**CHAPTER 76**

**Taking Action**

The Nursing Community Builds a Unified Voice

*Suzanne Miyamoto, Lauren Inouye*

Advocacy is a dish best served unified. No matter the issue, if more than one player in the process supports or opposes it, there is an increased potential that the final action will result in their favor. Although there are multiple factors that may impact this (i.e., the reputation of the players, their influence, or the political dynamics), the general rule is power in numbers. Legislators anticipate that their staff will thoughtfully investigate both sides of an issue and present them with sound options on how to proceed. The support of constituents, opinions of national or state organizations (depending on the legislative body), historical positions of the office, coalitions, and, of course, influence are major factors in the decision-making process. Of these, coalitions certainly make a sizable impression. If likeminded groups, particularly from diverse fields of expertise, join together for a common cause, it is noticed. There are many forms of coalitions, some more formal than others, but the question becomes, what makes a coalition effective? And, more importantly, why have they become increasingly necessary?

**The Necessity of Coalitions**

Competition often necessitates coalition formation when political pressure to win is intense. Competition, in other words, is defined as the scenario when multiple parties have differing interests at stake, and the outcome of a particular policy favors one group's interests over another's ([Holyoke, 2009](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0076.xhtml#bib5)). For example, in today's health care system, multiple parties, including health care professionals, hold interests and positions that do not always align and competition intensifies when the stakes are high. Essentially, the battle to advance a policy position focuses on who has the most presence on an issue, both the type that goes noticed and that which does not.

Consider any issue nurses would be passionate to promote. Does the profession have the resources to tip the odds in their favor (i.e., time, financial infrastructure, individual advocates)? The public assumes policy is formed on the basis of evidence, and this assumption is absolutely true. However, the wise citizen knows that evidence alone is not always the deciding factor. Take, for example, advanced practice registered nurses (APRNs) being able to practice to the full extent of their education and training. There are decades and mountains of evidence to show that APRNs are effective clinicians who can provide cost-effective, high-quality care. If evidence is all it took to create policy, then why is there not full practice authority for APRNs in all 50 states? There is much more to policy than evidence; there is politics. And politics is driven by competition. If competition is driven by those with the most resources to win, what are nursing's odds?

Time and time again we see advances made at the state level to amend practice acts that would allow APRNs to serve their patients to the level they were educated. Nursing organizations at the state level have made tremendous strides to find legislative champions, allies in the community, and partnerships among their associations, but when push **615**comes to shove, the odds do not end up in their favor. It would appear that a perfect campaign was run, but the effort fell short. Ask any nurse who has endured this encounter and they will say their competition was intense.

Take, for example, a 2014 case in Nebraska. The efforts of the nurses in the state to pass Legislative Bill 916 were formidable. This bill would have eliminated the requirement that nurse practitioners must have a practice agreement with a collaborating physician. It passed the state legislature. How­ever, when the bill was sent to the Governor's office, he notified the members of the legislature that he would not sign it, expressing the concern that the bill “goes too far too quickly” ([Nebraska.gov, 2014](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0076.xhtml#bib10), para 3), despite the fact that the legislation included a transition period in which new graduate nurse practitioners would have a 2-year transition into practice with a collaborating physician. In the Governor's official letter that vetoed the bill, he states,

*… the Chief Medical Officer expressed concern that the “total independent practice for nurses practitioners … without identifying an alternative means by which nurse practitioner can be included in viable practitioner referral networks creates potential safety issues for patients.” The Chief Medical Officer also stated that “recent graduates of nurse practitioner programs … lack sufficient clinical experience to practice independently”… (*[*Nebraska.gov, 2014*](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0076.xhtml#bib10)*, para 4)*

The Governor's letter does not mention the body of evidence supporting the APRN full practice authority or the Federal Trade Commission's (FTC) recent position that:

*As explained herein and in prior FTC staff APRN advocacy comments, mandatory physician super­vision and collaborative practice agreement requirements are likely to impede competition among health care providers and restrict APRNs' ability to practice independently, leading to decreased access to health care services, higher health care costs, reduced quality of care, and less innovation in health care delivery. For these reasons, we suggest that state legis­lators view APRN supervision requirements carefully. Empirical research and on-the-ground experience demonstrate that APRNs provide safe and effective care within the scope of their training, certification, and licensure. (*[*Federal Trade Commission, 2014*](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0076.xhtml#bib4)*, p. 38)*

One of the glaring issues in this debate is always education and clinical hours, not necessarily the outcomes. In a letter written by the American Association of Colleges of Nursing, the rigor of APRN education was presented ([American Association of Colleges of Nursing, 2014](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0076.xhtml#bib1)). Moreover, some health care disciplines are moving to a competency-based educational system over a prescriptive number of clinical hours. There are a host of factors that could have played a role in the Governor's decision, but he only cited one opinion in his veto letter: that of the Chief Medical Officer. One thing can be said in this case: there is competition in who helps inform the ultimate decision. Even the Institute of Medicine's (IOM's) *The Future of Nursing* report calls for nurses to assume more highly influential policy positions, stating, “Public, private, and governmental health care decision makers at every level should include representation from nursing on boards, on executive management teams, and in other key leadership positions” ([IOM, 2011](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0076.xhtml#bib6), p. 5).

In a competitive environment, as the number of players involved grows, the spectrum of positions becomes wider and the pot of resources needed to win becomes larger. Even within a larger group representing smaller, but similar interests, it is difficult to imagine that the positions and preferences of these smaller subgroups would be exactly the same ([Moe, 1980](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0076.xhtml#bib9)). For example, the nursing profession is represented by more than 100 national organizations. Conceivably, one could assume that there are at least 100 policy positions that represent a seg­ment of the nursing profession. Realistically, many of these nursing organizations have similar policy interests. Finding middle ground that appeals broadly helps to build the case for taking unified action ([Holyoke, 2009](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0076.xhtml#bib5)). When multiple groups can convene around their common interests, the collective action of these groups helps promote competition and secure an outcome in their favor.

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**Coalition Formation**

In nursing school, many learn the Gestalt theory as an approach to patient care: the whole is greater than the sum of its parts. This is true in policy and politics and is at the core of coalition formation. Establishing a coalition for the purpose of advancing a shared interest allows individual parties to pool together resources and to amplify a unified voice. Say, for example, 10 health care associations are vying for their issue (a proposed solution that would increase access to primary care) to be placed on the federal agenda. Five of these 10 groups realize they have similar policy solutions and it would be in their interest to act collectively. As five, formerly separate groups now recognized as one unified entity, these groups have placed themselves in a higher position to leverage the policy's outcome. They can merge their collective resources to advance their policy solution. As a coalition, these groups represent one half of the political influence on this issue. Before this coalition formation, individually, they only represented one tenth (i.e., the whole is greater than the sum of its parts).

Moreover, the collaboration of multiple, vested stakeholders (individuals, groups, or established organizations) is intensified if coalition members provide diverse representation. Greater diversity among coalitions can increase the chances that the collaboration (and thus their interests) as a whole will appeal to legislators. If a health care coalition includes nurses, physicians, pharmacists, and phy­sical therapists, legislators are less likely to see the issue as a provider issue, but rather as a health care issue. Knowing that coalitions are key in the policy process to overcome the competitive nature of the political process, what makes an effective coalition?

**Defining a Coalition's Success: the Importance of Leadership and Goal Setting**

As discussed earlier, generally speaking, a coalition comprising numerous organizations will represent a spectrum of positions, perspectives, and values. It takes a highly skilled leader to draw together multiple organizations and channel the energy and resources of these groups toward a specific, common goal. A coalition leader must be able to clearly and concisely dialogue with all members involved so that each feels that they are being heard and recognized. Coalition leaders must be able to balance the individual perspectives of the organizations and consider how they will weight in when the coalition formulates a policy position on an issue, all the while making sure that the resulting message is one that the coalition as a whole can support.

A 2001 study interviewed coalition leaders on the complexities of coalition building. When asked how they defined their coalition's success, the highest ranked answer was “achieving our goals” ([Mizrahi & Rosenthal, 2001](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0076.xhtml#bib8)). Although this may seem like an obvious response, it raises a very important point: it is not enough for interest groups to simply convene because they are likeminded; in addition to talking the talk, they must also walk the walk by channeling their collective support toward specific action. Setting goals helps coalitions to walk the walk. Goals may evolve over time, but it is important that they are communicated well among members of the coalition so that consensus and confidence in the coalition are maximized, and confusion, disappointment, and blame are minimized.

Goal setting is beneficial for a few reasons. First, the process of goal setting allows coalition members to create a clear plan of action and to divide up duties that are aimed at achieving that goal. This process creates commitment among the groups involved, which is essential for accountability. Second, goal setting ensures all members are on the same page regarding the desired result of the action plan. This is especially important because the end goal could realistically fall anywhere from raising awareness broadly about your issue of interest to a more concrete, long-term end goal, such as having a piece of legislation passed into law. Third, achieving goals builds a coalition's credibility. A coalition that can point to specific successes builds a reputation as being effective and collaborative. Within the nursing profession, the ability for nurses and nursing organizations to collaborate around **617**common goals and present a unified front has not always been their strongest suit. This sentiment has been echoed by multiple parties, including Congressional staff ([Begeny, 2009](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0076.xhtml" \l "bib2)), and is a challenge that nursing continues to grapple with today (though it is making great strides forward).

**A Perspective on Nursing's Unified Voice**

A 2010 Gallup study commissioned by the Robert Wood Johnson Foundation (RWJF) examined the perceived role of nurses in influencing health care reform, drawing on the opinions of 1500 leaders from several health-related industries (including insurance and health care services), as well as the government and academia. The survey unlocked perceptions about the degree to which nurses currently influence health care and to what extent nurses should influence the policies that dictate its delivery ([RWJF, 2010](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0076.xhtml#bib12)). When respondents were asked which barriers prevent nurses' ability to contribute to improvements in policy development, 56% identified “Nursing lacks a single voice in speaking on national issues” as a major barrier, and 29% identified this barrier as a minor one ([RWJF, 2010](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0076.xhtml#bib12), p. 10). This was the fourth highest-ranking barrier out of 11 ([RWJF, 2010](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0076.xhtml#bib12)). Furthermore, opinion leaders highlighted the importance of nurses taking accountability for elevating themselves into leadership roles. “In other words, respondents felt nurses should be held accountable for not only providing quality direct patient care, but also for health care leadership” ([Khoury et al., 2011](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0076.xhtml" \l "bib7), p. 304).

What does this study tell the profession? Unite and take accountability for your own actions. The political process is fast moving and intense. Historically, nurses have been upheld in the public eye as among the most, if not the most, trusted profession in the United States ([Swift, 2013](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0076.xhtml#bib13)). Nurses may believe it is not within their professional purview to be mingling in the political realm, or do not feel empowered to participate in the policy process as a result of feeling conflicted about what their role is when it comes to political leverage ([Des Jardin, 2001](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0076.xhtml#bib3)).

However, if nursing wants a seat at the policy table, it is not simply awarded because nurses are trusted and well-respected publicly; it has to be earned. Earning that seat involves an empowered nurse to engage in the political process necessary to gain that seat. Ultimately, in every setting there is competition for relevance and if uniting is a way to be relevant in the political process, nursing must shed the perceptions of the opinion leaders in the RWJF study and be the leaders our patients need us to be.

**Nursing Unites: the Nursing Community**

Comprising national nursing organizations, the Nursing Community (NC) coalition began as a forum of a handful of organizations with a shared interest in lobbying for federally funded nursing education programs. More specifically, the forum rallied around increasing federal support for the Nursing Workforce Development programs (Title VIII of the Public Health Service Act). Currently, the NC convenes 61-member organizations, and, over time, the expansion in its membership has brought with it an expanded portfolio of policy issues. Today, the NC is now a coalition representing more than 1 million registered nurses, APRNs, nurse executives, nursing students, faculty, and researchers who collaborate to improve the health of the nation by advancing the nursing profession (The [Nursing Community, 2014](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0076.xhtml#bib14)). The NC's diverse nursing representation provides the coalition with expertise and insights into several aspects of the profession and adds to its political clout.

Earlier in this discussion, we addressed the importance of nurses being in influential roles to advance policy. After the Patient Protection and Affordable Care Act (ACA, Public Law 111-148) was passed into law, the NC met and evaluated opportunities for collective action. One identified goal was to ensure nursing leaders served on the commissions and boards newly established through the ACA. The traditional process for nursing organizations to nominate leaders onto commissions and boards was to look at their own membership and put forth one of their leaders. This resulted in **618**multiple nurses being advanced for limited seats in a very competitive selection process. Two of the first calls for nominations into leadership positions from committees created through the ACA were the Patient-Centered Outcomes Research Institute (PCORI) and the National Health Care Workforce Commission. The NC realized that if nursing was to attain at least one representative within these policy bodies, the candidates must be supported on a unified front.

The mission of the PCORI is to “help people make informed health care decisions, and improved health care delivery and outcomes, by producing and promoting high integrity, evidence-based information that comes from research guided by patients, caregivers and the broader health care community” ([PCORI, 2014](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0076.xhtml#bib11), para 1). The NC engaged in creating a nomination process in which only a few, select nursing leaders would be nominated for these prestigious positions. Nursing organizations were able to submit candidates that would be collectively reviewed by all nursing organizations within the NC. The NC then established a vetting and voting process to select the top most-viable candidates from the names brought forth. The NC created a 168-page document outlining the strengths of each candidate. After nearly 2 months of thoughtful discussion among the organizations, four outstanding nursing candidates were put forth by the NC for the PCORI Board of Directors. The letter sent by the NC to the Comptroller General of the United States included the signatures of 33 organizations out of 55 national organizations belonging to the NC at the time.

The NC was pleased when one of the four candidates they put forth, Debra Barksdale, PhD, RN, FNP-BC, ANP-BC, CNE, FAANP, FAAN, was selected to serve on the PCORI Board of Governors ([U.S. Government Accountability Office [GAO], 2010a](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0076.xhtml#bib15)) and another one of the candidates, Robin Newhouse, PhD, RN, NEA-BC, FAAN, was later selected to serve on PCORI's Methodology Committee ([GAO, 2011](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0076.xhtml#bib17)).

The second policy body of interest, the National Health Care Workforce Commission, was established to “serve as a national resource for Congress, the President, and states and localities; to communicate and coordinate with federal departments; to develop and commission evaluations of education and training activities; to identify barriers to improved coordination at the federal, state, and local levels and recommend ways to address them; and to encourage innovations that address population needs, changing technology, and other environmental factors” ([GAO, 2010b](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0076.xhtml#bib16)). The NC put forth 5 candidates, with 32 NC member organizations supporting them. The Commission selected 15 leaders, and Peter Beurhaus, PhD, RN, FAAN, whom the NC supported as a nominee, was not only was selected onto the Commission but was also appointed as the Chairman by the Comptroller General.

Although the NC played a role in nominating these candidates, these nursing leaders engaged in the necessary process to gain a seat at the table. This example identifies the power of nursing unifying to meet goals set at the micro-level, which impacted the macro-level (i.e., the health care delivery system). As stated earlier, the IOM clearly calls for more nurses to serve in national leadership positions. The selection of Drs. Barksdale, Newhouse, and Beurhaus was a clear win in which the NC set goals and expectations, and delivered a successful outcome to meet this national agenda. Earlier in this chapter, we examined an example in Nebraska of how a few key individuals can significantly impact a policy dialogue. This story of the NC shows how it is imperative that our profession is represented in all policy and political circles, and this happens when we pool our resources. Since then, the NC has continued to collectively nominate nurse leaders such as Mary Naylor, PhD, RN, FAAN, who was appointed onto the Medicare Payment Advisory Commission, which is tasked with analyzing access to care, cost, and quality issues related to Medicare.

**Conclusion**

Effective coalitions can offer an amplified voice where the voice was once singular, marginal, or nonexistent. Leadership that can convene multiple perspectives is essential for setting the culture of the coalition and creating a unified voice. To use this **619**voice effectively, clearly identifiable goals must be set so that coalition members understand their responsibility in the advocacy process and what constitutes a successful outcome. The NC has proven itself as an effective coalition for nursing when the profession needed unification most (i.e., when a seat at the policy table would give nursing political strength). However, the work is not done. The spectrum of issues continues to expand for nursing to pool its resources and elevate our public view as policy leaders, so that we can insert the expertise of nursing into the decisions that impact our patients. Now more than ever, the profession must be accountable for the outcomes we want to achieve for the national health care goals. United, we can achieve this.

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**CHAPTER 77**

# Taking Action

## The Nursing Kitchen Cabinet: Policy and Politics in Action

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*“Alone we can do so little; together we can do so much.”*

Helen Keller

## The Context

Raising the voice and visibility of nurses in Virginia is an ongoing challenge for Virginia nurse leaders. For the past three gubernatorial campaigns, 2005, 2009, and 2013, Virginia nurse leaders employed the Kitchen Cabinet as a strategy to influence and educate the gubernatorial candidates. This case example chronicles the journey focusing on the development and growth of the Kitchen Cabinet, from its inception in 2005 to the 2013 campaign. Through three gubernatorial campaigns and with varying degrees of success, we have employed strategies that increase nursing's influence. We will share those strategies and offer pointers for others wishing to influence political campaigns within their own states using the Kitchen Cabinet model.

Our journey began with nurse leaders' commitment to working together in the policy and political arenas. The mission of the Kitchen Cabinet was to educate the candidates about current nursing issues through a policy agenda, influence political campaigns, increase nurses' involvement, and ultimately change public policy and increase the visibility of nurses within the executive branch of government. The members were volunteer nurse opinion leaders who were passionate about the mission and were able to be dynamic and agile as the process unfolded. Throughout the campaigns, all nursing stakeholders were at the table: practice, education, associations, and policy influencers. The methods required the Kitchen Cabinet to divide policy development from political action. Thus, the Kitchen Cabinet developed a common policy platform, although they differed on political persuasion.

### Policy Development

The Kitchen Cabinet agreed on a plan to work together to develop a consensus, nonpartisan policy platform that has resulted in policy agendas that are nursing-centric and within the power of the Commonwealth's chief executive to implement ([Box 77-1](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0077.xhtml#b0010)). These agenda items reflect the diverse perspectives of the nursing leaders and frame the issues that were (or continue to be) relevant in the campaign year.

**Box 77-1**

**Virginia Nurses' Kitchen Cabinet Policy Platforms 2005, 2009, and 2013**

| **2005 Campaign** | **2009 Campaign** | **2013 Campaign** |
| --- | --- | --- |
| • A commitment to nursing workforce development with the creation of a statewide center for nursing.  • A commitment from the Commonwealth to increase the educational capacity of the state's schools of nursing. | • A commitment from the Commonwealth to increase the educational capacity of the state's schools of nursing.  • A commitment from the Commonwealth to allow full access to nurse practitioners.  • A commitment for continued funding of the Department of Health Professions health care workforce data center. | • Enable advanced practice registered nurses to practice to their full scope of education and training.  • Increase educational capacity and faculty salaries at the state's schools of nursing.  • Ensure efficient regulatory process for the board of nursing.  • Increase the number of nurses on public policy and regulatory boards. |

### Political Action

After completing the policy agenda, the Kitchen Cabinet focused its attention on the political work involved with communicating the message to the campaigns and working toward election of the candidates. In reality, the Kitchen Cabinet be­comes two cabinets moving forward, Republican and Democrat.

The methods for achieving the political work have changed over the years. In 2005 and 2009, we were able to imbed nurses into the campaigns. In all three campaigns, meetings were held with the candidates themselves and/or their surrogates and Kitchen Cabinet members. The purpose of the meetings was to share with the candidates nursing's policy agenda, to educate about issues of importance to nurses, and to identify how they might assist the candidates toward successful election **621**campaigns. These nurses spearheaded efforts to hold nurses' fundraisers for the candidates and publicize their allegiances through bumper stickers and yard signs. In 2013, we scheduled meetings and looked for other opportunities to meet with the candidates and their campaign personnel. Increasingly, we are using social media to assist nurses in becoming politically active. This has involved posting candidate profiles on the Virginia Nurses Association's (VNA) website and information about campaign appearances through links to the candidates' websites.

### Results of Our Work

In 2005, we met with huge success in our inaugural launch of the Kitchen Cabinet. Timothy Kaine was elected Governor, and he appointed two Kitchen Cabinet nurses to his health policy transition team. Both of these nurses then received gubernatorial appointments in the administration; one serving as the first nurse to head the Department of Health Professions (the umbrella health professions regulatory agency), and one as the Chair of the Virginia Council on Women.

The Governor also appointed other nurses in his administration and fostered the implementation of one of the long-term goals of the nursing com­munity: he appointed a nurse, Marilyn Tavenner, as the Secretary of Health and Human Resources, a cabinet-level position (Tavenner is now the Administrator for the Centers for Medicare and Medicaid Services). In 2006, he also appointed nurses to serve on his Health Reform Commission (HRC) and on Commission workgroups.

In addition to ensuring the presence of nurses in the executive branch and on gubernatorial appointed councils and commissions, we were incredibly successful in advancing our policy agenda. The primary overarching health workforce recommendation of the Governor's HRC was that the Commonwealth should invest in a health workforce data center. Although nursing's request and dream was a nursing workforce center, through the art of negotiation and compromise, we recognized the need for data on all health professions and thus supported this concept.

Our second policy platform request, to increase the educational capacity and faculty salaries in schools of nursing, was realized in 2007. The Governor submitted a budget request for a 10% increase in nurse faculty salary at all public colleges and universities. This request has been sustained throughout difficult economic realities.

In 2009, Virginia elected Bob McDonnell as Governor, who appointed Bill Hazel, MD, as his Secretary of Health and Human Resources. Sec­retary Hazel engaged all health care stakeholders around health reform and appointed VNA President Shirley Gibson to the Governor's Health Reform Initiative. Secretary Hazel ultimately recommended **622**that nurses, especially advanced practice nurses, be used to the full extent of their scope of practice. To that end, the Virginia Council of Nurse Practitioners worked with the Medical Society of Virginia over a year-long process of negotiations to update the 1971 law, which required supervision of nurse practitioners by physicians. The result was a compromise bill that made incremental changes (dubbed the Virginia Way), removing some practice barriers. In particular, the language of physician supervision was replaced with consultation and collaboration. This relationship between the nurse practitioner organization and the physicians is ongoing, as nurse practitioners wish to fully implement the [Institute of Medicine's (2011)](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0077.xhtml#bib1) *The Future of Nursing*recommendation on utilization of advanced practice nurses.

In 2013, Virginia elected Governor Terry Mc­Auliffe and nurses were involved with developing questions for the gubernatorial candidates for a well-received and well-attended mental health forum. As Governor McAuliffe enters office at the time of this writing, he is informed about nursing issues and has key contacts who can advise him. These relationships are a direct result of nurses engaging early and throughout in the electoral process.

Through these years, Virginia nurses have grown in their ability to work collectively and collaboratively to achieve an agreed-upon set of common nursing policy goals. We also realize that our Kitchen Cabinet approach needs ongoing nurturing and rejuvenation with each election cycle. For the Kitchen Cabinet leaders, this process takes energy and commitment to advance the profession in a political environment. The goal continues to bring nursing leaders from both political party affiliation and all arenas of nursing to the table to develop a common public health policy agenda for nursing. Once the policy is established, poli­tical action is implemented to advocate/lobby/communicate/educate candidates based on the nurse leaders' party affiliation.

The major changes noted as the Kitchen Cabinet has evolved include:

• *Issues:* Policies needed reframing based on political realities and turbulence in the health care environment, such as passage and implementation of the Affordable Care Act (ACA) including Medicaid expansion and the health insurance exchange.

• *Communication styles:* Kitchen Cabinet mem­bers' face-to-face meetings have been replaced with conference calls, e-mails, and social media to increase political involvement.

• *Organizational dynamics:* Nursing organizations have a natural ebb and flow depending upon leadership. Kitchen Cabinet leaders must be attuned to these changes and inclusive of stakeholders.

## Discussion Questions

1. The Nursing Kitchen Cabinet members are meeting to develop the nurses' public/health policy agenda to present to the gubernatorial candidates in the upcoming statewide election. A serious concern for nursing is the lack of sufficient nursing faculty members for the student pipeline. The state is in financial difficulty. How would the Kitchen Cabinet proceed in developing a policy agenda?

2. The President of the State Nurses Association is invited to represent nursing at a fundraiser for a candidate for Governor. The President does not share the candidate's viewpoint. What are the President's options in responding to this request?

3. Describe three political actions nurses could take to strengthen their role in policymaking.

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**CHAPTER 78**

# Taking Action

## Improving LGBTQ Health: Nursing Policy Can Make a Difference

*Peggy L. Chinn, Michele J. Eliason, David M. Keepnews, Katie Oppenheim*

*“There are few moments in our lives that call for greater compassion and companionship than when a loved one is admitted to the hospital…Yet every day, all across America, patients are denied the kindnesses and caring of a loved one at their sides – whether in a sudden medical emergency or a prolonged hospital stay…”*

Barack Obama, Presidential Memorandum, Hospital Visitation, April 15, 2010

People with sexual and gender minority identities experience problems with access to quality health care and suffer physical and mental health disparities caused by societal stigma ([Institute of Medicine [IOM], 2011](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0078.xhtml#bib5)), but their health care issues have not been sufficiently acknowledged in nursing edu­cation, research, policy, or practice ([Eliason et al., 2009](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0078.xhtml" \l "bib4)). In this chapter, we use both the acronyms LGBTQ (lesbian, gay, bisexual, transgender, and questioning/queer) and LGBTQI (lesbian, gay, bisexual, transgender, questioning/queer, and intersex), but there are a host of other identities that also comprise the larger population of sexual and gender minorities ([Table 78-1](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0078.xhtml#t0010)). This chapter discusses nursing initiatives to address the needs of LGBTQ populations and outlines important steps that nursing organizations and individual nurses can consider to improve the quality of care to LGBTQ patients and their families.

**TABLE 78-1**

**Definitions**

| **Term** | **Definition** |
| --- | --- |
| Lesbian | A woman who has romantic and sexual relationships primarily with other women and identifies as a lesbian. |
| Gay man | A man who has romantic and sexual relationships primarily with other men and identifies as gay. |
| Bisexual | Individuals whose romantic and sexual relationships are not dependent primarily on the sex of their partners. |
| Transgender | Individuals whose gender identification and/or expression differs from the sex assigned at birth. Trans men were born with female bodies; trans women with male bodies. Some have surgeries or use hormones to alter their bodies and some do not. |
| Queer | Some people do not identify with terms like lesbian, gay, or bisexual, but consider themselves to be outside of the mainstream heterosexual identity. Many youth use the term “gender queer” to indicate that they do not fit sexual or gender norms. |
| Questioning | Some individuals are not sure what sexual or gender identification best fits them and are in the process of exploring identities. This can happen at any age. |
| Intersex | A small subset of the population is born with genetic or endocrine differences that place their bodies somewhere on the spectrum between male and female. Because of the stigma often associated with a body that does not conform to societal norms, many people with intersex conditions have similar experiences of hiding their condition or experiencing shame and guilt about it as do LGBT people. Some people with an intersex condition identify as LGBTQ. |
| Allies | Many people who do not identify as LGBTQ are strong and active supporters of the struggle for LGBTQ equality. |
| LGBT, LGBTQ, LGBTQI, LGBTQIA, and so on | Organizations vary in how inclusive they are regarding the varieties of sexual and gender identifications. The most common acronym is LGBT, but if the organization serves many people with other identities, they may choose to include them all in their written materials. Every agency must make decisions about whom to include (and whom to exclude) when they issue policies or statements about cultural sensitivity. They may choose to use terms from specific populations they serve, such as Two Spirit (used by many indigenous people in the Americas) or Same Gender Loving (used by many African Americans). |
| Behavioral terms | Men who have Sex with Men (MSM) and Women who have Sex with Women (WSW) are terms often used by public health professionals to encompass individuals who have sex with others of the same sex but who may not identify as lesbian, gay, or bisexual. |

## LGBTQ Rights in the United States

Although organized advocacy for LGBTQ people in the United States dates back to at least the 1950s, the beginning of the current gay rights movement in the United States is most often attributed to the 1969 Stonewall riots in New York City in 1969. These riots erupted against a police raid, typical of the time, of gathering places for LGBTQ people. The riots also awakened widespread anger and frustration related to discrimination in housing, employment, health care, and other social institutions. The 1970s was a decade of progress for LGBTQ visibility. In the early 1980s, the advent of the HIV/AIDS epidemic initially sparked a backlash against LGBTQ rights, but by revealing widespread and damaging effects of stigma suffered by LGBTQ people it also raised their visibility. The epidemic was by no means limited to gay and bisexual men, the effect on these communities was devastating, and rallied many people to press for an end to health care practices that discriminated against or ignored the unique health challenges faced by LGBTQ people. The culture of silence that had shrouded the LGBTQ experience began to break open as more and more people came out to friends, family, and co-workers. Early in the twenty-first century, movements toward full equal rights for all LGBTQ individuals accelerated and scored significant successes in public policy and law. As of early 2015, 37 states and the District of Columbia had legalized same-sex marriage, and the U.S. Supreme Court had struck down legal prohibition of federal benefits for same-sex couples. In addition, research on health-related topics for LGBTQ people has broadened beyond HIV/AIDS and sexually transmitted infections to include issues of access to health care, quality of care, parenting, aging, and other topics.

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## Nursing and LGBTQ Advocacy

Nurses were active in responding to the HIV/AIDS crisis. State and national nursing organizations advocated for HIV/AIDS care and funding and opposed discrimination against people with HIV/AIDS, including HIV-positive health professionals. The California Nurses Association played a leading role in initiating train-the-trainer programs to educate health professionals about the disease. Nurses helped to initiate specialized AIDS units in many hospitals to ensure compassionate, appropriate care for hospitalized patients with AIDS. They continue to be actively involved in HIV/AIDS care and research in the United States and globally.

However, the profession has been inconsistent in its willingness to advocate for LGBTQ issues in practice, education, research, or organizational policy ([Keepnews, 2011](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0078.xhtml" \l "bib7)). The American Nurses Association (ANA) adopted a statement in support of lesbian and gay rights in 1978, and in the 1990s opposed military discrimination against lesbian and gay people. The following sections summarize existing public policies and organizational **625**initiatives that provide a foundation for LGBTQ advocacy in nursing.

### Antidiscrimination Policies

One of the most important steps that organizations and institutions can take is to create explicit nondiscrimination policies related to LGBTQ people, including patients, employees, students, members, or participants. These examples of recent policy initiatives provide guidance in forming nursing antidiscrimination initiatives:

• In November, 2010, the U.S. Department of Health and Human Services issued a rule requiring hospitals to ensure equal visitation rights for same-sex partners ([U.S. Department of Health and Human Services, 2010](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0078.xhtml#bib11)).

• The Joint Commission as of July 1, 2011 required that hospitals prohibit discrimination on the basis of sexual orientation and gender identity ([Joint Commission, 2011](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0078.xhtml#bib6)).

• In 2011, the Institute of Medicine issued a landmark report that provided recommendations for an emphasis on LGBT populations in research, including improved methods for collecting and analyzing data to build a more solid evidence base for LGBT health care ([IOM, 2011](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0078.xhtml#bib5)).

### Public Policy Statements on LGBTQ Health Issues

Adopting public policy statements representing a group's support for LGBTQ rights is a step that organizations can take. Recent policy statements provide examples that orga­nizations can consider in making public policy statements.

• Two policy statements were initiated by the American Academy of Nursing (AAN) Expert Panel on LGBTQ Health in 2012: a statement in support of marriage equality and one on health care for sexual minority and gender-diverse individuals ([American Academy of Nursing, 2012](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0078.xhtml#bib1)). The statement on marriage equality was also supported by the AAN Expert Panel on Cultural Competency and was subsequently endorsed by the Association of Nurses in AIDS Care. The ANA also adopted a position in support of marriage equality.

• The American College of Nurse Midwives issued a policy statement in December 2012 supporting access to safe, comprehensive, and culturally competent health care for transgender and gender-variant individuals and their families ([American College of Nurse Midwives, 2012](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0078.xhtml#bib2)).

• The National Association of School Nurses adopted a revised statement entitled *Sexual Orientation and Gender Identity/Expression (Sex­ual Minority Students): School Nurse Practice* ([National Association of School Nurses, 2012](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0078.xhtml#bib8)).

• The National Student Nurses Association (NSNA) adopted resolutions on LGBT health:

• In 2010, the NSNA adopted a resolution submitted by Johns Hopkins University students calling for culturally competent education about LGBT individuals ([National Student Nurses Association [NSNA], 2010](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0078.xhtml#bib9)).

• In 2012, the NSNA adopted a resolution calling for implementation of The Joint Commission field guide ([NSNA, 2012](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0078.xhtml#bib10)).

## Taking Action

It is time for nurses and nursing to take major steps to create policy changes and improve quality of care for all LGBTQ people and their families. Some of the changes require organizational actions and changes, but individual nurses can also take important steps to assure safe, culturally competent, and quality care for all LGBTQ people by being aware of their own beliefs and behaviors. All nurses can also refrain from engaging in any conversation that is derogatory or demeaning toward LGBTQ people, and interrupt such conversations by others.

In [Table 78-2](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0078.xhtml#t0015), we provide an LGBTQI Welcoming and Inclusive Services Checklist that nurses can use to assess the LGBTQI competency of an organization and to raise awareness of areas that need work. There are five sections on the Checklist. The first section, Institution or Agency Policies and Procedures, involves creating policies, procedures, and practices that assure LGBTQI patients, families, and employees are treated with respect and offered all the benefits and privileges afforded anyone else. The second section, Staff Training/Conduct, sets standards for educating providers about LGBTQI **627**appropriate care and assures that all patients and families have access to a provider who has sensitivity in caring for LGBTQI patients and families.

**TABLE 78-2**

**LGBTQI Welcoming and Inclusive Services Checklist**

| **Yes** | **No** | **Institution or Agency Policies and Procedures** |
| --- | --- | --- |
| □ | □ | We have a nondiscrimination policy for staff members that includes sexual orientation and gender identity |
| □ | □ | We have a nondiscrimination policy for patients that includes sexual orientation and gender identity |
| □ | □ | Our mission statement is inclusive; it names LGBTQI people |
| □ | □ | We offer domestic partner benefits to LGBTQI employees |
| □ | □ | Patient confidentiality policies include how to deal with patients who do not want information about sexuality or gender on their records |
| □ | □ | Our sexual harassment policy includes LGBTQI issues |
| □ | □ | We have a procedure for staff or patients to grieve issues of discrimination based on sexuality and/or gender |
| □ | □ | Written notice is given to patients about when and for what reason information about them may be disclosed to a third party |
|  |  | **Staff Training/Conduct** |
| □ | □ | All staff get basic training on LGBTQI people and issues at least once |
| □ | □ | Some staff get advanced training |
| □ | □ | At least one staff member has expertise in working with LGBTQI patients |
| □ | □ | All staff treat LGBTQI patients with respect and honor confidentiality |
| □ | □ | Staff members know how to intervene when patients act in a discriminatory manner to LGBTQI patients or their families |
|  |  | **Inclusive Language: Forms/Assessments/Treatment** |
| □ | □ | Written forms have inclusive language and encourage disclosure |
| □ | □ | Assessments are inclusive and encourage discussion of whether gender or sexuality issues need to be addressed in treatment |
| □ | □ | Case management, treatment, and aftercare plans include issues related to sexuality and gender if appropriate |
| □ | □ | Staff members get a sexual history from all patients |
| □ | □ | Treatment groups, social activities, and all aspects of the institution are safe for LGBTQI patients (receptionists, laboratory technicians, housekeepers, ward clerks, kitchen staff, clergy) |
|  |  | **Visibility of LGBTQI People and Issues** |
| □ | □ | We advertise employment opportunities in LGBTQI publications |
| □ | □ | We have openly LGBTQI people on staff |
| □ | □ | We have openly LGBTQI people on the board of directors, community advisory panels, agency task forces, and so on |
| □ | □ | We have openly LGBTQI people as volunteers, sponsors, mentors |
| □ | □ | Our nondiscrimination policy that includes LGBTQI is prominently displayed |
| □ | □ | Families of LGBTQI patients are included in visitation policies |
| □ | □ | LGBTQI issues are discussed in treatment groups, health education sessions, case management sessions, and other group settings when appropriate |
| □ | □ | Posters, pamphlets, magazines, and other materials reflect our LGBTQI patients |
| □ | □ | We do outreach/market our services to local LGBTQI communities |
|  |  | **Resources and Linkages** |
| □ | □ | We have checked our referral sources to make sure that they are LGBTQI-sensitive (home care, clinics for follow-up care, community agencies, and so on) |
| □ | □ | We have linkages to our local LGBTQI community |
| □ | □ | We screen clergy, guest speakers, volunteers, mentors, sponsors, and so on, to make sure they know that we are welcoming and inclusive of LGBTQI people |

The section titled Inclusive Language: Forms/Assessments/Treatment is also part of a comprehensive program of staff training and conduct and involves changing both written and spoken language. This section and Visibility of LGBTQI People and Issues are essential to create a welcoming environment for any person or family who might identify as LGBTQI. If there is not a welcoming environment, the care that LGBTQI people receive is compromised because of fear of discrimination. The final section, Resources and Linkages, prompts an agency to become familiar with the groups, individuals, and organizations in the community that can provide additional care and support for LGBTQI employees, patients, and families. Achieving all of the points on the checklist is a formidable task, but well worth working toward!

## Conclusion

Although nursing as a whole has been slow to respond to the needs of LGBTQ communities ([Eliason, Dibble, & DeJoseph, 2010](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0078.xhtml" \l "bib3)), as we have shown, significant policy initiatives have started to appear, and resources (see Online Resources) are beginning to appear in the nursing literature to guide institutions toward quality care for all patients in the communities that they serve ([Eliason et al., 2009](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0078.xhtml" \l "bib4)). The most important steps are for all nurses to be aware of biases and stereotypes that interfere with quality care for LGBTQ people and their families; to be sensitive to the perspectives, fears, and particular needs of LGBTQ people as they encounter a health care situation; and to be knowledgeable about LGBTQ health.

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## Online Resources

The Joint Commission: Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care for the Lesbian, Gay, Bisexual and Transgender (LGBT) Community.

[www.jointcommission.org/assets/1/18/LGBTFieldGuide\_WEB\_LINKED\_VER.pdf](http://www.jointcommission.org/assets/1/18/LGBTFieldGuide_WEB_LINKED_VER.pdf).

Fenway Health: Information for Providers.

[www.fenwayhealth.org/site/PageServer?pagename=FCHC\_res\_ProviderDocuments](http://www.fenwayhealth.org/site/PageServer?pagename=FCHC_res_ProviderDocuments).

Institute of Medicine: The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding.

[www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx](http://www.iom.edu/Reports/2011/The-Health-of-Lesbian-Gay-Bisexual-and-Transgender-People.aspx).

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**CHAPTER 79**

# Taking Action

## Campaign for Action

*Susan B. Hassmiller*

*“Commitment is an act, not a word.”*

Jean-Paul Sartre

There has long been a consensus across the political spectrum that the country's health care system is not doing all it can to improve patient and population health and that nurses are well positioned to be part of the solution to this problem. The Robert Wood Johnson Foundation (RWJF) has a proud history of supporting nurses, investing more than $600 million over its history in programs to support, grow and strengthen the nursing workforce. But change is never simple or easy, and persistent barriers to expanding nurses' roles exist.

To begin overcoming those barriers, identifying ways to address a debilitating nurse faculty shortage and to build an evidence base to support change, RWJF made what is arguably its most impactful nursing investment ever: a partnership with the esteemed Institute of Medicine (IOM) to support a major study on the future of nursing. The IOM brought together respected experts from diverse fields to define the health care challenges facing the United States and the role of nurses in meeting them. Chaired by Donna E. Shalala, president of the University of Miami and a former U.S. Secretary of Health and Human Services, the IOM committee spent two years reviewing scientific literature and talking to diverse experts about the nursing workforce.

## The Future of Nursing Report

The product of its work was [*The Future of Nursing: Leading Change, Advancing Health* (2011)](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0079.xhtml#bib1), a report that envisioned new roles for nurses in the rapidly evolving U.S. health care system. The report noted the essential roles played by nurses, who are the providers who spend the most time directly caring for patients and, at 3.1 million in number, make up the largest segment of the health care workforce. The IOM report was a blueprint for action on nursing and it made a compelling case for a nursing workforce that is diverse, well educated, and prepared to practice to the full extent of its education and training to meet patient needs and become full partners in the implementation of health care reform.

The report recommended improving nurse education, fostering inter-professional education and collaboration, making nurses full partners in redesigning the health care system, creating an infrastructure to collect nursing workforce data, diversifying the nursing workforce, implementing nurse residency programs, and preparing and supporting nurses to lead change. It recommended increasing the number of nurses with bachelor's degrees to 80% by the year 2020 and removing barriers that prevent nurses from practicing to the full extent of their training and abilities. If implemented, these recommendations would be transformational for the nursing professional and the country's health care system.

## A Vision for Implementing the Future of Nursing Report

RWJF put a plan in place to ensure that the IOM's *Future of Nursing* report did not simply sit on bookshelves. It created the Future of Nursing: Campaign for Action, a partnership between RWJF, the nation's largest health philanthropy, and AARP, the nation's largest consumer organization, to implement its recommendations. The ultimate test of the Campaign's **629**success would be whether or not the IOM's *Future of Nursing* became a catalyst for change ([Box 79-1](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0079.xhtml#b0010)).

**Box 79-1**

**Join the Campaign for Action!**

You can join the Future of Nursing: Campaign for Action by visiting its website *(*[*www.CampaignForAction.org*](http://www.campaignforaction.org/)*)* which contains a wealth of information on the Institute of Medicine report *The Future of Nursing: Leading Change, Advancing Health (*[*CampaignforAction.org/evidence/iom-report*](http://campaignforaction.org/evidence/iom-report)*),* and the work to implement its recommendations. The Campaign website offers information about recent accomplishments, state activity, and upcoming events, as well as resources for those who want to support its work. In addition, you can follow the Campaign for Action on Facebook *(*[*www.facebook.com/CampaignForAction*](http://www.facebook.com/CampaignForAction)*)* or Twitter *(@Campaign4Action).*

Launched in conjunction with the report's release, the Campaign moved quickly to mobilize the nursing community, sending the message that implementing the IOM recommendations was every nurse's responsibility. It also engaged a broad spectrum of partners from business, consumer organizations, government, health care, philanthropy, academia, and other sectors. The engagement strategy was successful, and the future of nursing became the IOM's most-read report in the years after its release, as well as the top reason people visited the IOM website.

Because much policy change happens at the state level, the Campaign created state Action Coalitions, each co-led by a nurse and a partner who is not a nurse. The focus on nurse leadership was designed both to harness enthusiasm in the nursing community and to help nurses see themselves as agents of change. In 2 years, Action Coalitions were active in all 50 states and the District of Columbia. All 51 chose to focus on the IOM's academic progression recommendation; many also opted to promote nurse leadership, seek to expand nurses' scope of practice, and support data collection on the nursing workforce. Most of the IOM recommendations were welcomed enthusiastically, but, as is often the case, there was some resistance also. At the federal level and for the Action Coalitions, progress came quickly on some fronts and barriers emerged on others.

Engagement with the Campaign for Action was impressive, with the nurse academic community engaging nursing students, nursing associations, and highly educated nurses. Some nurses with associate degrees voiced concerns, however, regarding their ability to go back to school to get bachelor's degrees and that they would not be able to compete for jobs and promotions without them. Efforts to promote interprofessional education and collaboration picked up steam; nurse residency programs began springing up; and efforts to diversify the nursing workforce began to show slow but steady progress. However, efforts to remove barriers that restrict nurses' scope of practice faced opposition in Missouri, California, and several other states.

## Success at the National Level

Progress has been tangible. Examples to date include: (1) For the first time in its history, Medicare announced it would pay to support training of **630**advanced practice nurses through a $200 million demonstration project in five major hospital systems. (2) The late Sen. Daniel K. Inouye (D-HI) and Sen. Jay Rockefeller (D-WV) reached out to the Federal Trade Commission (FTC) regarding scope of practice restrictions in nursing. The FTC responded by challenging those limits in several states. (3) The Leapfrog Group reported that a hospital's Magnet status is an indicator of having an adequate and competent nursing staff and good nursing leadership in its 2011 Hospital Survey. The Magnet Recognition Program recognizes health care organizations for quality patient care, nursing excellence, and innovations in professional nursing practice. Before a hospital could apply or reapply for Magnet status, it would be required to adopt a plan that advances the goal of having 80% of its nurses holding baccalaureate degrees. (4) The National Organization for Associate Degree Nursing published a commentary expressing support for associate degree nurses to continue their education and urged employers to help them get higher degrees. A roundtable convened by RWJF found common ground between community colleges and nursing leaders on key issues, including the central role community colleges play in preparing and diversifying the nursing workforce and the need for all nurses to be lifelong learners. In several states, nursing and community college leaders began exploring ways to help both aspiring nurses and those already in the workforce to obtain higher degrees. At the state level, Action Coalitions made progress as well.

## Success at the State Level

### Academic Progression

Texas, Idaho, and Washington were among the states to strengthen and standardize nursing education classes to create more seamless progression for associate degree nurses looking to continue their education. In 2013, New Mexico's governor announced a common curriculum between community college- and university-based nursing schools, and California implemented a groundbreaking effort to help nurses get advanced degrees.

### California: Opening Doors to Academic Progression

An initiative designed to ease the transition between associate and baccalaureate degree nursing programs admitted its first students in the summer of 2013. Based at the School of Nursing at California State University, Los Angeles, the program enables students with associate degrees in nursing to earn baccalaureate degrees in nursing in just 12 months. Typically, this transition has taken students 2 years to complete and often involved redundant coursework because of inconsistent curricula across nursing schools. The new program allows students to get their bachelor's degrees in nursing with no repetition of courses. The program also enhances diversity in the nursing workforce and helps develop more nurse leaders.

### Scope of Practice

In state after state, regulatory barriers to nurse practitioners' ability to practice to the full extent of their education and training were challenged, and some fell. Although some physicians groups opposed eliminating such barriers, many individual physicians spoke out in favor of doing so. In Colorado and Iowa, courts struck down barriers on nurses' scope of practice. In Nevada, the Action Coalition helped win a law eliminating them.

### Nevada: Achieving Political Change on a Contentious Issue

Nevada's governor signed a law in 2013 that gave advanced practice registered nurses full practice authority and expanded prescriptive authority. Enacting this law was a key priority of the Nevada Action Coalition because it frees advanced practice registered nurses from practice restrictions that required them to work under the supervision of a physician. The removal of that requirement is expected to increase access to care and to prescription medication in the heavily rural state, which has a low physician-to-population ratio, an aging population, and a shortage of primary care providers.

### Nurse Leadership

Across the country, Action Coalitions have focused on preparing nurses to serve on boards of directors **631**and on creating opportunities for them to do so. In Virginia, the Action Coalition created a statewide mentorship program to support emerging nurse leaders. The Texas and Montana Action Coalitions pioneered strategies to place nurses on boards of directors of health institutions. The New Jersey Action Coalition prioritized this work from the start.

### New Jersey Prioritizes Placing Nurses on Boards of Directors

Shortly after it was formed, the New Jersey Action Coalition created a leadership workgroup that compiled a list of names of nurse leaders to recommend for appointments to various boards and other leadership positions. At the same time, the Action Coalition created a list of leadership opportunities to disseminate, so that nurses could prepare for becoming members of these boards and could develop leadership skills with these open positions in mind. Very quickly, nine nurses identified on the list assumed positions of influence, and the progress has continued.

## Conclusion

By developing strategic partnerships, mobilizing a broad base of supporters, deploying resources wisely, and helping parties with different perspectives find common ground, the Future of Nursing: Campaign for Action has made progress in implementing the recommendations of the IOM's nursing report. However the work has really just begun. More challenges, and more progress, lie ahead in achieving the Campaign's goal: that everyone in America can live a healthier life, supported by a system in which nurses are essential partners in providing care and promoting health ([Figs. 79-1](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0079.xhtml#f0010) to [79-3](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0079.xhtml#f0020)).

**FIGURE 79-1** Risa Lavizzo-Mourey, MD MBA, President and CEO of the Robert Wood Johnson Foundation being interviewed at the 2013 Future of Nursing Campaign Summit. Interviewer is Linda Wright Moore, Senior Communications Officer, Robert Wood Johnson Foundation.

**FIGURE 79-2** (From right to left) Susan Hassmiller, PhD, RN, FAAN, Director of the Future of Nursing: Campaign for Action, welcomes two new members of the District of Columbia Action Coalition, Pier Broadnax, PhD, RN, and Delores Clair Oliver, RN, MHA, CNAA, BC.

**FIGURE 79-3** Future of Nursing: Campaign for Action members participating in a national summit.

## References

Institute of Medicine. *The future of nursing: Leading change, advancing health*. National Academies Press: Washington, DC; 2011 [Retrieved from]  [www.iom.edu/nursing](http://www.iom.edu/nursing).

## Online Resources

Institute of Medicine: The Future of Nursing: Leading Change, Advancing Health.

[*www.iom.edu/Reports/2010/The-future-of-nursing-leading-change-advancing-health.aspx*](http://www.iom.edu/Reports/2010/The-future-of-nursing-leading-change-advancing-health.aspx).

Future of Nursing: Campaign for Action.

[*www.CampaignforAction.org*](http://www.campaignforaction.org/).

Robert Wood Johnson Foundation (nursing information).

[*www.RWJF.org/Nursing*](http://www.rwjf.org/Nursing).

Robert Wood Johnson Foundation: Charting Nursing's Future policy briefs.

[*www.rwjf.org/en/search-results.html?cs=content\_series%3Acharting-nursings-future*](http://www.rwjf.org/en/search-results.html?cs=content_series%3Acharting-nursings-future).

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**CHAPTER 80**

**Taking Action**

The Nightingales Take on Big Tobacco

*Kelly Buettner-Schmidt, Ruth E. Malone*

*“Neglecting to discuss the industry's role as the disease vector in the tobacco epidemic is like refusing to discuss the role of mosquitoes in a malaria epidemic or rats in an outbreak of bubonic plague.”*

Rob Cushman, MD, Medical Officer of Health, Ottawa

**Tobacco Kills**

Tobacco use caused 100 million deaths in the twentieth century and kills about 6 million people worldwide annually ([World Health Organization [WHO], 2013](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib55)). Describing this in understandable numbers for laypeople should be among a nurse's roles. This translates into 1 out of every 10 adult deaths or one person every 6 seconds. In the United States, tobacco use and exposure remains the leading cause of preventable death, killing 480,000 people annually between 2005 and 2009, including more than 1000 infants ([U.S. Department of Health and Human Services [HHS], 2014a](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib51)). Since the first U.S. Surgeon General's Report in 1964, more than 20 million have died from tobacco use and exposure to secondhand smoke in the United States ([HHS, 2014a](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib51)).

Meanwhile, in the United States alone, in 2011 the tobacco industry spent $8.4 billion promoting cigarettes and another $450 million pushing smokeless tobacco products ([Federal Trade Commission, 2013](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib18)). Globally, tobacco companies are now aggressively targeting low- and middle-income countries, seeking new generations of young people and women who will develop tobacco addiction. Electronic cigarettes (e-cigs) are the latest tobacco industry deception, with many tobacco control advocates concerned about the lack of regulation, misleading advertising, and the rapid uptake by youth.

**Ruth's Story**

“The latest news from me is that I died May 9, 1990, of lung cancer. Maybe my widower would like your free trip. Although I doubt it … You see, he has been mourning my death for 4 years. I was all he had left—me and my Benson & Hedges. Wish you were here” ([Halpin, 1994](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib22)). An elderly widower, perhaps sitting alone under the lamp at the kitchen table where he and his wife had eaten many meals together, wrote these words to the Philip Morris tobacco company in a trembling hand on the back of a glossy Benson & Hedges cigarette brand mailer.

I found his letter online, one of perhaps thousands written to tobacco companies by suffering customers and their families. Something about it would not let me rest. In many ways, he and the many others whose letters I found, were the founders of the Nightingales Nurses.

I smoked for years and felt guilty as I cared for patients suffering from emphysema, lung cancer, or heart disease. I tried to quit so many times but would slip back. I felt so alone. More than 20 years ago, I vividly remember reading about new studies showing that smoking was not really so bad, comparing it with eating chocolate or having a glass of wine. I never dreamed, then, that the tobacco industry was behind those phony studies ([Smith, 2007](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib45)).

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What I didn't know then would fill a book, and several good ones have been written since by historians. Mainly, I didn't realize that the tobacco industry (TI) had set up front groups, hired scientists, organized massive campaigns to promote bogus ideas, and sponsored distracting scientific studies selected by industry lawyers to be sure they would result in findings favorable to the industry. They had promoted their intentionally deceptive ideas through an astonishingly large and varied assortment of paid consultants and front groups ([Bero, 2003](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib4), [2005](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib5); [Glantz, Slade et al., 1996](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib19)). I had no idea that the TI had special marketing plans developed to reassure those, like me, who worried even as we lit up another cigarette ([Brown and Williamson Tobacco Company, 1971](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib8); [Cataldo & Malone, 2008](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib14)) and that they were working on a global scale to fight tobacco control policies to ensure that smoking remained socially acceptable ([Malone, 2009](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib27); [McDaniel, Intinarelli, & Malone, 2008](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib30); [McDaniel & Malone, 2009](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib31); [Zeltner et al., 2000](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib57)).

I didn't know that the cigarette had been carefully engineered to make it easy to start smoking and harder to quit and that in the process it had been made even more deadly ([Proctor, 2011](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib40)). I didn't realize then that tobacco companies had explicitly targeted their aggressive marketing and outreach efforts to the most vulnerable groups: the poor, less educated, and minority groups ([Apollonio & Malone, 2005](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib1); [Balbach, Gasior, & Barbeau, 2003](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib2); [Cook et al., 2004](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib16); [Landrine et al., 2005](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib25); [McCandless, Yerger, & Malone, 2011](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib29); [Muggli et al., 2002](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib34); [Smith & Malone, 2003](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib46); [Yerger & Malone, 2002](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib56)).

**The Personal Becomes Political**

I finally quit smoking for good after struggling for years. Going back to school helped build my confidence. In a postdoctoral fellowship, I began research on tobacco-control policy and I learned more about tobacco than I ever had in nursing school.

I learned that until the advent of the machine-rolled cigarette in the late 1800s, almost nobody ever died from lung cancer. It was once such a rare disease that most physicians never saw a case in their lifetimes. Those same entrepreneurs who introduced machine-rolled cigarettes also introduced aggressive, innovative advertising techniques that linked cigarettes with glamour, freedom, sexuality, and status ([Kluger, 1997](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib23)). I realized we were facing an industrially produced disease epidemic from tobacco.

More than 10 million internal tobacco company documents became publicly available as the result of multiple state attorneys general lawsuits in the late 1990s and are now accessible online at the Legacy Tobacco Documents Library. They offer an amazing window into this incredibly destructive industry. I developed a program of research drawing on these documents, and while doing this research, I stumbled upon the letters.

**Compelling Voices**

“My father died last October at the age of 50 due to lung cancer,” one read. “He purchased many of your items in your *Marlboro Country Store Catalog* with his cigarette coupons … Now myself and my 16 year old sister are left fatherless … smoking does cause cancer, does kill and destroy families. You don't need to be a scientist or conduct a study to figure that out, just visit my Dad's grave if you want proof.” The words were in the fat, round script of a teenage girl, and the file I found contained many more such letters, written by every sort of human hand. Most were written on the backs of or in response to slick mailers from tobacco companies: catalogs, birthday cards, and offers of coupons for cigarette discounts. There were letters from grieving mothers, widows, sons, and daughters; letters from friends and family; and letters from dying smokers and those struggling to escape tobacco addiction. They were testimony: “I know that we all have to work to put food on the table and pay bills. But are there no other choices?”

The letters weren't asking for money, they wanted their human pain and loss to be acknowledged by those who had furthered it through promoting tobacco use. A woman, grieving over her mother's death at 57 from lung cancer, wrote, “My mother wanted to quit so badly … When I close my eyes at night, all I can see is my mother's face as she lay dying, and all the hell that she went through … that will haunt our family forever.”

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As a nurse, I could easily fill in the terrible subtext accompanying every anguished word. Behind each letter were family members who had used every economic and emotional resource they had trying to cope with the suffering and loss of a loved one, orphaned children who would never have the guidance of a father or mother, and aging parents who helplessly watched their children die before them. I knew that the suffering from tobacco-related illnesses was often terrible to witness, and far worse to experience. And these stories were repeated more than 440,000 times every year, year after year, in the United States alone ([HHS, 2013](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib50)).

By the early 2000s, I knew the tobacco industry had tried to undermine the work of WHO and other public health bodies ([Zeltner et al., 2000](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib57)) and to interfere with tobacco-control efforts ([WHO, 2009](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib54)). I knew that the industry's political and philanthropic contributions bought silence from policymakers and groups that should have been protecting the public ([Tesler & Malone, 2008](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib47); [Yerger & Malone, 2002](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib56)). But somehow, I had never once considered that these companies had been getting letters like these for decades and filing them away, year after deadly year. Although I tried to continue with my research projects the letters would not let me rest. It simply wasn't right for them to remain forever hidden in the tobacco industry's files.

Inspired by youth activists who had attended the Altria/Philip Morris shareholders' meeting to speak out about the industry's targeting of youth, I decided to buy one share of stock and go to the shareholders' meeting as a nurse, taking some of the letters with me to read aloud in protest. I recruited 11 other nurses from around the country who agreed to buy one share of Altria stock (only shareholders or their representatives could attend the meeting) and travel with me to the meeting in New Jersey. Other nurses paid for the airfares. We picked the Altria/Philip Morris meeting because Philip Morris is the largest U.S. tobacco company.

With our theme, nurses bearing witness, we sought to point out the contradictions in the company's claims to be changed and socially responsible while continuing the aggressive promotion of the most deadly consumer product ever made. Our key message: “A socially responsible company would not continue to promote products that it admits addict and kill.” We were the first nursing group to confront Big Tobacco on its own turf ([Schwarz, 2004](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib43), [2005](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib44)).

**Strategic Planning**

A nurse in New Jersey who was active with the American Lung Association scoped out the site for us. Other activists working with youth invited us to be part of a post-shareholder's meeting press conference. We assembled a selection of the letters into a 30-foot banner and made handouts about our efforts, including some of the letters and a press release ([Box 80-1](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#b0010)). We learned from other activists about the meeting format and how long we might have to speak. We wore white lab coats and black armbands, indicating solidarity with those who suffered from tobacco. That year, and every year since, the Nightingales Nurses have borne witness at tobacco company shareholder meetings.

**Box 80-1**

**Nightingales' Press Release (Example)**

PRESS RELEASE

NIGHTINGALES NURSES ACCUSE PHILIP MORRIS OF SOCIAL IRRESPONSIBILITY

DATE: Embargo release until 12:00 Noon Eastern Time Thursday April 29, 2010

CONTACT: Ruth Malone, RN, PhD, ruth.malone@ucsf.edu, (415) 123-4567

PRESS CONFERENCE: 12:00 Noon at Philip Morris entrance, 188 Rover Road, East Hanover, NJ

EAST HANOVER, NJ: Nurses from across America will attend the annual shareholders meeting of Philip Morris/Altria tomorrow to call on the company to demonstrate genuine corporate social responsibility by voluntarily ending all active promotion and marketing of tobacco products. A press conference will be held immediately after the meeting, with the Nightingales Nurses reading and sharing letters sent to the company by its dying customers and their families.

“We're here to say that this can't go on,” said Nightingales organizer Ruth Malone, RN, Professor of Nursing at the University of California, San Francisco, School of Nursing. “The tobacco industry spends more than $1 million an hour, 24/7, on making their deadly, addictive products look fun, cool, and glamorous—but these letters show the terrifying, painful reality of what cigarettes do.”

As the largest group of health care providers, the nation's 3.1 million nurses are in a unique position at the bedside and in the community to witness firsthand the deadly effects of tobacco products. “A socially responsible company would not continue to promote a product that they themselves admit addicts and kills,” said Diana Hackbarth, RN, Professor of Nursing at Loyola University in Chicago and a Fellow of the American Academy of Nursing.

Wearing black armbands to honor the memories of their patients who have suffered and died from cigarette-caused diseases, nurses are attending the meeting to tell their patients' stories, giving voice to those who can no longer speak because tobacco addiction has robbed them of breath and life.

The Nightingales is a group of nurses who use advocacy, activism, and education to focus public attention on the role of the tobacco industry in creating the epidemic of tobacco-caused suffering, disease, and death.

For more information or to join, visit the Nightingales Website at [*www.nightingalesnurses.org*](http://www.nightingalesnurses.org/).

**Kelly's Story**

When I first heard of the Nightingales, I searched the Internet to learn more and immediately joined. I had never heard of shareholder advocacy, but I had a long history of activism and advocacy for tobacco control. My own journey in tobacco policy had begun with my first cigarette puff in junior high school. I was nauseated and then embarrassed. The next year, while playing basketball, I realized that smoking and playing ball were in conflict, and I quit. I was one of the lucky ones, I escaped addiction.

In my first nursing position, I saw so many who did not escape. I once shut off the oxygen in an elderly man's room to allow him to smoke. I did not tell him about the dangers of smoking, but I found it ironic that he needed oxygen because of his smoking and yet he still desired to smoke. I now recognize this was a testament to nicotine's addictiveness.

Teaching smoking cessation classes in the late 1980s was moving, frustrating, and unsettling. Unfortunately, at the time, tobacco was considered a habit, and nicotine was not declared an addiction by the U.S. Surgeon General until 1988 ([HHS, 1988](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib49)). Midway through the program was quit day, but often less than a quarter of the participants **635**would remain quit for 48 hours, the disappointment and frustration showed clearly on their faces, if they came back to class at all. Seeing firsthand the power of addiction in people who strove so hard to quit was disturbing. Although smoking cessation success rates can be complex, currently 43% of all adults who tried to quit smoking succeeded for more than one day ([Centers for Disease Control and Prevention [CDC], 2011](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib15)). To increase success in cessation, best practices call for systems level changes to support individuals, increased coverage by insurance for cessation, and enhancements of state quit lines (CDC, 2014).

**Policy Advocacy**

In 1992, I led a local public health tobacco prevention program in Minot, North Dakota. After developing a broad-based coalition, Stop Tobacco Access by Minors Program (STAMP), we successfully advocated for five local youth access laws. The policy and advocacy lessons learned through these efforts were invaluable for our later work on smoke-free environments that resulted in Minot being the first community in the state to pass a local smoke-free ordinance ([Buettner-Schmidt, Muhlbrad & Brierley, 2003](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib13); [Rosenbaum, Barnes & Glantz, 2012](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib42); [Welle, Ibrahim & Glantz, 2004](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib53)).

Our smoke-free environment efforts included public education events and billboard contests, collaborating with the American Cancer Society to encourage restaurants to be smoke-free the day of the Great American Smoke Out, and publicly recognizing restaurants that met public health standards and were smoke-free. In 2000, a new father and Minot city council member called me asking if the coalition would assist him in having restaurants become smoke-free. With a newborn, he was concerned about the exposure of his child and others to secondhand smoke. A partnership began and approximately 1 year later, after much political and media maneuvering, the city council passed the smoke-free ordinance. As we basked in our victory, however, opponents gathered enough signatures to put the new ordinance to a public vote. The battle-weary coalition began to meet weekly again to strategize how to defeat this referendum. Strategy for influencing city council members is vastly different **636**from strategy to educate and influence an entire community. Thankfully, we were not alone in the fight. In conjunction with the Campaign for Tobacco Free Kids, Americans for Nonsmokers' Rights, the Robert Wood Johnson Foundation's Smokeless States program, the North Dakota Nurses Association, the North Dakota Medical Association, the American Lung Association, the American Cancer Society, the American Heart Association, and others, we defeated the referendum 55% to 45% on July 10, 2001. The new ordinance became effective January 1, 2002.With a chill, I later learned that the tobacco companies had also tracked STAMP's activities from at least 1996 ([Nelson, 1996](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib35)) through 2001 ([Malito, 2001](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib26)).

I later took a consulting position assisting other communities working on tobacco policy, helping pass several local ordinances and facilitating a statewide coalition that passed a bill banning tobacco use in certain public places and workplaces. I was involved in evaluating the effects of the local ordinance and the state law ([Buettner-Schmidt, 2003](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib9), [2007](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib10); [Buettner-Schmidt, Mangskau & Boots, 2007](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib11); [Buettner-Schmidt & Moseley, 2003](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib12)). In a university faculty role, I developed a project within my Community Health Nursing course wherein senior nursing students conducted an assessment of college-age smoking and smoking policies on university campuses. The students developed a smoke-free campus recommendation and presented it to the university president. After going through many committees, our campus became smoke-free in June 2006.

**Shareholder Advocacy: “the NURSES are Coming…”**

After all this, when I heard about the Nightingales' call for more nurse volunteers to speak out at the shareholder meeting, I could not resist. I had seen the industry in action before. Locally, lobbyists of organizations who collaborated with the tobacco industry attempted to derail our city-level policy efforts. Statewide, the tobacco industry lobbyists themselves would roam the halls of the legislature, something I never would have believed in my pretobacco activist years.

Now I was on my way into the belly of the beast. After a long flight and a meeting with other nurse activists the night before, feeling the solidarity among colleagues working on tobacco control in many different roles, I was excited as we drove through luxurious acreage leading to the corporate offices. As we parked and entered the building, there were Men in Black everywhere speaking into hidden microphones and we could hear whispers: “The nurses are here…,” “The nurses are coming…” It felt very James Bond–like, almost surreal.

Envision a cold-sounding CEO, a transfixing video presentation about cigarettes and other products, and an opulent environment; these are my memories of the shareholder meeting. After the video, CEO Louis Camilleri highlighted how successful the company had been in increasing cigarette sales worldwide and how profitable the stock was. Then it was time for the shareholder question-and-answer period. I told my family story and the stories of others whom I knew. Other nurses spoke of the suffering they had witnessed. A nurse practitioner spoke about the harm tobacco does to pregnant women, and a burn nurse spoke about caring for burn victims from cigarette-caused fires. Each time, the room fell silent as we spoke; I felt the symbolic power of our white lab coats and our nursing presence. Some of the protesting youths stood boldly to interrupt the meeting; the CEO repeatedly told them to sit down. Then the Men in Black forced the youths to the back of the room and out the door. I remember wondering if we had made an impact.

In our debriefing later and in self-reflection, I realized that although we cannot know whether our words on that one day will create change, it is essential for nurses to continue to speak out because we are nurses. People who profit from selling death should not be able to do so without, at the very least, hearing about the suffering and devastation that their product causes. As nurses, we have a responsibility to speak truth to power.

**Extending the Message**

Currently, we have Nightingales existing in more than half of the United States and in Canada. We **637**annually attend both the Altria and Reynolds American tobacco company shareholders' meetings. We've challenged the company's claims of responsibility at Philip Morris public relations events. Our work is all voluntary.

Of course, tobacco companies are still promoting tobacco products but our efforts have borne fruit in several respects. First, we have sent a strong message to the tobacco industry that nurses are their opponents. Nurses such as Susan Priano and Elisabeth Gunderson, both from California, have found their voices after attending shareholder meetings. In 2011, cancer nurse Gunderson attracted international media attention when she told the story of her dying patient who said quitting smoking was harder than quitting heroin. The Philip Morris International CEO responded that “…it's not that hard to quit” and the story went viral ([Daily Mail, 2011](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib17); [USA Today, 2011](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib48), para 4), reminding the public of the tobacco industry's duplicity.

Nurses are trusted and respected by the public, and we owe it to our patients to speak out, tell the whole truth about Big Tobacco, and speak truth to power. Nurses need to promote public dialogue on how to end this industrially produced tobacco disease epidemic ([Malone, 2010](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib28); [Warner, 2013](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib52)). From removing the profit from selling tobacco products ([Borland, 2013](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib7)) to decreasing cigarette nicotine levels until addiction does not occur ([Benowitz & Henningfield, 2013](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib3)) to setting a year where individuals born after that year are not allowed to possess tobacco products ([Berrick, 2013](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib6)) or phasing cigarettes off the market altogether ([Proctor, 2013](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib41)), many proposals are being discussed.

Whether our clients are starting to smoke or trying to quit, they receive constant messages from the tobacco industry, straight into their homes, and increasingly through more subtle marketing methods such as experiential programs, Internet marketing, and musical events. In 2003, Philip Morris had a database of more than 20 million smokers, which it uses to establish personalized relationships and targeted communications ([Philip Morris USA, 2003](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib39)). We need to help clients understand how the industry has studied their every psychological weakness, segmenting the market to reach everyone from starter replacement smokers, as the industry calls youths, to worried older smokers whom they seek to reassure. We would not treat malaria victims without ever mentioning the mosquito that transmits the disease. As patient advocates, we must likewise name, discuss, and find ways to combat the industry vector of the tobacco disease epidemic.

Second, our efforts have inspired others. The youths we joined are still talking at meetings about the nurses and how we helped them feel part of something larger. Perhaps some of them will become nurses. We need their passion and political awareness in nursing. Finally, speaking out empowers us as nurses. As past shareholder meeting attendees have said: “This experience has changed the whole way I feel about being a nurse” and “Now I feel that I can say anything to anyone with confidence.”

**What NURSES Can Do**

There is perhaps no other health issue on which nurses could have so much impact. Tobacco affects almost every body system and every demographic group across the lifespan. It affects individuals, families, and communities; there is no nurse for whom tobacco could not be relevant.

**FIGURE 80-1** Nightingales at the 2013 Philip Morris International shareholders meeting.

The tobacco industry has worried that nurses might take them on. Among the industry documents is a report on organizations the industry viewed as its opponents, with each one's strengths **638**appraised, including the American Nurses Association, the American Public Health Association, and others. “Nurses, as a group, feel strongly and negatively about tobacco use,” the report reads. “As they become more active in politics … at all levels, they could easily become formidable opponents for the tobacco industry” ([Osmon, 1990](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib37)). Formidable opponents. We are not used to thinking of nurses in those terms. But when it comes to the tobacco industry, we need to be its formidable opponents in every possible way.

**FIGURE 80-2** Nightingales participating in a press conference after the 2013 Phillip Morris International shareholders meeting in New York City.

The Nightingales build on and inspire the great work of many nurses and nursing organizations. The newly formed Tobacco Control Nurses International's mission is to promote the visibility of nurses' involvement in tobacco control and facilitate professional collaboration and leadership to curb the tobacco epidemic ([Global Bridges, 2013](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib20)).

Tobacco Free Nurses, which aims to help nurses themselves quit smoking, is managed by Drs. Linda Sarna, Stella Bialous, and Erika Froelicher. Drs. Sarna and Bialous have been focusing on educating nurses on evidence-based tobacco dependence treatment interventions in the United States, China, the Czech Republic, and Poland. They recently collaborated with WHO on a monograph on enhancing nurses' role in addressing the non-communicable disease epidemic, in which tobacco plays a major role. At University College, Los Angeles (UCLA), Professor Sarna helped pass a policy against accepting tobacco industry research funding and more recently spearheaded the effort to make UCLA a tobacco-free campus.

Nightingales member and nursing professor Dr. Sophia S. Chan, PhD, RN, FAAN, is the first nurse in Hong Kong to be selected as a Fellow of the American Academy of Nursing. She conducted the first Asia Pacific Workshop on Tobacco Control and Nurses; in Hong Kong, developed the Women Against Tobacco Taskforce (WATT); launched the first Youth Quit line; and influenced the governmental funding of smoking cessation clinics.

The University of Kentucky's Tobacco Policy Research Program and the Kentucky Center for Smoke-free Policy are led by Ellen J. Hahn, PhD, RN, FAAN, and Carol A. Riker, MSN, RN. They are involved in community engagement, smoke-free and tobacco-free campus policy development, and research and have helped a total of 39 communities pass smoke-free laws or regulations since 2007.

In 2012, the Nightingales' founding member, Carol Southard, RN, MSN, won the American Lung Association and Koop Foundation Unsung Heroes in Tobacco Control award, making her the first woman and the first nurse to have ever received this honor. Since 2013, Carol has been involved with a Chicago Department of Public Health initiative, providing information at Town Hall meetings about the effects of flavored tobacco products and with the goal of recommending policies for curbing the use of these products and reducing health disparities.

Healthy Communities International currently at North Dakota State University and led by Buettner-Schmidt, was funded to conduct research and provide education and assistance to tobacco grantees throughout North Dakota. She assisted in a statewide ballot measure mandating tobacco settlement dollars be allocated to a fully funded, CDC Best Practices based, tobacco prevention program. North Dakota has the first tobacco prevention program in the country to be fully funded at the CDC recommended level.

Other nurse examples include Canadian Registered Nurse Joan O'Connor, who keeps statistics on every cigarette not smoked by members of her Tobacco Fighters and Survivors Club, a smoking reduction and cessation group for people living with mental illness. By 2011, more than 470,000 cigarettes were not smoked, equaling more than 23,000 packs not bought, 470,000 butts not in the **639**environment, and approximately 30 pounds of tar not in human lungs. Nightingales founder Ruth Malone went on to become editor-in-chief of the leading international journal in the field, *Tobacco Control*, published by the British Medical Association.

Other nurses are organizing letter-writing campaigns, developing cessation services for special populations, conducting tobacco-related research, and working on a wide range of policy efforts to reduce tobacco's deadly toll. The Nightingales are always looking for more nurses to help; even writing a letter to the editor once a year can make a difference. Nurses play an active role as leaders of the global movement to end this preventable epidemic.

**Nursing is Political**

Some nurses are afraid of being political, but health is political: resources, education, and care are unevenly distributed in our society. Tobacco is a social justice issue. Just caring about those beyond us and our immediate families is a deeply political act. Our most powerful nursing roots lie in our concern for those who feel voiceless and powerless, as exemplified by the early leaders in public health nursing.

As early as 1916, writings of Florence Nightingale referred to her knowledge of politics ([Gourlay, 2004](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib21); [Kopf, 1916](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib24); [McDonald, 2006a](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib32), [2006b](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib33); [Pfettscher, 2006](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml" \l "bib38)). Nightingale emphasized having political will, using the media, and seeking the support of professionals and leaders ([McDonald, 2006b](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib33)). She encouraged others to lobby: “Agitate, agitate, agitate …” ([McDonald, 2006b](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib33)). Ms. Nightingale would surely support the Nightingales' tobacco-control policy efforts ([Nightingale, 1946](https://digitalbookshelf-jigsaw.southuniversity.edu/books/9780323241441/epub/OEBPS/xhtml/chp0080.xhtml#bib36)).

**Lessons Learned: Nursing Activism**

*The Power of a Few:* The first lesson is that a few committed individuals can make a difference. It does not take a complex organization and big dollars to begin to become political on a local, state, or even national level. The Nightingales started with a few committed nurses and a loosely organized network and remain so, but now the group is also a member of the Framework Convention Alliance, a coalition of over 300 civil society organizations from more than 100 countries working on implementing the provisions of the world's first global public health treaty, the World Health Organization Framework Convention on Tobacco Control *(*[*www.fctc.org*](http://www.fctc.org/)*).*

*Clarify Policy Goals:* Second, determine your policy goals and objectives. Attempt to obtain a consensus, but also agree on a process for making decisions if there is disagreement.

*Stakeholder Analysis:* Third, educate yourself or your group. What are the arguments for and against the goals? Who are the opposition and how will you counter their arguments? Review the literature for the science behind your goals. Identify the personal stories that will allow policymakers, the media, and the public to connect to and support your cause. Determine how you will frame the issue. Identify a spokesperson or have all members prepared and ready to counter arguments.

*Build Coalitions:* Fourth, identify natural allies. Reach out to others to join forces. Build on common ground and share resources. For example, the Nightingales Nurses coordinated our press conferences with Essential Action, a youth-focused tobacco-control group.

*Determine Leverage Points:* Fifth, if you are seeking a policy change, determine who has the power to make that change. If it is a board or committee, try to identify amongst yourselves who on the board/committee strongly supports or opposes your goals. Identify those who influence the policymakers. Determine a strategy to educate those influential people and supportive policymakers and ask for their assistance and guidance, but maintain your organizational boundaries so you can attract support from people across the political spectrum. Seek an insider champion. Educate your group on the policy processes needed to change the policy. Develop a tentative and realistic timeframe, recognizing that this will need to be revisited as events change.

*Engage Media:* Sixth, develop a plan to engage the media. Media advocacy is a skill. For example, one of our group's aims was to get media coverage of our activism to change perspectives about the tobacco industry.

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*Build on Your Strengths:* Seventh, celebrate small successes to sustain energy. Build on the strengths of all members. With activism, realize that not everyone is comfortable with public speaking or confrontation; however, they may contribute in other ways, such as preparing press releases, managing logistics, or working on a website. Know that policy and politics is ongoing; once a policy passes, next is policy implementation and evaluation.

*Use Your Power and Passion:* Lastly, know that as an individual, it is easy to be a politically active nurse as many organizations use web-based advocacy opportunities. Find an entity focused on a health-related cause that stirs your passion, become a member, and express a willingness to become involved. Soon you may be emailing letters to your policymakers, meeting with editorial boards, and improving the health of your clients not only as individuals, but also at the policy level.

**Discussion Questions**

1. Discuss a public problem that would benefit having nurses speak truth to power.

2. What health-related issue sparks your passion? Discuss existing organizations that advocate for this issue and the pros and cons of joining the organization or developing a new entity.

3. Do you think tobacco cessation is an important issue to nursing? Why or why not?

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**Online Resources**

Legacy Foundation.

[*www.legacyforhealth.org/our-issues*](http://www.legacyforhealth.org/our-issues).

Legacy Tobacco Documents Library.

[*legacy.library.ucsf.edu*](http://legacy.library.ucsf.edu/).

Nightingale Nurses.

[*www.nightingalesnurses.org*](http://www.nightingalesnurses.org/).

Tobacco Control Nurses International.

[*www.globalnurses.org*](http://www.globalnurses.org/).

Tobacco Free Nurses.

[*www.tobaccofreenurses.org*](http://www.tobaccofreenurses.org/).

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