 31 (see enclosed letter for explanation).

Ernest D. Mason, Ph.D.

Helen Sullivan Miller, M.S.N., R.N.

cc: Marion Davis Whiteside, Chairperson
Commission on Human Rights

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AGENDA ITEM VIII-A

AMERICAN NURSES' ASSOCIATION

COMMISSION ON HUMAN RIGHTS

Historical Background

In December 1976, the Commission on Human Rights sent a questionnaire to ANA members who identified themselves on their membership applications as members of an ethnic/minority group. The purpose of this questionnaire was to poll the ethnic/minority membership concerning its needs, in an effort to make programmatic activities more responsive. The Commission on Human Rights also wanted to receive feedback from its constituency about the establishement of the Commission.

The responses to the questionnaire were very favorable. Many members expressed a desire to become more involved in the professional association but did not believe that the present organizational arrangements permitted this.

In July, 1977, the Commission on Human Rights held a luncheon and workshop in New York City to honor those women who were officers of the National Association of Colored Graduate Nurses, and were instrumental in its dissolution so that its members could be become organized within ANA. At this meeting, many conference participants expressed a desire to work, with the commission through an affiliation with the Commission on Human Rights under an appropriate organizational arrangement.

Since its inception, the commission realized that it needed more person-power if it was to be effective in carrying out its programmatic activities at the national and constituent levels. The appropriate arrangement for greater participation of ethnic and minority members is the formation of a council under the commission.

In an effort to obtain a commitment from ANA members regarding Council membership the commission developed a (attachment #1) form and distributed it at its 1978 Convention Program, and at its June 1979 Conference in Albuquerque, New Mexico. The additional cost for council membership was indicated on this form. Approximately 130 ANA members from these two meetings expressed a desire to join the proposed Council of Intercultural Nursing.

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Assessment of Need

A number of ethnic and minority national nursing organizations have been established during this decade. These organizations exist because of the need to address those specific areas peculiar to its constituency. These organizations look to ANA as the professional association to address the collective needs of ethnic and minority groups. Members of ethnic and minority nursing organizations are encouraged to hold membership in ANA.

Two national nursing organizations have been established within the past two years to address the collective needs of ethnic nurses and consumers during the past year, ANA has received a formal request to establish a Division on Intercultural Nursing within ANA.

The Commission on Human Rights has been in existence for three and one half years. A great deal of that time has been utilized organizing internally, planning programmatic activities, and projects for the future. The commission is at the stage in its development that in order to move forward with implementing its programs (attachment #2), it must have a greater support group. Establishing a Council of Intercultural Nursing would provide an opportunity for ANA ethnic and minority nurses to organize around areas of mutual concern within ANA. A council would also provide the person power to implement the commission's programmatic activities.

The following guidelines for a Council of Intercultural Nursing have been adopted by the Commission on Human Rights. Members of the Commission recommended that the ANA Board of Directors approve establishing a Council of Intercultural Nursing under the Commission on Human Rights.

Ethelrine Shaw, M.S., R.N., Chairperson
Grayce Sills, Ph.D., R.N., Vice-Chairperson
Annie J. Carter, M.S.N., R.N.
Tita Corpuz, M.S.N., R.N.
Lorene Sanders Farris, M.S., R.N.
Ildaura Murillo-Rohde, Ph.D., R.N.
Lauranne Sams, Ph.D., R.N.
David Waldron, R.N.
Marian Davis Whiteside, M.P.H., R.N.

AMERICAN NURSES' ASSOCIATION

COMMISSION ON HUMAN RIGHTS

GUIDELINES FOR COUNCIL ON INTERCULTURAL NURSING

Section I Membership Eligibility

There shall be a Council on Intercultural Nursing.
Membership shall be open to ANA members who are interested in the human rights concerns of nurses and consumers from the perspectives of social justice; affirmative action; equity in terms of the availability and accessibility to health and nursing care to underserved populations.

Section II Purpose

To provide direction in the development and implementation of policies and programs which relate to human rights concerns. To improve the quality of nursing care by being responsive to the cultural and ethnic variances among consumers.

Section III Relationships

The council will be directly accountable to the Commission on Human Rights and will implement the policies and programs of the CHR.
The council will provide the opportunity for its members to participate in the development and implementation of council activities.
The council will work toward the inclusion of human rights policies and practices in the programming of ANA structual units and constituencies.

Section IV Functions of the council shall include:

a. developing human rights standards which will be assistive to nurse educators, researchers, and practitioners in defining their role.

b. participating in the development of research activities which relate to human rights.

c. collecting data about ethnic and minority consumers and providers.

d. defining ways in which the Association can be more responsive to human rights needs.

e. planning conferences about human rights.

f. collaborating with other associations and organizations with similar purposes.

g. reviewing the Association's documents for the inclusion of human rights principles.

h. planning an annual or biennial conference on the upholding of human rights in nursing practice and nursing education, as well as inclusion of cultural diversity in nursing curricula;

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Section V Executive Committee

There shall be a minimum of five council members.

a. the term of office is two years.

b. the officers of the council shall be chairperson, vice-chairperson, and secretary.

c. the vice-chairperson shall automatically become chairperson and serve for one term in that capacity.

d. the vice-chairperson and secretary shall be elected biennially in the even years by the council membership.

e. the other members of the executive committee shall be elected biennially on the odd years by the council membership.

f. no executive member may serve for more than two consecutive terms.

g. any council member may be considered for nomination to the executive committee by being recommended by another member. A consent-to-serve form and biographical data must be submitted with the recommendation.

h. in the event a vacancy occurs in other positions on the executive committee the position will be filled in the next year.

Section VI Standing Committees

The Nominating Committee:

a. shall consist of 3 council members.

b. shall solicit suggestions for nominees from the membership.

c. shall take into consideration nominating members from various geographical regions.

d. shall obtain consent-to-serve forms from nominees selected by the nominating committee.

e. shall prepare a ballot consisting of two or more nominees for each of the vacant positions on the executive committee.

f. shall notify the membership of the ballot at least one month prior to the voting deadline.

Section VII A few additional committees may be created as the need arises.

rw
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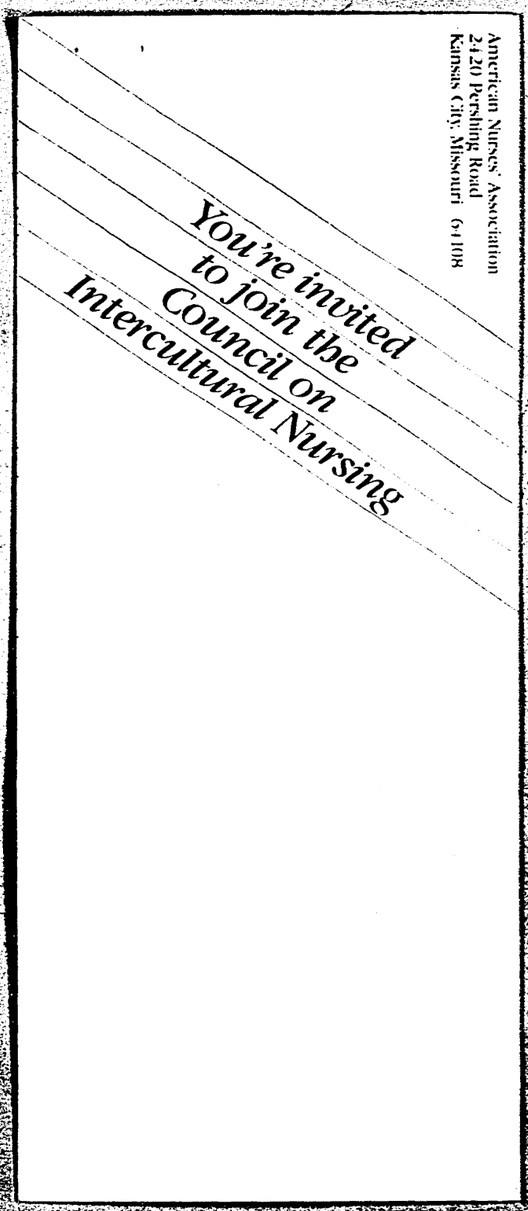

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June 14, 1983

1108 Scranton Place
Durham, N. C. 27713

Dr. Juanita Hunter
127 Shirley Avenue
Buffalo, New York 14215

Dear Juanita:

It was good to hear from you a few days ago. I was disappointed over the prospects of seeing you in May and wondered what happened. It sounds as though Chairing the Cabinet on Human Rights is almost a full time job.

As you've probably heard by now, I attended NLN Convention and spent one or two hours every day at the ANA Booth. I wanted to get the reaction for sales, etc. Many were quite impressed with what they saw and I believe this fall we'll see sales rise.

It was a real pleasure to meet Miss Eunice Cole, who brought along her book for me to autograph, Mr. Moore in Marketing and of course several of the staff.

Now about the concern raised at Board meeting re: Ethelrine and Barbara Nichols. Ethelrine was correct, she did not respond to either the first or second letter. Barbara was sent three letters. After not hearing from her, I discussed the situation with Cheryl and she took a fourth letter from me and had Barbara's Secretary place it with "urgent" correspondence and still she did not reply. One would assume after these attempts and no response that she did not care to be included.

There are several others who also failed to respond. Only one of these, Oliver Osborne had the courtesy to send a reply. For your information, I am enclosing the original list of Afro-Americans and you can see who they are. Please return this list.

Grace Sills of the Human Rights Cabinet suggested several names for inclusion. Cheryl and I followed through with them and only one, Juanita Fleming sent in the necessary materials.

The Native Americans were supplied by Lorene Farris and the ANA talent bank. Letters went from Cheryl after only eleven of twenty-five responded. The same is true of Hispanics. Illdura Rohde supplied several names, the ANA talent bank some and by word of mouth others. Hector Gonzalez was in the first mailing.

The news about Charles Hargett is almost unbelievable. I wonder what happened.

Take care and let me know of anything further to be done.

Sincerely,

Helen

Helen S. Miller, M.S.N.

HSM:pj

Enclosure

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AMERICAN NURSES' ASSOCIATION

TO: Cheryl D. Thompson
Staff Specialist, Human Rights

FROM: Edward W. Kriss
General Counsel

DATE: September 20, 1982

RE: Vulnerability of ANA to suit for publication of Health Care Services for Native Americans

---

I have reviewed the above-referenced publication, and in my opinion it is unlikely that a successful suit against ANA could be maintained because of the publication.

A lawsuit against ANA for the publication would most likely have to be an action for libel. It is questionable whether or not an agency of the federal government, the Indian Health Service, can be libeled and has standing to sue for libel. Further, my reading of the publication shows that there are no direct references to individuals that might be construed to be defamatory.

Even if it is assumed that the Indian Health Service or an individual has standing to bring a libel action, ANA might well have a defense by asserting the publication is not actionable because of the privilege of (1) fair comment or criticism on matters of public interest or concern, or (2) reports of proceedings of public interest.

However, the law of defamation is fluid and there can be no guarantee that suit will not be filed, albeit on tenuous grounds. A lawsuit for libel is sometimes used as a device to get the plaintiff's "side of the story" on the "public record". Conversely, lawsuits for libel are often not brought because the potential plaintiff wishes to avoid further public airing of the publication deemed objectionable.

On the whole I doubt that ANA will be subjected to suit over the publication. Those who may be aggrieved over the publication, including the Indian Health Service, will probably find it more fruitful to pursue other means to rectify the misrepresentations they believe are contained in the publication.

EWK:njh

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AGENDA ITEM VI-A

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August 18, 1982

Thomas E. Stenvig, Chairperson
Council of Nursing
Public Health Service, Aberdeen Area
Indian Health Service
Federal Building, Room 309
Aberdeen, South Dakota 57401

Dear Mr. Stenvig:

I am responding on behalf of the Commission on Human Rights about concerns regarding the publication, Health Care Services for the Native American, in testimony presented at a hearing on June 8, 1979.

The intent of this consumer hearing was to solicit testimony from as many sources as possible. A press release and accompanying materials were mailed extensively to all health and human service agencies in the area, reservation newspapers and newsletters, and organizations whose primary purpose is working with Native Americans. The commission did not deny any individual and/or organization the opportunity to present testimony. The above publication is the result of all testimony which was provided at this hearing. We regret that you did not have someone from your agency present testimony on your behalf.

Thank you for forwarding your concerns regarding this publication to the commission. I apologize for the delay in responding. It was necessary to contact the members of the CHR prior to our written response. If you have additional concerns, please contact me at the headquarters of the American Nurses' Association in Kansas City.

Sincerely,

Cheryl D. Thompson
Staff Specialist, Human Rights
Research and Policy Analysis Department

CDT:tlw:81

cc: Eunice Cole
Judith A. Yates
William Weiler

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Health Services Administration

Billings Area
Indian Health Service
2727 Central Avenue
P.O. Box 2143
Billings MT 59103

September 3, 1982

Our Reference: CN

Ms. Cheryle Thompson
Staff Specialist, Human Rights
Research and Policy Analysis Department
American Nurses Association, INC
2420 Pershing Road
Kansas City, MS 64108

SEP 10 1982

Dear Ms. Thompson:

I am writing as an active member of the American Nurses Association to express my dismay that a structural unit of my professional association would publish and distribute a document such as Health Care Services for the Native American, without first confirming the accuracy of the statements made at the hearing, or at a minimum, a disclaimer.

I am the Clinical Nurse Consultant for the Billings Area Indian Health Service, and have always supported and encouraged membership in the American Nurses Association. I find it difficult to continue such support when a document is distributed by the same organization that portrays such a false picture of our agency. In my own personal opinion, the information you so prompty circulated was a direct and negative reflection on the many hundreds of dedicated professional nurses who were deligently raising the level of health care of the American Indian population, before the American Nurses Association deemed in appropriate to hold such a hearing.

I am currently the only candidate running for president-elect in the Montana Nurses Association. It is my hope that perhaps by holding that office I might be able to promote a more responsible attitude in the national organization toward publication of such questionable material.

Sincerely,

Rolland W. Arnold

Rolland W. Arnold, R.N., M.S.N.
Area Clinical Nurse Consultant

cc: Eunice Cole, President, American Nurses Association
Judith Yates, Executive Director, American Nurses Association
Tom Stenvig, Chairman, Council of Nurses