

CHAPTER 5

Social Context of Professional Nursing

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Learning Objectives

After completing this chapter, the student should be able to:

1. Describe the social context of professional nursing.
2. Identify factors that influence the public's image of professional nursing.
3. Identify ways that nurses can promote an accurate image of professional nursing.
4. Discuss the gender gap in nursing.
5. Recognize connections between changing demographics and cultural competence.
6. Evaluate current barriers to health care in our society.
7. Discuss present trends in society that influence professional nursing.
8. Identify present trends associated with the profession of nursing.

When you hear the word *nurse*, what images, thoughts, perceptions, and assumptions come to mind? Ask yourself, “Why did I have those perceptions and assumptions about nurses?” The answer to your question reveals much about the social context of nursing or how society views nurses and the nursing profession. For many, the image that first comes into view is one of a white female who is dressed in a meticulously ironed white uniform with white hose, white shoes, and wearing a stiff white cap. For those of us in nursing, we recognize that this traditional American view of nursing is rarely seen in the real world of professional nursing. So, how do we communicate the true image of nursing in the 21st century?

In this chapter, we explore the social context of professional nursing and identify major influences that affect nursing in today's society. This quest for a deeper understanding of nursing challenges us to identify our

Key Terms and Concepts

- » Stereotypes
- » Cultural competence
- » Access to care
- » Incivility
- » Violence
- » Global aging
- » Consumerism
- » Complementary and alternative medicine
- » Disaster preparedness
- » Nursing shortage
- » Nursing faculty shortage

Key Terms and Concepts

- » Clinical nurse leader (CNL)
- » Doctor of nursing practice (DNP)

individual responsibilities in educating our patients and the public about professional nursing as well as meeting our professional obligations to the public. The end result is not necessarily an immediate change in the picture that comes to mind when one says “nursing”; however, we might begin to see nursing and those of us committed to nursing in new, more accurate ways.

Nursing’s Social Contract with Society

A mutually beneficial relationship exists between nursing and society. The profession of nursing grew out of a need within society and continues to evolve based on the needs of society. Because nursing has a responsibility to society, the interest of the profession must be perceived as serving the interests of society. Society provides the nursing profession with the authority to practice, grants the profession authority over functions, and grants autonomy over professional affairs. The profession is expected to regulate itself and act responsibly. This relationship is the essence of nursing’s social contract with society (American Nurses Association [ANA], 2010, pp. 3, 5).

Foundational to nursing’s social contract with society are some basic values. In brief, these values include that humans manifest an essential unity of mind, body, and spirit; human experience is contextually and culturally defined; health and illness are human experiences; and the relationship between the nurse and the patient occurs within the context of the values and beliefs of the patient and the nurse. In addition, public policy and the healthcare delivery system influence the health and well-being of society and professional nursing, and individual responsibility and interprofessional involvement are essential (ANA, 2010, pp. 6–7).

According to *Nursing’s Social Policy Statement* (ANA, 2010, pp. 4–5), nursing is particularly active in relation to six key areas of health care that include the organization, delivery, and financing of quality health care; provision for the public’s health through health promotion, disease prevention, and environmental measures; and expansion of nursing and healthcare knowledge (through research and evidence in practice) and application of technology. Also included are expansion of healthcare resources and health policy to enhance capacity for self-care; definitive planning for health policy and regulation; and duties under extreme conditions, which means that nurses weigh their duty to provide care with obligations to their own health during extreme emergencies.

Public Image of Nursing

The public values nursing. According to a Gallup poll in 2014, nurses received the top ranking for honesty and ethical standards (Riffkin, 2014). The honor of being the most trusted profession has been bestowed on the profession of nursing every year but one since 1999, when nursing was first added to the Gallup poll. The only year when nurses did not rank number one was in 2001 when firefighters took the top spot after the September 11th terrorist attacks. When asked to defend this nationwide trust of nurses, people often respond with anecdotal stories of personal experiences with nurses. Popular stories include those of relatives or friends who are nurses and positive experiences with nurses in a clinical setting. The fact that nurses serve society seems to have an automatically positive impact on society's value of nursing.

Although the trust is evident, there remains a gap between the public's perception of the nursing profession and the reality of nursing. For example, the general public might think that it requires only 2 years to become a registered nurse (RN), with the "training" consisting primarily of learning to administer medications, providing personal care, and sitting at the bedside. However, reality provides a stark revelation that nurses are educated at the baccalaureate, master's degree, and doctoral levels and work in areas of education, research, and independent clinical practice.

Nurses are aware of the gaps in society's knowledge of nursing. Hence, nurses should take the lead in making sure the public has an accurate picture of the vast knowledge and expertise that are present in the 3 million RNs in the United States (U.S. Department of Health and Human Services [USDHHS], 2010). So, where do we start? We must first begin with the realization that not all nurses are the same. As previously stated, many well-educated persons do not understand the various educational programs available to become an RN. Likewise, knowledge about the differences in preparation and responsibility of licensed practical nurses, RNs, and advanced practice nurses is lacking.

As you are preparing to be a professional nurse, ask yourself, "How do I clarify and communicate the significance of professional nursing?" First, become familiar with the scope of practice of professional nurses and understand the multifaceted roles for which you are being educated. Second, be able to identify the unique place that professional nurses have in the healthcare system. This comes by acquiring knowledge of the nursing profession and being aware of the roles, responsibilities, and contributions of other healthcare professionals. Most important, it is imperative you share your story of nursing. Although the public holds nurses in high regard, they know very little about what nurses actually do (Buresh & Gordon, 2000). Without articulating more clearly and loudly on our profession's behalf, we might be at a loss when trying to defend our place in the current healthcare system.

Suzanne Gordon, an award-winning journalist, has dedicated much of her career to telling the stories of nursing. Not a nurse herself, Gordon writes to empower nurses to find their voice and be heard. Gordon is committed to obtaining a first-hand account from nurses as they face the real challenges of being a nurse that include (1) inconvenient problems of improving patient safety (Gordon, Buchanan, & Bretherton, 2008), (2) the challenges of standing up for themselves, their patients, and the nursing profession (Gordon, 2010), and (3) the effect of cutting healthcare costs on patient care (Gordon, 2005), to name a few. If a journalist can commit to sharing “our” stories, that should provide a spark of motivation in us to share our experiences, triumphs, and defeats.

When nurses are asked about the nurse’s reluctance to promote nursing effectively, the responses are riddled with excuses such as a lack of time, resources, and support from colleagues. Professional nurses work in very demanding, stressful, and taxing jobs. Frequently, we are so consumed with the responsibilities of our work that we fail to notice what we are actually getting accomplished. Additionally, we rarely take time to become fully aware of and celebrate what our nursing colleagues are doing within the profession. Professional nursing organizations exist to communicate and support these achievements. However, only a small percentage of RNs are actually members of their professional nursing associations.

Better insight into professional nursing must start with nurses at all levels of practice and education. Once we have obtained the necessary insight, we can provide a clear picture of the nursing profession to society. When these two actions are taken, the public image of nursing will be directly reflective of the reality of nursing. We want to maintain the positive impression the public now holds of nursing and sustain the earned trust, but nursing and the public deserve a great deal more than that. All of us should be convinced of the expertise that professional nursing offers: mastery of complicated technological skills; appreciation for the whole person; commitment to public health for all people; a keen knowledge of anatomy, physiology, pathophysiology, biochemistry, pharmacology, and other disciplines; the ability to think critically and connect the dots in today’s ever-changing healthcare system; and proficiency in communication. The list continues.

KEY COMPETENCY 5-1

Examples of Applicable *Nurse of the Future: Nursing Core Competencies*

Professionalism:

Knowledge (K5b) Under-
stands the culture of nursing
and the health care system

Skills (S5b) Promotes and
maintains a positive image
of nursing

Source: Massachusetts Department of Higher Education. (2010). *Nurse of the future: Nursing core competencies* (p. 14). Retrieved from <http://www.mass.edu/currentinit/documents/NursingCoreCompetencies.pdf>

Media’s Influence

It is obvious that the media (television, radio, Internet) play a major role in how society views professional nursing. Historically, the nurse has been portrayed in the media in a variety of ways. First, the nurse appears as a young, seductive female whose principal qualification is the length of her slender legs and the amount of cleavage showing through her uniform. Needless to say, this nurse is usually depicted as one who is not educated and lacks common sense and intelligence. Another popular view of the nurse as portrayed by the media is an unattractive, overweight, and mean female. Her intelligence is not

questioned, but her compassion for others is highly debatable. This nurse is shown as threatening and uncaring. Neither of these views is accurate, and probably no one would argue with this. At the same time, we continue to be perplexed when asked to define or describe the professional nurse.

In their book *From Silence to Voice: What Nurses Know and Must Communicate to the Public*, Buresh and Gordon (2006) state that “a profession’s public status and credibility are enhanced by having its expertise acknowledged in the journalistic media” (p. 1). Buresh and Gordon also cite the study “Who Counts in News Coverage of Health Care,” where the data show that many professional groups had a greater voice on health issues compared to nurses. Physicians were quoted the most in media, followed by government, business, education, public relations, and so forth. This is significant and shocking because nurses are the largest group of healthcare professionals, yet we are the most silent group. As nurses, we have been complacent about refuting the negative stereotypes portrayed in the media. Furthermore, we have been lax in articulating our expertise to the media.

Buresh and Gordon (2006) describe three communication challenges faced by the nursing profession that need to be addressed:

1. Not enough nurses are willing to talk about their work.
2. When nurses and nursing organizations do talk about their work, too often they intentionally project an inaccurate picture of nursing by using a “virtue” instead of a “knowledge” script.
3. When nursing groups give voice to nursing, they sometimes bypass, downplay, or even devalue the basic nursing work that occurs in direct care of the sick while elevating an image of “elite” nurses in advanced practice, administration, and academia. (p. 4)

Nurses should face the **stereotypes** present in our society and erase the lines that define us. To do this, we must first recognize our value to society and ourselves. When introducing ourselves in the professional role, we should do so with confidence and clarity. For example, we can say, “Good morning, Mr. Smith. I’m Susan Jones, your registered nurse.” Such day-to-day engagement is important. We must tell the world what we do.

In *From Silence to Voice*, the authors identify the following actions to promote the real image of nursing:

- Educate the public in daily life.
- Describe the nurse’s work.
- Make known the agency—independent thinker—of the RN.
- Deal with the fear of angering the physician.
- Accept thanks from others.
- Be ready to take advantage of openings to promote nursing.

CRITICAL THINKING QUESTION ★

How can you, as a student nurse, tell members of society what professional nurses do? ★

- Respond to queries with real-life stories from nursing.
- Tell the details.
- Avoid using nursing jargon.
- Be prepared ahead of time to tell your story.
- Do not suppress your enthusiasm.
- Reflect the nurse's clinical judgment and competency.
- Connect your work to pressing contemporary issues.
- Respect patient confidentiality.
- Deal with and confront the fear of failure.

In an effort to address the challenges faced by nursing, Buresh and Gordon (2006) provide a history and understanding of modern media and provide examples of how to interconnect with them. Knowing how news media work, how to write a letter to the editor, how to present oneself on television or radio, and how to converse with community groups are among the guidelines provided. Being proactive is essential, especially at a time when healthcare costs and cuts demand that only the fundamental players are left standing. Society needs to know that nurses are fundamental players.

Sigma Theta Tau International commissioned the 1997 Woodhull Study on Nursing and the Media, which reported the lack of representation that nurses have in the media (Sigma Theta Tau International, 1998). In approximately 20,000 articles from 16 major news publications, nurses were cited only 3% of the time. Among the healthcare industry publications, only 1% of the references were nurses. Although nurses are highly relevant participants in patients' stories, they were neglected in almost every case. Key recommendations from the Woodhull Study include the following:

- Nurses and media should be proactive in establishing ongoing dialogue.
- If the aim is to provide comprehensive coverage of health care, the media should include information by and about nurses.
- Training should be provided to nurses on how to speak about business, management, and policy issues.
- *Health care* needs to be clearly identified as the umbrella term for specific disciplines, such as medicine and nursing.
- Nurses with doctoral degrees should be identified correctly as doctors, and those with medical doctorate (MD) degrees should be identified as physicians.
- Language needs to reflect the diverse options for health care by avoiding phrases such as "Consult your doctor." Rather, media need to state, "Consult your primary healthcare provider."

In recent years, we have seen more accurate portrayals of nurses supported in the media. Instead of portraying sexual prowess or disrespect and anger, nurses have been presented as intelligent, competent, and essential to

patient care. Johnson & Johnson continues the Campaign for Nursing's Future to raise public awareness of professional nursing. This positive promotion has supported student and faculty recruitment into the profession. Johnson & Johnson has taken additional steps to recognize the courageous efforts of many nurses, including those who were intensely engaged in responding during national crises such as Hurricane Katrina. Nurses must continually evaluate the portrayal of nurses in the media. After all, if the image is inaccurate, we have a responsibility to correct it.

The Gender Gap

Women in Nursing

In Western culture, women have traditionally been socialized as the more passive of the genders—to avoid conflict and yield to authority. The implications of this conventional thought are still evident in nursing practice today. Many nurses lack confidence in dealing with conflict and communicating with those in authority. For some, it is a matter of short supply of energy and too many other commitments. Others perceive assertiveness as clashing with people's expectations. We should ask ourselves, "Isn't the reward of knowing we do a good job enough?" For female nurses who assume multiple personal and professional roles, career is often not at the top of our priorities. This can be attributed to the fact that the role of women in past society was primarily geared toward family responsibility, not career. Many women who chose nursing did so without the expectation of a long-term commitment to the profession. Rather, nursing was a "good job" when and if a woman needed to work. This centeredness on service continues in nursing today, albeit with less intensity than in the past.

The women's movement in the 1960s empowered intelligent career-seeking women to enter professions other than the traditional ones of teaching and nursing. After some years of competing for students, nursing saw a return of interest in the 1980s and 1990s. At this point, more women chose nursing as a career because nursing provided a natural complement to their gifts, not because it was one of only a few options available to them (Chitty & Campbell, 2001). As the message of varied opportunities for women and men in nursing is shared, the social status of all nurses is elevated.

Another facet of women in nursing is the changing demographic of women entering the nursing profession. In the United States, a larger number of women from underrepresented groups are becoming nurses. According to the USDHHS (2010), approximately 170,235 RNs living in the United States obtained their initial nursing education in another country or U.S. territory. There was an increase from 3.7% in 2004 to 5.6% in 2008.

About 50% of the internationally educated RNs living in the United States in 2008 were from the Philippines, 11.5% were from Canada, and 9.3% were from India.

Men in Nursing

At the start of the new millennium, men represented approximately 5.4% of the RN population in the United States (Trossman, 2003). By 2004, men comprised 5.8% of the RN population, and then 6.6% in 2008 (USDHHS, 2010). This steady increase can be attributed to recruitment campaigns focused on attracting men into nursing. For example, the Oregon Center for Nursing (2002) created a poster of men in nursing with the slogan “Are you man enough to be a nurse?” The Mississippi Hospital Association published an all-male calendar with monthly features of men in nursing, ranging from men who were nursing students to practicing professionals in a variety of roles. The calendar was used as a recruiting tool to help encourage men, young and old, to consider career opportunities in nursing (Health Careers Center, 2012). These strategies help diminish the stigma associated with men in nursing.

The ANA inducted the first man into its Hall of Fame in 2004 (ANA, 2007). Dr. Luther Christman was recognized for his 65-year career and contributions to the profession, including the founding of the American Assembly for Men in Nursing. In 2007, the ANA established the Luther Christman Award to recognize the contributions of men in nursing. Current literature also helps to keep the discussion of men in nursing at the forefront. In 2006, *Men in Nursing* journal was launched as the first professional journal dedicated to addressing the issues and topics facing the growing number of men who work in the nursing field.

Although a seemingly recent topic, men have served in nursing roles throughout history. In the 13th century, men played a vital role in providing nursing care to vulnerable individuals. John Ciudad (1495–1550) opened a hospital in Grenada, Spain, so that he (along with friends) could provide care to the mentally ill, the homeless, and abandoned children (Blais, Hayes, Kozier, & Erb, 2001). Saint Camillus de Lellis (1550–1614) was the founder of the Nursing Order of Ministers of the sick. Men in this order were charged with providing care to alcoholics and those affected by the plague (Blais et al., 2001). In the United States, in the 1700s James Derham was an African American man who worked as a nurse in New Orleans and was subsequently able to buy his freedom and become the first African American physician in the United States.

Despite her many contributions to the nursing profession, Florence Nightingale did not encourage the participation of men in nursing. She believed that traits such as nurturance, gentleness, empathy, and compassion were needed to provide care and that these traits existed primarily in women.

Nightingale opposed men being nurses and stated that their “hard and horny” hands were not fit to “touch, bathe, and dress wounded limbs, however gentle their hearts may be” (Chung, 2000, p. 38). Thus, nursing became a predominantly female discipline in the late 1800s.

Even with negative societal perceptions and stereotypes, men are now more open to pursuing nursing as a career choice (Berlin, Stennett, & Bednash, 2004). In the fall of 2003, the percentage of men enrolled in undergraduate schools of nursing was 8.4%. In 2014, the percentage of male students enrolled in baccalaureate nursing programs increased to 11.7%. Male students enrolled in master’s degree nursing programs represented 10.8% of that group of students. Male students represented 9.6% of the students enrolled in research-focused doctoral programs and 11.7% of students enrolled in practice-focused doctoral programs (American Association of Colleges of Nursing [AACN], 2015a). These increases are largely the result of diminishing misconceptions and increased recruiting efforts. Men tend to prefer distinct practice areas, including high-technology, fast-paced, and intense environments. Emergency departments, intensive care units, operating rooms, and nurse anesthesia are examples of areas to which men are often attracted (American Society of Registered Nurses, 2008; Gibbs & Waugaman, 2004). Some speculate that men make these choices to avoid potential role strain if they were to choose other areas, such as obstetrics and pediatrics, and because they prefer areas that require more technical expertise (American Society of Registered Nurses, 2008).

There is some debate that men in nursing have an advantage over their female peers. It is not unusual for patients to assume that a male nurse is a physician or a medical student. On the other hand, men in nursing have been mistaken for orderlies. However, the percentage of men in leadership roles in nursing is much higher than the percentage of men in nursing overall. This is partly because male nurses are more oriented and motivated to upgrade their professional status (American Society of Registered Nurses, 2008). As a result, women in nursing are challenged to learn how to promote themselves within the profession.

What issues and challenges do men face in nursing? According to research conducted by Armstrong (2002) and Keogh and O’Lynn (2007), male nurses are unfairly stereotyped in the profession as homosexuals, low achievers, and feminine. These false assumptions and perceptions deter other men from entering the profession, create gender-based barriers in nursing schools, and decrease retention rates of male nurses once they are licensed. Also, because most nursing faculty are female, most nursing textbooks are written by females, and most leaders in nursing are female, men might have to learn new ways of thinking and understanding to find a comfortable place of belonging in the nursing profession. For example, it is reported that a male nursing student was having difficulty answering questions on a nursing examination. When the student shared a sample question with his wife (who was not a nurse), she answered the question correctly (Brady & Sherrod, 2003).

CRITICAL THINKING QUESTIONS ★

What advantages do women have in nursing? What advantages do men have in the profession? What are the risks of being gender exclusive? ★

As a consequence of gender bias, some patients might refuse or feel reluctant to allow men in the nursing role to care for them (American Society of Registered Nurses, 2008; Cardillo, 2001). During labor and delivery, patients and their partners might request a female nurse to be at the bedside. Overall, the presence of a male nurse alone in the room with a patient is out of the ordinary.

On the other hand, male nurses are assumed to be physically stronger and willing to do the heavier tasks of nursing care, such as lifting and moving patients (Cardillo, 2001). Still, many men and women are learning to appreciate and enjoy the emerging culture in the profession (Meyers, 2003). The old biases continue to disappear as patients and providers become more educated about the need for gender diversity in nursing.

Changing Demographics and Cultural Competence

Despite national trends of increasing diversity, with ethnic and racial minorities reaching almost one-third of the U.S. population, minorities overall are underrepresented in the healthcare profession. The 2010 U.S. Census reports that 63.7% of the population is white and non-Hispanic. In contrast, the RN population remains predominantly female (94.2%) and 83.2% white, non-Hispanic (Health Resources and Services Administration [HRSA], 2010). The Sullivan Commission (2004) highlights the diversity gap in its hallmark report *Missing Persons: Minorities in the Health Professions*. Together, African Americans, Hispanic Americans, and American Indians make up more than 25% of the U.S. population but only 9% of the nation's nurses, 6% of its physicians, and 5% of dentists. Similar disparities show up in the faculties of health professional schools. For example, minorities make up less than 10% of baccalaureate nursing faculties, 8.6% of dental school faculties, and only 4.2% of medical school faculties. If the trends continue, the health workforce of the future will resemble the population even less than it does today. If these data are viewed in the context of the prediction that no racial or ethnic group will compose a majority by the year 2050, such a decline in a diverse workforce could be catastrophic.

In 2003, the Institute of Medicine (IOM) warned of the “unequal treatment” minorities face when encountering the healthcare system. Cultural differences, a lack of access to health care, high rates of poverty, and unemployment contribute to the substantial ethnic and racial disparities in health status and health outcomes (IOM, 2003b). Health services research shows that minority health professionals are more likely to serve minority and medically underserved populations. Increasing the number of

underrepresented minorities in the health professions as well as improving the cultural competency of providers are key strategies for reducing health disparities (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; IOM, 2003b).

Cultural competence in multicultural societies continues as a major initiative for health care and specifically for nursing. The mass media, healthcare policymakers, the Office of Minority Health and other governmental organizations, professional organizations, the workplace, and health insurance payers are addressing the need for individuals to understand and become culturally competent as one strategy to improve quality and eliminate racial, ethnic, and gender disparities in health care (Purnell & Paulanka, 2008).

Culturally competent healthcare providers reduce patient care error and increase access to and satisfaction with health care. The beginning of cultural competence is self-awareness. Culture has a powerful unconscious impact on health professionals and the care they provide. Purnell and Paulanka (2008) believe that self-knowledge and understanding promote strong professional perceptions that free healthcare providers from prejudice and facilitate culturally competent care.

Nursing has a long history of incorporating culture into nursing practice (DeSantis & Lipson, 2007). In 2008, the AACN released a publication identifying cultural competency in baccalaureate nursing education (AACN, 2008). Yet some maintain that no matter how culturally competent the nurse might be, the patient's experience remains structured in the nurse's culture (Dean, 2005). Despite nurses' best efforts to understand the culture of the patient, nurses often fail to understand that the patient might be experiencing health care for the first time, not in his or her own culture, but in the nurse's culture of healthcare delivery. The understanding of this concept associated with cultural competence increases the reality of the urgency of increasing the diversity in the nursing workforce.

The National Advisory Council on Nurse Education and Practice (NACNEP) was established to advise the secretary of the USDHHS and Congress on policy issues related to Title VIII programs administered by HRSA. NACNEP identified as an issue the need to increase the racial and ethnic diversity of the RN workforce. In its third report, NACNEP recommended that the country "expand the resources available to develop models that will effectively recruit and graduate sufficient numbers of racial/ethnic students to reflect the nation's diverse population" (NACNEP, 2003).

Currently, most RNs are white women, but more minority students are enrolling in nursing programs now than in past decades. In 2014, 30.1% of students enrolled in baccalaureate programs were minorities, as were 31.9% of nurses enrolled in masters programs, 28.7% of nurses enrolled in practice-focused doctoral programs, and 29.7% of nurses enrolled in research-focused doctoral programs. These numbers have increased substantially since 2005,

KEY COMPETENCY 5-2

Examples of Applicable
*Nurse of the Future: Nursing
Core Competencies*

Patient-Centered Care:

Knowledge (K4) Describes how diverse cultural, ethnic, spiritual and socioeconomic backgrounds function as sources of patient, family, and community values

Skills (S4b) Implements nursing care to meet holistic needs of patient on socioeconomic, cultural, ethnic, and spiritual values and beliefs influencing health care and nursing practice

Attitudes/Behaviors (A4b) Recognizes impact of personal attitudes, values, and beliefs regarding delivery of care to diverse clients

Source: Massachusetts Department of Higher Education. (2010). *Nurse of the future: Nursing core competencies* (p. 10). Retrieved from <http://www.mass.edu/currentinit/documents/NursingCoreCompetencies.pdf>

when only 24.1% of students enrolled in baccalaureate programs, 22% of nurses enrolled in masters programs, and 18.4% of nurses enrolled in research-focused doctoral programs were minorities (AACN, 2015a).

The Joint Commission and the National Committee for Quality Assurance also identified the need for healthcare professionals to recognize and respect cultural differences, including dialects, regional differences, and slang (Levine, 2012). In an effort to respond to this national message, many hospitals and healthcare agencies have initiated the use of interactive patient-engagement technology as part of their education programs. These services are provided in several languages, including Russian, Spanish, and Mandarin. Nurses know that illness and associated stress, pain, and fear can hinder patients' comprehension when learning about their condition and treatment plan. Language barriers compound the problem, resulting in major obstacles to learning and subsequent issues with adhering to the treatment plan. As nursing focuses more on cultural behaviors, norms, and practices, healthcare outcomes can move in a positive direction (Levine, 2012).

As the general population of healthcare consumers becomes increasingly diverse, there is a greater need for culturally competent care (Jacob & Carnegie, 2002). To provide such nursing care, we must strive for a nursing population that more accurately represents the communities we serve. As the population continues to become more diverse, culturally competent care will be the basis for quality care, access to care, and alleviation of health disparities, thus promoting healthier population outcomes. Being culturally competent, that is, having the ability to interact appropriately with others through cultural understanding, is an expectation for people entering the nursing profession (Grant & Letzring, 2003), keeping in mind that there is a difference between *learning of* another culture and *learning from* another culture.

Access to Health Care

Many Americans have health insurance coverage and access to some of the best healthcare professionals in the nation. However, a large number of individuals experience disparities in our healthcare system. These disparities, or unfair differences in access, can result in poor quality and quantity of health care. According to the Agency for Healthcare Research and Quality (AHRQ, 2010), individuals who are at greatest risk for experiencing healthcare disparities are racial and ethnic minorities and those with a low socioeconomic status. Lack of health insurance is the most significant contributing factor to a decrease in disease prevention and thus is one of the foci of the Patient Protection and Affordable Care Act. Although lack of health insurance has a major effect on access to health care, other factors, such as continuity of care, economic barriers, geographic barriers, and sociocultural barriers, have a detrimental effect on the health and quality of life of individuals and are discussed in the following subsections.

Continuity of Care

Individuals who have a provider or facility where they receive routine care are more likely to receive preventive health care (AHRQ, 2010). These individuals usually have better health outcomes and experience reduced disparities. In 2008, the percentage of people with a specific source of ongoing care was significantly lower for poor people than for high-income people (77.5% compared with 92.1%). The AHRQ also notes that having a routine provider of care correlates with a greater trust in the provider and increased likelihood that the person coordinates care with the provider. In this regard, one role and responsibility of the nurse is to educate the community and patients on the importance of continuity of care with a routine healthcare provider and/or facility.

Economic Barriers

Undoubtedly, poverty poses the greatest risk to health status (Kavanagh, 2001). The United States has a long-standing reputation for providing the highest quality health care to persons in the highest socioeconomic strata. Likewise, the lowest quality health care is provided to those at the other end of the socioeconomic continuum (Jacob & Carnegie, 2002). As the largest segment of the healthcare industry, RNs can have a positive impact on the change required in this established system. Recognizing the stronghold that poverty currently has on the health care of citizens is a beginning to the much-needed work in the fight for equality.

Although stereotypes communicate to us that poverty is limited to certain groups, we understand that poverty affects people of all cultures and ethnicities. We must recognize the impact that poverty has on healthcare practices. If poverty were eradicated, there would be no homelessness, none who are uninsured, and no more choices between food and medicine. Until that time, nursing continues to face the challenge of meeting the needs of all people.

Geographic Barriers

Those living in rural areas have unique concerns regarding **access to care**. As many rural hospitals close due to a lack of financing, more communities find themselves struggling to find primary care providers who will work in those areas. State and national efforts attempt to provide more service to these areas, but the demand outweighs the supply.

Urban dwellers are not immune to geographic barriers. Large cities have economically depressed sections with fewer healthcare providers than the more affluent areas. Dependency on public transportation is another factor to be managed. Finally, most rural and many urban communities do not support a full range of healthcare services in one location. These variables

affect patients' access to care and their continuation in prescribed treatment plans. It is imperative for the nurse to collaborate with other members of the healthcare team to become aware of various services available to enhance the health and quality of life of patients.

Sociocultural Barriers

The need for cultural and ethnic diversity in the nursing workforce has been discussed. Moreover, healthcare settings are challenged to provide an environment where people of various sociocultural backgrounds are respected. For example, having translators on site or within easy contact is critical for ensuring safe care to non-English-speaking clients. Written materials should also be provided in appropriate languages and at an appropriate reading level. It is not feasible or cost effective to provide educational materials and products to patients who will not use them because they are in a foreign language or too advanced. Specifically, consent forms for surgery and other procedures must be available in the client's language. To ignore the need for language-appropriate literature leads to patient harm, as well as disrespect for the uniqueness of others.

One subculture that has garnered much attention in recent years is the military patient population. The Department of Defense operates and finances health care through TRICARE, a comprehensive healthcare coverage program for members of the uniformed services, their families, and survivors. With national resources decreasing and demands for health care of our military population on the rise, nurses play a pivotal role in influencing the direction of care for this special group.

In an effort to address the needs of the military population and their families specifically, First Lady Michelle Obama led the "Joining Forces" national initiative to mobilize all sectors of the community to give service members, veterans, and their families the support they deserve, especially in regard to employment, education, and wellness. According to Joining Forces (White House, 2012), military service members, veterans, and their families have made significant contributions to the nation's safety and security. This contribution comes at great cost to each veteran and family. The profession of nursing has a long and established history of meeting and supporting the physical and mental health needs of our nation's military service members, veterans, and their families. The profession of nursing has pledged to inspire and prepare each nurse to recognize the unique health and wellness concerns of the population. One hundred fifty nursing organizations and 500 nursing schools pledged their support to help educate nurses on post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI) in the coming years. Although each organization and nursing school has its unique mission and vision, various strategies to be employed include (1) increasing nurse awareness of PTSD and TBI,

(2) recognizing the signs and symptoms in patients, and (3) integrating PTSD and TBI content in nursing school curricula, to name a few. The ANA, American Academy of Nurse Practitioners, AACN, and National League for Nursing took the lead in seeking nationwide support from nursing organizations and schools of nursing.

CRITICAL THINKING QUESTIONS ★

What barriers to health care do you see in your community? How are the underprivileged served in our current healthcare system? ★

Societal Trends

At any time in history, societal trends affect the nursing profession. Major current movements include incivility, violence in the workplace, global aging, consumerism, complementary and alternative care, and disaster preparedness. Discussion of these issues allows us to see more clearly the social landscape and some of the challenges we face as a profession.

Incivility

Incivility, or “bullying,” has been exposed in the media to a great extent in the past few years. This heightened attention is partly the result of media coverage of suicide attempts and homicides that were instigated by harassment at the physical, verbal, and electronic levels. Incivility is seen in every area of society, including high school, college, and even on the job. Nursing is not immune to this behavior. Greater light has been shed on the incidence and prevalence of bullying in nurse-to-nurse, faculty-to-student, and even student-to-faculty interactions. Rucker (2008) reports that some of the behaviors include criticism, humiliation in front of others, undervaluing of effort, and teasing. It is also reported that bullying contributes to burnout, school dropout, isolation, and even attempted suicides. Bullying is costly to organizations because it contributes to increased leave, nurse attrition, and decreased nurse productivity, satisfaction, and morale.

In light of this, it is vital that the nursing profession take an active step in preventing incivility not only in our communities, but also in nursing programs and places of employment. The ANA (2012) has taken such action by developing a booklet, *Bullying in the Workplace: Reversing a Culture*, to help nurses recognize, understand, and deal with bullying in the work environment. The ANA supports zero-tolerance policies related to workplace bullying. In addition, in its professional performance standards, the ANA (2015) indicates that nurses are required to take a leadership role in the practice setting and within the profession. Two of the competencies listed that demonstrate the expected performance related to this standard include communicating in a way that manages conflict and contributing to environments that support and maintain respect, trust, and dignity (p. 75).

Violence in the Workplace

The **violence** in our society is evident and appears to be increasing in frequency and severity. What is more alarming is our desensitization to the constant exposure by Internet, radio, and television. As nurses, we can easily put a face on violence. We see the man in the emergency department with a gunshot wound to the chest. Only 30 minutes before, he was leaving work for a weekend with family when someone decided that they needed his car more than this man needed his life. We see violence at the women's shelter when we rotate through that clinical site in community health nursing. We also see troubled individuals who take out their frustration on colleagues and supervisors by going on a shooting rampage, leaving a path of death and destruction. All of these examples affect nurses because we are caring for the ones who are injured and also providing care to the injurer. Nurses are required to be knowledgeable of how to act and provide competent care when violent incidents occur.

RNs can assume additional roles when addressing violence. The role of the nurse is not limited to providing care in the hospital or emergency department. To work aggressively to address violence, nurses can function in the role of a sexual assault nurse examiner (SANE) or forensic nurse (Littel, 2001). Forensic nurses are trained to recognize and collect evidence related to criminal acts of trauma or death (Santiago, 2012). The SANE RN must have advanced education and preparation in forensic examination of sexual assault victims. One result of the SANE programs is that victims of sexual assault consistently receive attention and compassion without delay (Littel, 2001).

Nurses must become socially aware and politically involved in preventing violence. We have to support legislation that proactively addresses violence and lobby for funding that provides nursing research into violence prevention and treatment. In every potential case, nurses have to use keen assessment skills to identify people at risk and to promote reporting, treatment, and rehabilitation.

Global Aging

In 2010, adults 62 years of age or older comprised 16.2% of the U.S. population (49.9 million) compared to 14.7% (41.2 million) in the year 2000. By 2030, it is estimated that the population of older adults will rise to 71 million (Howden & Meyer, 2011). By 2050 it is estimated that one in five Americans will be 65 years or older, with the greatest increases being in the group over 85 years (USDHHS, 2014).

However, this is not a trend unique to the United States. The Year of the Older Person—this is what the United Nations called the year 1999 to recognize and reaffirm **global aging**, the fact that our global population is aging at an unprecedented rate (U.S. Census Bureau, 2001). After World War II, fertility increased and death rates of all ages decreased. Not only are people in developed countries living longer and healthier, but so are those in the

developing world. In the 1990s, developed countries had equal numbers of young (people 15 years or younger) and old (people 55 years or older), with approximately 22% of the population in each category. On the other hand, 35% of the people in developing countries were children compared with 10% who were older. Still, absolute numbers of older persons are large and growing. In the year 2000, more than half of the world's older people (59%, or 249 million people) lived in developing nations.

In the United States, a decrease in fertility, an increase in urbanization, better education, and improved health care all contribute to this social phenomenon. In addition, the older baby boomers who have turned 65 years of age have started to affect health care significantly with increasing numbers receiving Medicare benefits. The impact this will have on our healthcare system is daunting. According to the USDHHS (2014), more than 60% of older adults manage more than one chronic medical condition, such as diabetes, arthritis, heart failure, and dementia. Currently 46% of critical care patients and 60% of medical-surgical patients in U.S. hospitals are older adults. These acute care patients are challenging for nurses and resource intensive to the healthcare system because these vulnerable patients generally have multiple chronic conditions to treat simultaneously (Ellison & Farrar, 2015).

There is a need for clear health policy at a national level if we are to be prepared to care for the increasing number of aging citizens. Preventive health services for older adults are delineated as provisions made in the Affordable Care Act of 2010. Healthy People 2020 included objectives specifically for older adults that should be used by healthcare professionals, including nurses, to promote healthy outcomes, including improved health, function, and quality of life for this population. Issues that emerge as nurses promote these outcomes may include coordination of care and helping older adults manage their own care (USDHHS, 2014).

In response to the global aging phenomenon and the specialized set of skills required to care for older adults, most schools of nursing have either incorporated gerontology courses or increased the geriatric content throughout the curriculum. Geriatric Nurse Practitioner programs have grown in number, and some schools offer dual-track Adult/Geriatric Nurse Practitioner and Geriatric Psychiatric Mental Health Nurse Practitioner programs in graduate programs. Clinical experiences in nursing programs include many experiences with older persons. Still, as a nation, we lack an organized plan to make certain that healthcare needs will be met—not just for the aging, but also for those who come after them.

Consumerism

Since the American Hospital Association's development of A Patient's Bill of Rights in 1973, consumers have assumed more control of their healthcare experiences; this shift is called **consumerism**. The 1992 version of the

document was replaced by the brochure *The Patient Care Partnership: Understanding Expectations, Rights, and Responsibilities* (American Hospital Association, 2003b). This brochure is available in several languages and can be accessed in its entirety via the American Hospital Association website at www.aha.org/advocacy-issues/communicatingpts/index.shtml. A summary of the original document is presented in **Box 5-1**. Gone are the days when patients blindly followed the instructions of their physicians. This is cause for celebration in the nursing arena because nursing has long sought to empower patients to take responsibility for their own health. Although pockets of medical paternalism may continue to exist, a shift has occurred and consumers of health care now hold healthcare providers to a higher standard than ever before.

In addition to *The Patient Care Partnership*, the American Hospital Association also developed a resource toolkit entitled *Strategies for Leadership: Improving Communications with Patients and Families: A Blueprint for Action* (2003a). The resource includes checklists to help hospitals assess their strengths and weaknesses related to communications with patients and families. The resource also includes case studies that illustrate initiatives that other hospitals have implemented to foster improved communication.

Information technology has given patients an enormous resource for gaining knowledge about diseases, medications, and treatment options, as well as support groups and other self-help resources. In today's environment, consumers of healthcare search for answers to their healthcare questions and compare provider and healthcare system outcomes online. Based on the information available, they are able to make informed choices related to health care.

KEY COMPETENCY 5-3

Examples of Applicable
*Nurse of the Future: Nursing
Core Competencies*

Patient-Centered Care:
Attitudes/Behaviors (A2b)
Respects and encourages
the patient's input relative to
decisions about health care
and services

Source: Massachusetts Department of Higher Education. (2010). *Nurse of the future: Nursing core competencies* (p. 9). Retrieved from <http://www.mass.edu/currentinit/documents/NursingCoreCompetencies.pdf>

BOX 5-1 THE PATIENT CARE PARTNERSHIP

What to expect during your hospital stay:

1. High-quality patient care
2. A clean and safe environment
3. Involvement in your care
 - a. Discussing your medical condition and information about medically appropriate treatment choices
 - b. Discussing your treatment plan
 - c. Getting information from you
 - d. Understanding your healthcare goals and values
 - e. Understanding who should make decisions when you cannot
4. Protection of your privacy
5. Preparing you and your family for when you leave the hospital
6. Help with your bill and filing insurance claims

Complementary and Alternative Approaches

As the consumer's perspective grows in influence, and individuals take on greater responsibility in their healthcare decisions, they explore approaches to health care that can actually contrast with Western traditions. Different terminology has been used synonymously to define this growing field, such as *complementary care practices* and *alternative medicine*. According to the National Center for Complementary and Alternative Medicine (2012), "Complementary and alternative medicine is a group of diverse medical and healthcare systems, practices, and products that are not presently considered to be part of conventional medicine." Complementary medicine refers to an approach that combines conventional medicine with less conventional options, whereas alternative medicine is an approach used instead of conventional medicine. Major types of **complementary and alternative medicine** include the following:

- Alternative medical systems (built on complete systems of practice such as homeopathic medicine or naturopathic medicine)
- Mind–body interventions (techniques designed to enhance the mind's capacity to affect bodily function such as meditation, prayer, music, and support groups)
- Biologically based therapies (use of substances found in nature such as herbs, foods, and vitamins)
- Manipulative and body-based methods (based on manipulation or movement of one or more parts of the body such as chiropractic manipulation or massage)
- Energy therapies (involves the use of energy fields through either biofield therapies such as therapeutic touch, qi gong, or Reiki, or bioelectro-magnetic-based therapies such as magnetic therapy)

Alternative and complementary therapies affect the selection of traditional choices for treatment, and ignoring that they exist is not an option. People persist in the use of alternative and complementary therapies for obvious reasons: (1) the therapies have been found valuable, and (2) Western medicine has limited options. Many people are inclined not to divulge information about complementary therapy to their healthcare provider; however, some alternative therapies may interact with medications and may be contraindicated in certain circumstances, so it is imperative that healthcare providers seek out this information. Nurses should provide a safe, trusting atmosphere where patients feel free to discuss their healthcare routines and preferences.

Disaster Preparedness

Prior to the turn of this century, **disaster preparedness** was not a major topic of discussion in programs of nursing. Further, the key roles that professional nurses now play in preparing and responding to disasters were unexplored

until recently. The World Trade Center attack in 2001 and the shock of Hurricane Katrina in 2005 opened the nation's eyes to our vulnerabilities and our strengths. As a result, disaster management has become common language in our schools, agencies, and communities.

Disaster management, plans designating responses during an emergency, are coordinated by local, state, and federal groups. Firefighters, police officers, and healthcare professionals are part of response teams. Disaster training is also available to other volunteers. We have learned that caring for large groups affected by disaster requires an organized, thoughtful, unbiased approach. Professional nurses carry the burden of being knowledgeable about potential disasters, educating the public about the risks, and responding when persons are affected.

Disaster resources are available from many organizations. The American Red Cross and the ANA make available policies, resources, and educational opportunities on disaster preparedness for nurses. In addition, the IOM (2009) provides guidance for entities establishing standards of care for disaster preparedness. The Centers for Disease Control and Prevention (CDC) Clinician Outreach and Communication Activity program formed in 2011 in response to the anthrax attacks in the United States. The mission of the outreach program is to help healthcare professionals provide optimal care by facilitating communication between clinicians and the CDC about emerging health threats, identifying clinical issues during emergencies to help inform outreach strategies, and disseminating evidence-based health information and public health emergency messages (CDC, 2012).

Trends in Nursing

The profession of nursing is currently facing some daunting challenges that include a projected nursing shortage, workplace issues, the education–practice gap, unclear practice roles, and changes in population demographics. Although it is true that each of these issues is not a new challenge to nursing practice, it is critical to now acknowledge the collective impact of all of these together in the contemplation of future directions in professional nursing practice.

Nursing is rich in history, resilient in its journey to develop as a profession and a discipline, and adaptive in its practice to meet the healthcare needs of the patient. Throughout the history of nursing, there are identifiable periods of time in which the practice and education of nurses responded to the evolving changes in health care and in society. Today, nursing is again at the crossroads of a major transition in its education and practice. An awareness of the merging of these issues creates urgency when contemplating the role, practice, and education of nurses.

Nurse Shortage

The shortage of nurses is not a new issue; the predicted **nursing shortage** has been prominent in the media for most of nursing's history and more recently in the past several years. The U.S. Bureau of Labor Statistics estimated that more than 1 million new and replacement nurses would be needed by 2016 (Dohm & Shniper, 2007). Buerhaus, Auerbach, and Staiger (2009) project the shortage of nurses in the United States could be as high as 500,000 in 2025. These projections are based on the following trends: an increase in population, a larger proportion of elderly persons, increases in technology, and advances in medical science (HRSA, 2002). Other issues affecting the projected supply of nurses include declines in the number of nursing school graduates, aging of the RN workforce, declines in relative earning, and emergence of alternative job opportunities, especially for women, who are the prominent gender in nursing.

History documents a cyclic pattern of nursing shortages, making it difficult to comprehend the seriousness of this shortage, especially viewed through the lens of history. The economic slowdown; the decreased vacancies in healthcare agencies, especially hospitals; and the uncertainty of the consequences of healthcare reform given the Affordable Care Act (2010) further complicate predictions related to the future nursing workforce. In the 2013–2014 academic year, schools of nursing documented that a significant number of qualified nursing school applicants (57,944) were denied admission to undergraduate nursing programs (AACN, 2014) due to lack of faculty and resource constraints that prohibit further increases in student enrollments. In recent years, employers in various parts of the United States have reported a decrease in the demand for RNs, and nursing students report that it is more challenging after graduation to find employment, sometimes taking 6 months to a year.

These findings have led many people to question whether the nursing shortage still exists. Experts claim that the recession might have given some hospitals a temporary reprieve from chronic shortages, but it is not curing the longer-term problem and might be making it worse (Robert Wood Johnson Foundation, 2009). The Tri-Council for Nursing (2010) released a joint statement cautioning stakeholders about declaring an end to the nursing shortage. The statement says, "The downturn in the economy has led to an easing of the shortage in many parts of the country, a recent development most analysts believe to be temporary." The council raises serious concerns about slowing the production of RNs given the projected demand for nursing services, particularly in light of healthcare reform. It further states that diminishing the pipeline of future nurses can put the health of many Americans at risk, particularly those from rural and underserved communities, and leave our healthcare delivery system unprepared to meet the demand for essential nursing services.

Where do we stand today? A report from the Bureau of Labor Statistics on employment projections identifies the registered nursing workforce as the top occupation in terms of job growth through 2020 (Bureau of Labor Statistics, 2012). The number of employed nurses is expected to grow from 2.74 million in 2010 to 3.45 million in 2020, and a need for 495,500 replacements in the nursing workforce is projected for 2020.

Data collected in the 2008 National Sample Survey of Registered Nurses (HRSA, 2010) document that the average age of the RN population is 46.8 years. It is significant to note that the average age of the RN population did not increase from the 2004 survey. The plateau in the average age reflects an increase in employed RNs younger than 30 years of age. Between 1988 and 2004, the percentage of employed nurses younger than 30 years fell from 18.3% to 9.1%. The trend of increasing enrollments in schools of nursing, especially baccalaureate programs, is credited for the increased employment of younger nurses (HRSA, 2010).

A recent report from the AACN shows an increase in the enrollment of generic baccalaureate students by 3.1% in 2011–2012 and by 17% in the past 5 years (AACN, 2012). There was no increase in 2012–2013, but this was followed by an increased enrollment of baccalaureate students, more than doubling to 6.6% in 2013–2014 (AACN, 2015a). Yet, the following statement is included with the documentation of increased enrollment: “Although the dramatic rise in enrollments and the increase in graduations over the past five years are encouraging, many more baccalaureate-prepared nurses will be needed to meet the health care needs of the population” (AACN, 2012, p. 3).

A national nurse shortage still exists. Although nursing school enrollments and graduations are increasing, and the statistics on younger nurses in the workforce are encouraging, the following factors must be considered in addressing the future of professional nursing practice. Baccalaureate and graduate programs in nursing report that 75,587 qualified applicants were not admitted into nursing programs because of lack of clinical space and faculty shortage. There is a prediction that more than 32 million Americans will soon gain new access to healthcare services, and the aging population is increasing and will require management of their chronic illnesses (AACN, 2012). This leaves us with questions such as: Who will provide these healthcare services? Who will care for the old? As people age and experience health problems, their needs are often more complex and acute, thereby demanding an even more highly skilled nursing force.

Nurse Faculty Shortage

In previous cycles of nursing shortages, the primary solution was to increase the enrollment in nursing programs. However, ample evidence supports the conclusion that a national **nursing faculty shortage** also exists. In a 2013–2014 survey, the AACN reported that the professoriate continues to age, and an exodus

from the ranks of faculty looms before us due to retirement. The mean age of doctoral faculty holding the rank of professor is 61.6 years, for faculty holding the rank of associate professor it is 57.6 years, and for assistant professors it is 51.4 years. The national faculty vacancy rate is 6.9%. Of the reported vacancies, 89.6% involve doctoral-prepared faculty. This shortage is limiting student capacity in nursing programs across the nation (AACN, 2015b).

The number of nurses employed in nursing education has changed little since 1980, with 31,065 nurses working as faculty. When the number of nurse educators is compared to the increase in the number of RNs, the result is actually a decline (2.4%) in the percentage of nurses working in education (HRSA, 2010). The statistics associated with nursing faculty are concerning, especially in consideration of the nursing shortage and healthcare projections of nurse demand in the future.

Nursing Practice and Workplace Environment

Given the anticipated nursing shortage and the increased demand for nurses, it is important to address the issues associated with the practice of nursing and the environment where nurses work. It is understandable how the shortage of nurses affects the practicing nurse, especially in staff and patient ratios and workload and the resulting influences on nurse turnover rate. However, other issues associated with the nurse practice setting result in problematic quality outcomes, such as nurse job dissatisfaction, unsafe patient care, unhealthy workplace environment, and unclear role expectations.

It is evident that health care and healthcare delivery have changed significantly in the past two decades. Most of these changes have been associated with response to the increasing cost of care, the decreasing reimbursement to healthcare providers, increased use of technology in practice, and the knowledge explosion concerning disease management. A full discussion of each of these issues is beyond the scope of this chapter; however, it is important to note that most of the changes result from a focus on reducing the cost of health care. Cost containment strategies aim to determine the setting of the delivery of care, the length of stay in the hospital, the cost reimbursed to providers of care, and the designation of the appropriate provider of care.

Hospitals remain the most common employment setting for RNs in the United States, with 62.2% of employed RNs reporting hospitals as their primary place of employment (HRSA, 2010). Contrary to earlier predictions, the percentage of nurses working in hospitals increased from 2004 to 2008 (HRSA, 2010); however, note that the percentage of nurses working in home health services has also increased. Data from the national survey of RNs reflect that the percentage of nurses working in hospitals decreases with the increasing age of nurses. Only 50% of RNs age 55 years or older work in hospital settings.

Nurses in hospitals provide care for patients who are sicker, older, and have more complex physical, psychosocial, and economic needs (Brown, 2004; Clark, 2004). The combination of older patients with higher acuity, sophisticated technology, and shorter hospital stays creates a chaotic environment and demands that nurses assume greater responsibility (Cram, 2011). This chaos increases not only the risk of errors in patient care, but also the risk of health concerns for the nurse, such as the threat of infection, needle sticks, ever-increasing sensitivity to latex, back injuries, and stress-related health problems. In addition to these health risks, nurses are susceptible to workplace violence (e.g., physical violence, horizontal violence) and sexual harassment (Longo & Sherman, 2006; Ray & Ream, 2007; Smith-Pittman & McKoy, 1999; Valente & Bullough, 2004).

The issues associated with the hospital work environment have been shown to dominate problems and outcomes associated with nursing practice. Because of this environment, the profession of nursing has been challenged to evaluate its practice and outcomes. In fact, a majority of nurses completing surveys stated they perceived that the unsafe working environment interfered with their ability to provide quality patient care (ANA, 2011; Pellico, Djukic, Kovner, & Brewer, 2009). Staff nurses strongly desire a practice setting in which they feel that they have the ability to provide quality patient care (Schmalenberg & Kramer, 2008) and a work environment that facilitates clinical decision making.

Confounding the issues of the workplace environment are the shortage of qualified non-nurse healthcare workers, the supervision of unlicensed personnel, the appropriate delegation of care, mandatory overtime, and staffing ratios. The debate over the use of unlicensed personnel and the use of other licensed personnel in providing patient care is well documented in the literature (ANA, 1992, 1997, 1999; Zimmerman, 2006). Research studies indicate that a decrease in RN staff increases patient care errors, infection rates, readmission, and morbidity (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Needleman, Buerhaus, Mattke, Stewart, & Zelevinsky, 2002; Sofer, 2005; Stanton & Rutherford, 2004).

Given that research indicates that a decrease in RN staff or the use of unlicensed personnel and other licensed personnel influences patient quality outcomes, what is a rationale for this practice? One answer that is quickly provided is the increased costs of a higher RN–patient ratio. Nurses represent about 23% or more of the hospital workforce. The salary of a licensed RN is higher compared to other nonphysician healthcare providers. Thus, the basic assumption is that to employ more unlicensed personnel or other licensed personnel reduces the cost of care. This assumption is not necessarily true when costs other than salary, such as costs of hiring, benefits, training, staff turnover, and responsibilities that must be assumed by a licensed care provider, are considered. Aiken et al. (2002) find that nurses in hospitals with low nurse–patient ratios are more than twice as likely to experience

job-related burnout and dissatisfaction with their jobs when compared to nurses in hospitals with the highest nurse–patient ratios. Cooper (2004) and Kalisch and Kyung (2011) note that lower nursing staff ratios also indicate higher costs in a plethora of areas that reflect the actual reality of nursing practice. McCue, Mark, and Harless (2003) find that a 1% increase in non-nurse personnel increases the operating costs by 0.18% and diminishes profits by 0.021%. These data are significant in the overall budget considering the rising costs of health care and current emphasis on the association of quality and safety indicators with reimbursement.

Nurse Retention

There is a connection among nurse satisfaction, work environment, and nurse retention. The strongest predictor of nurse job dissatisfaction and intent to leave a job is personal stress related to the practice environment. The various causes of job stress include patient acuity, work schedules, poor physician–nurse interactions, new technology, staff shortages, unpredictable workflow or workload, and the perception that the care provided is unsafe (Groff-Paris & Terhaar, 2010). Surveys of practicing nurses document that job dissatisfaction, patient safety concerns, decreases in quality care, inadequate staffing, patient care delays, and mandated overtime are issues that negatively affect nursing practice (Aiken et al., 2002; Cooper, 2004; Pellico et al., 2009). Nurses have also reported their concern about their own health and safety issues, with job stress the most frequent health problem reported.

Despite the effort to address the issues of the chaotic and potentially harmful work environment, strategies to address these issues have fallen short of the target, and the dissatisfaction of hospital nurses persists. In national studies, 41% of nurses currently working report being dissatisfied with their jobs, 43% score high in a range of burnout measures, and 22% are planning to leave their jobs in the next year. Of the latter group, 33% are younger than age 30 years (Beecroft, Dorey, & Wentin, 2008; Laschinger, Finegan, & Welk, 2009). These factors help to fuel the shortage of nurses.

In 2008, 29.3% of RNs reported that they were extremely satisfied with their principal nursing positions, 50.5% were moderately satisfied, and 11.1% were dissatisfied (HRSA, 2010). Nurses working in academic education, ambulatory care, and home health settings reported the highest rate of job satisfaction (86.6%, 85.5%, and 82.8%, respectively). Almost 12% of RNs employed in hospitals reported moderate or extreme dissatisfaction (HRSA, 2010).

The retention of competent professional nurses in jobs is a major problem of the U.S. healthcare industry, particularly in hospitals and long-term care facilities. An average yearly nurse turnover rate is reported as 5–21% (PricewaterhouseCooper's Health Research Institute, 2007). Other research has found that during the first year of professional practice, new RNs experience turnover rates around 35–61% (Almada, Carafoli, Flattery,

French, & McNamara, 2004). Kovner and colleagues (2007) found that 13% of newly licensed RNs had changed principal jobs after 1 year, and 37% reported that they felt ready to change jobs (Huntington et al., 2012; Pellico et al., 2009). In a comprehensive report initiated by the AHRQ, the authors found that the shortage of RNs, in combination with an increased workload, poses a potential threat to the quality of care. In addition, every 1% increase in nurse turnover costs a hospital about \$300,000 a year.

Complexity of Nursing Work

The healthcare workplace has changed over the past 20 years in response to economic and service pressures. However, some of these reforms have had undesirable consequences for nurses' work in hospitals and the use of their time and skills. As the pace and complexity of hospital care increases, nursing work is expanding at both ends of the complexity continuum. Nurses often undertake tasks that less qualified staff could do, while at the other end of the spectrum they are unable to use their high-level skills and expertise. This inefficiency in the use of nursing time can also negatively affect patient outcomes. Nurses' work that does not directly contribute to patient care, engage higher-order cognitive skills, or provide opportunity for role expansion can decrease retention of well-qualified and highly skilled nurses in the health workforce (Duffield, Gardner, & Catling-Paull, 2008).

The major barrier to making progress in patient safety and quality is the failure to appreciate the complexity of the work in health care today. Current research focusing on work complexity and related issues enables an increased understanding of RN decision making (the invisible, cognitive work of nursing) in actual care situations and demonstrates how both the knowledge and competencies of RNs as well as the complex environments in which RNs provide care contribute to patient safety, quality of care, and healthy work environments or lack thereof (Ebright, 2010).

Krichbaum et al. (2007) identify a nurse care-delivery experience they term "complexity compression" and note this experience occurs when nurses are expected to assume, in a condensed time frame, additional, unplanned responsibilities while simultaneously conducting their other multiple responsibilities. Nurses report that personal, environmental, practice, administrative, system, and technology factors, as well as autonomy and control factors, all contribute to this experience. Associated with complexity compression is the phenomenon of stacking. Stacking is the invisible, decision-making work of RNs about the what, how, and when of delivering nursing care to an assigned group of patients (Ebright, Patterson, Chalko, & Render, 2003). This process results in decisions about what care is needed, what care is possible, and when and how to deliver this care.

A commitment to understanding and appreciating the complexity involved in RN work is needed to guide the more substantive and sustained improvements required to achieve safety and quality. Attention to

and action based on an understanding of the complexity of RN work and the value of safe, quality care; desired patient outcomes; and nurse recruitment and retention have the potential to achieve the goals of healthy work environments. Using complexity science to understand the work of nursing is becoming increasingly accepted as a very fitting approach to explaining healthcare organizational dynamics and the work of nursing (Lindberg & Lindberg, 2008).

Nursing Education

The healthcare system of the 21st century is complex, technologically rich, ethically challenging, and ever changing. The roles of all healthcare providers evolve continually, and boundaries of practice shift regularly. Knowledge explodes at unprecedented rates, and although the evidence base for practice grows stronger every day, healthcare providers must repeatedly make decisions and take action in situations that are characterized by ambiguity and uncertainty (Cowan & Moorhead, 2011).

Throughout the years, nursing education has made an effort to transition its curriculum and programs to accommodate the knowledge explosion and the advanced technology associated with health care. However, the transition within the programs of nursing has assumed a patchwork approach instead of significant reform. This is in part the result of the tradition associated with the history of nursing education, the inability to resolve the differences in prelicensure programs, and faculty propensity to be reluctant to “leave behind” what is no longer successful in a changing practice arena. In addition, nurse educators are caught in the “perfect storm” composed of a changing healthcare delivery system, changing practice models, nursing shortage, faculty shortage, changes in external standards of care and educational accreditation, university budget cuts, and changes in external funding that support new nursing programs.

In 2003, the IOM issued a report titled *Health Professions Education: A Bridge to Quality* (IOM, 2003a). This report, which focuses on knowledge that healthcare professionals need to provide quality care, states that students in the health professions are not prepared to address the shifts in the country’s demographics nor are they educated to work in interdisciplinary teams. It further states that students were not able to access evidence for use in practice, determine the reasons for or prevent patient care errors, or access technology to acquire the latest information. Specifically, the report expresses concern with the adequacy of nursing education at all levels, yet focuses intensely on education at the prelicensure level. The report identifies five core competencies that all clinicians should possess: (1) provide patient-centered care, (2) work in interdisciplinary teams, (3) use evidence-based practice, (4) apply quality improvement and identify errors and hazards in care, and (5) utilize informatics (IOM, 2003a).

KEY COMPETENCY 5-4

Examples of Applicable
*Nurse of the Future: Nursing
Core Competencies*

Systems-Based Practice:

Knowledge (K2a)

Understands the impact of
macrosystem changes on
planning, organizing, and
delivering patient care at
the work unit level

Attitudes/Behaviors (A2a)

Appreciates the complexity
of the work unit environment

Source: Massachusetts Department of Higher
Education. (2010). *Nurse of the future:
Nursing core competencies* (p. 19). Retrieved
from [http://www.mass.edu/currentinit/
documents/NursingCoreCompetencies.pdf](http://www.mass.edu/currentinit/documents/NursingCoreCompetencies.pdf)

KEY COMPETENCY 5-5

Examples of Applicable
*Nurse of the Future: Nursing
Core Competencies*

Leadership:

Knowledge (K1) Identifies
leadership skills essential to
the practice of nursing

Attitudes/Behaviors (A1)
Recognizes the role of the
nurse as leader

Source: Massachusetts Department of Higher
Education. (2010). *Nurse of the future:
Nursing core competencies* (p. 17). Retrieved
from [http://www.mass.edu/currentinit/
documents/NursingCoreCompetencies.pdf](http://www.mass.edu/currentinit/documents/NursingCoreCompetencies.pdf)

In 2005, the National Council of State Boards of Nursing (NCSBN) released five recommendations regarding prelicensure clinical instruction. These recommendations address the appropriate or desired setting of clinical experience, the scope of clinical experience, the qualifications of clinical faculty, the role of nursing faculty in clinical education, and the need for research. The NCSBN board has also done work associated with postgraduate nurse competence that includes clinical reasoning and judgment, patient care delivery and management skills, communication and interpersonal relationships, and recognizing limits and seeking help (Li, 2007).

Despite these changes, new standards of instruction, and new competencies for postgraduates, the educational preparation of nurses has remained virtually unchanged for more than 50 years. Nursing education remains content focused and teacher centered (Valiga & Champagne, 2011). Recently the results of two national studies reinforced the belief that nursing education must be reformed. The two reports, *Educating Nurses: A Call for Radical Transformation* (Benner, Sutphen, Leonard, & Day, 2010) and *The Future of Nursing: Leading Change, Advancing Health* (IOM, 2011), explore the issue of whether nurses are entering practice equipped with the knowledge and skills needed for today's practice and prepared to continue clinical learning for tomorrow's nursing, given the enormous changes in and complexity of current nursing practice and practice settings. In both reports the response is that nurses are not prepared for future healthcare change. Both reports challenge nursing education to make reforms in preparation of new graduates in terms of establishing new competencies and outcomes for graduates, new curriculum designs, new pedagogy, better evaluation models, and new models for clinical education, such as residency programs.

In response to the changes in healthcare delivery and the call for new roles in nursing, two new degrees have been introduced by the AACN since the turn of the century: the doctor of nursing practice and the clinical nurse leader (AACN, 2007). The **clinical nurse leader (CNL)** is an advanced generalist role prepared at the master's level of education. The CNL oversees the coordination of care for a group of patients, assesses cohort risk, provides direct patient care in complex situations, and functions as part of an interdisciplinary team (AACN, 2007). The lateral integration of care has been what is missing in the delivery of care to patients with complex needs. No single person oversees patient care laterally and over time and is able to intervene, facilitate, or coordinate care for the entire patient experience. The CNL will be instrumental in helping all disciplines see the interdependencies that exist between and among them (Begun, Hamilton, Tornabeni, & White, 2006).

The other new program within nursing is the **doctor of nursing practice (DNP)**. The need for this terminal practice degree is based on the series of reports from the IOM that

CRITICAL THINKING QUESTION *

How do changes in nursing education reflect nursing's responsibility in the context of the social contract discussed earlier in this chapter? *

address quality of health care, patient safety, and educational reform, as well as following the movement of other healthcare professions to the practice doctorate. After much national debate, it was determined that a practice doctorate was needed that encompasses any form of nursing intervention that influences healthcare outcomes for individual patients, management of care for individuals and populations, administration of nursing and health organization, and the development and implementation of health policy (AACN, 2004). It is clearly stated that this practice degree is not the same as the research doctoral degree and that graduates would be prepared to blend clinical, economic, organizational, and leadership skills and to use science in improving the direct care of patients, care of patient populations, and practice that supports patient care (Champagne, 2006).

The development of the DNP and the CNL programs of study represents a bold effort by the profession of nursing to address new roles of nursing and educational reform needed to prepare graduates to meet the healthcare needs of the future. Although questions and concerns related to the implementation of these new programs still exist, the evaluation of the implementation of these programs is mostly positive. One must applaud the spirit of evidence-based educational innovation.

Closing the Education and Practice Gap

The gap between education and practice looms larger as the healthcare setting continuously changes. In general, curriculums in nursing programs have not evolved to keep pace with changes in the practice setting; however, the current emphasis on integrating clinical simulation, the dedicated education unit, and nurse residency programs are steps in the right direction.

Evidence supports that a better-educated nurse is needed in practice. The initial educational preparation for the largest proportion of RNs is the associate degree. During the last national nurse survey in 2008, the initial educational level of RNs indicated that 20.4% were diploma, 45.4% were associate degree, and 34.2% were baccalaureate (HRSA, 2010). Leaders in nursing education must identify a way to move younger students to the desired graduate level of education more expediently.

Where do we go from here? The IOM report *The Future of Nursing: Leading Change, Advancing Health* provides us with a blueprint (IOM, 2011). The IOM and Robert Wood Johnson Foundation partnered to access and respond to the need to transform nursing to ensure that the nursing workforce has the capacity, in terms of numbers, skills, and competence, to meet the present and future healthcare needs of the public. This transformation would enable nurses to be partners and leaders in advancing health for the future. The key messages of the study include: (1) nurses should practice to the full extent of their education and training, (2) nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic

KEY COMPETENCY 5-6

Examples of Applicable
*Nurse of the Future: Nursing
Core Competencies*

Leadership:

Knowledge (K5) Explains the importance, necessity, and process of change

Skills (S5b) Anticipates consequences, plans ahead, and changes approaches to get best results

Attitudes/Behaviors (A5b)
Values new ideas and interventions to improve patient care

Source: Massachusetts Department of Higher Education. (2010). *Nurse of the future: Nursing core competencies* (p. 18). Retrieved from <http://www.mass.edu/currentinit/documents/NursingCoreCompetencies.pdf>

CRITICAL THINKING QUESTIONS ★

Based on the trends and recommendations presented in this chapter, what do you think nursing education will look like in 2025? What do you think the profession of nursing will look like in the year 2025? ★

progression, (3) nurses should be full partners, with physicians and other health professionals, in redesigning health care in the United States, and (4) effective workforce planning and policy making require better data collection and an improved information infrastructure (IOM, 2011, p. 4). Recommendations include to: (1) remove scope-of-practice barriers, (2) expand opportunities for nurses to lead and diffuse collaborative improvement efforts, (3) implement nurse residency programs, (4) increase the proportion of nurses with a baccalaureate degree to 80% by 2020, (5) double the number of nurses with a doctorate by 2020, (6) ensure that nurses engage in lifelong learning, (7) prepare and enable nurses to lead change to advance health, and (8) build an infrastructure for the collection and analysis of interprofessional healthcare workforce data. It is imperative that professional nurses control their future and redefine their roles in practice; the recommendations and the strategies identified in this report provide the way.

Conclusion

Now, when you hear the word *nursing*, what image comes to mind? If the picture is blurry or confused by the expanding social context presented in this chapter—good! The cloudiness indicates that the tradition continues to be questioned. We have looked at some of the social phenomena and trends that help define nursing. Because those experiences change constantly, what we envision now will also be transformed. Are you ready to be a part of transforming professional nursing practice as we transition our profession into a future that continues to meet the needs of society?

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