

# NURSING

## Our Mission and Passion

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By MELANIE C. DREHER, RN, PhD

**A**s a nurse of many decades and as chair of the Trinity Health board of directors, there is seldom a day I do not contemplate the nearly 26,000 nurses in 21 states who capably and compassionately perform their healing ministries in the clinics, patients' homes, hospitals, nursing homes and physician practices that comprise Trinity Health. Their stories and the stories of nurses in this issue of *Health Progress* are a tribute to the millions of colleagues throughout the world who leave their homes each day to do the hardest job they'll ever love. The gathering of experiences and insights in this volume, by nurses, about nurses and the work they do, is testimony to their expansive and essential role in health care.

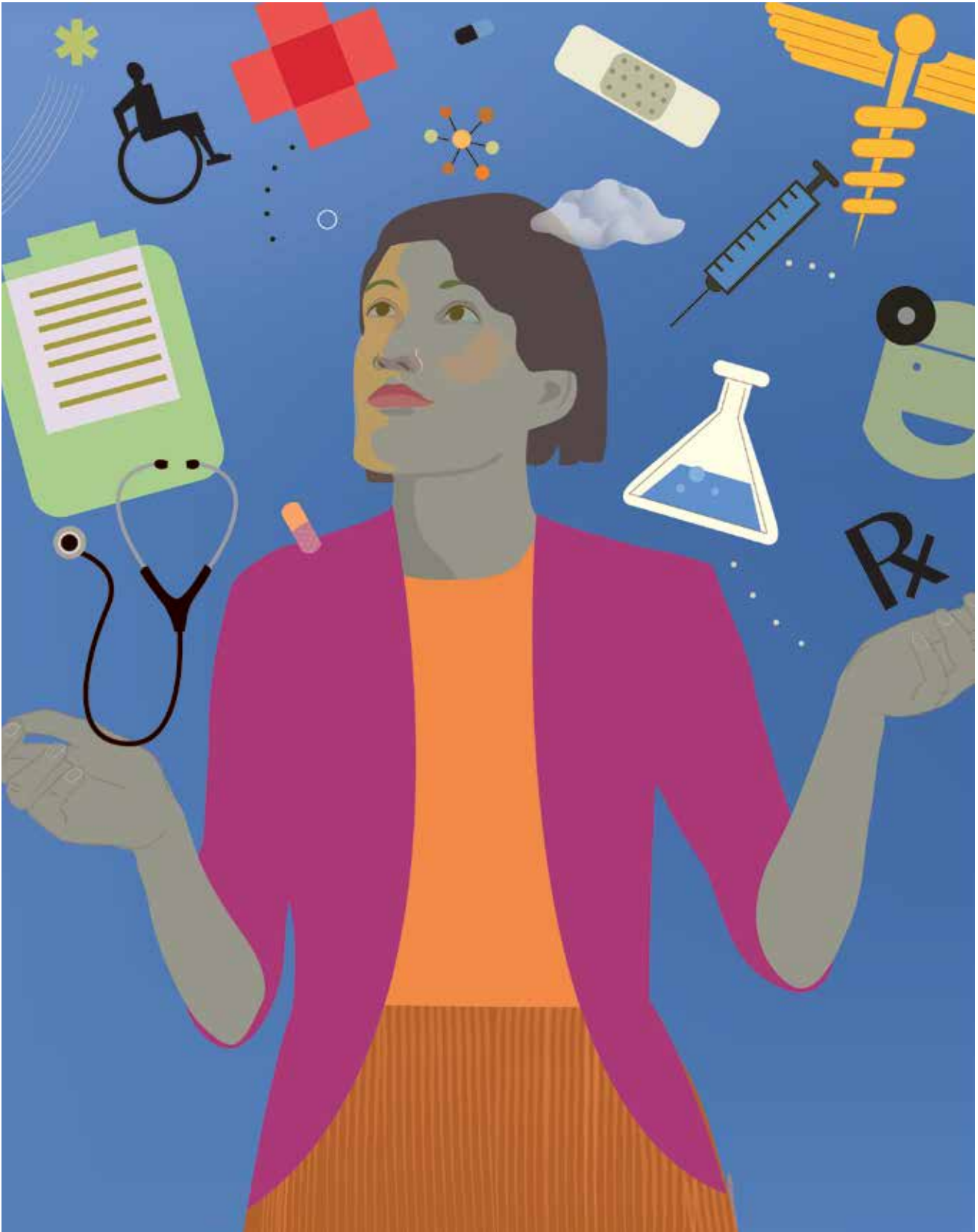
With the presence of three nurses on the Trinity board, it is easier to communicate the centrality of nursing to a people-centered care mission. One of the things I have learned, however, from serving on health industry boards, composed mostly of non-health-care providers, is that nurse work isn't well understood. How many times have we heard patients surprised by the knowledge and expertise of the nurses who cared for them? Most people have no idea that it was likely a nurse who administered their anesthesia or that the hospitalist who ordered their transfer to intensive care was a nurse, or that nurses are CEOs of hospitals, chief officers of health departments, researchers and scientists, policymakers and presidents of universities.

The traditional image of nurses taking vital signs, administering medication, changing dressings, ambulating, hydrating, turning, and carrying out physicians' care plans is not incorrect, but it is just a slice of a much bigger narrative. Interestingly, the poignant nurse stories in these pages seldom mention such activities. Rather, they are about the mission and passion of nursing: keep-

ing people well, safe, comfortable, informed and whole; they are about building the capacity to manage their health in every stage of life, or, as Florence Nightingale succinctly described it, "helping people live well."

People are admitted to hospitals and nursing homes, home care and hospice services because they require the ongoing expert vigilance of nurses who will protect them, advocate for them and promote their recovery or transition. Whether nurses work in acute, long-term or home

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care, in clinics, physician offices, schools or factories, and whether their patient is an individual, family, organization or entire community, they are about creating health as well as treating disease. They establish therapeutic relationships, assess and evaluate, purposefully communicate, monitor conditions, apply clinical judgment, determine their patients' expectations and goals and formulate their care plans accordingly.

Nurses also oversee the "house": those places where nurses work, physicians visit and patients are cared for 24 hours a day, 365 days a year. In hospitals and other residential care venues, nurse administrators design and organize caregiving; they recruit and retain the volume and quality of staff required for complex patients; they review standards and protocols and translate evidence into practice so that patient-care technology is both safe and cost-effective. Ultimately, they lead a culture of safety and patient-centric care, in which nurses practice at their full potential

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in high functioning interprofessional teams. Far beyond Disney hospitality programs, checklists and rounds, this culture's development begins with a scrutiny of patients' total experience and a penetrating grasp of the barriers nurses face when ministering to patients at the point of care. Framed in the vernacular of Catholic health care, they create a spiritual culture of encounter that is authentic and formative for both the patient and the nurse.

### THE INVISIBLE NURSE

Given their pivotal role in health care, why should there be so much confusion about what nurses do? Given that we are 3 million strong and have been voted the most trusted profession in America since our inclusion in the Gallup poll in 1997, why is it that the same public considers nurses the least influential profession in health care reform? The answer may lie in the invisibility of nurses and nurse work, an invisibility that takes many forms, writ small and large. It would be hard, for example, to find the word "nurse" on a hospital

invoice, even though nurses constitute the hospital's core business, largest professional group and greatest cost. Even in magnet hospitals, nursing services are folded into room-and-board charges, not unlike housekeeping in the hotel industry.

The professional title "nurse" has been replaced by "colleague" or "associate," and some nurses still are not permitted to put their last names, professional degrees or certifications on their identification badges. This would never be tolerated by other health professionals. And despite protestations, advanced practice registered nurses (APRNs) still are commonly referred to as "physician extenders" and "mid-level providers," as if advanced nurse work were simply a component of physician work — that if we didn't have APRNs, physicians would be doing everything APRNs do.

There also is a tendency to measure the value of nurse work by what does *not* happen. Like firefighters or security officers, nurses are in a perpetual state of watchfulness and anticipation — prepared to rescue or, even better, to avert the need to rescue. The non-occurrence of negative outcomes is, of course, a desired goal of patients, families and the nurses who oversee their care. But when acknowledgment of nurse work is almost exclusively about the avoidance of harm (e.g. falls, pressure ulcers, central line infections), it creates a kind of career dissonance: Most nurses enter the profession because they want to "do good" and "help people."

Not surprisingly, nurses are rarely invited to decision-making tables. Less than 3 percent of directors on hospital boards are nurses, and 76 percent of hospitals have no nurses on their governing boards. Marie Rohde's article (see page 12) that describes the struggles nurses encounter in pursuit of influence provides insight into this kind of invisibility. Her examples of nurses who hid or altered their professional identity in order to be considered for leadership roles in health care are legendary. Dame Cicely Saunders, dedicated nurse and founder of the worldwide hospice movement, could not convince the powerful UK physician community to support humane and holistic care of the dying until she went to medical school and became a physician herself. Sr. Carol Keehan, DC, was able to retain her nursing identity, yet her experience of having



her ideas for making health care accessible to the poor “shot down” by the businesspeople of health care (whose imagination stopped at what was “covered”) until she acquired a master’s in business administration, is all too familiar.

#### NURSING’S SPECIAL POWER TRIP

Of course, Dame Cicely and Sr. Keehan both went on to become two of the most influential health care leaders in the world, driven not by the pursuit of power, but by their deep commitment to social justice and their understanding of the people they serve. Women and men choose to be nurses for many reasons, but becoming rich, famous or powerful typically are not among them. Nurses pride themselves on relationships with patients that are intimate and egalitarian rather than authoritative. They value their reputation as the honest brokers of health care, guided by the needs of patients rather than personal or professional advantage.

While these values are reinforced in nursing education, learning how to sustain them in practice is seldom included in the curriculum. Unequipped to navigate organizational power gradients and political nuances they may face when entering certain practice environments, some new graduates discover that doing the right thing for the people they serve calls for more courage and self-confidence than they imagined. There are times when even the most clinically adept and value-driven nurses may wonder whether advocating for their patients will put their professional relationships and even their employment in jeopardy.

The problems created by nurse powerlessness — whether perceived or real — are not trivial. Patients, vulnerable and in crisis, expect nurses to act on their behalf. When nurses cannot meet these fundamental expectations, the people for whom they care are at risk. Nurses experience frustration, disengagement and moral fatigue. Some even leave the profession. Others, as Roxanne O’Brien’s insightful commentary indicates, (see page 68), may turn to unions where the strength of collective bargaining mitigates individual powerlessness, but not without creating new ethical dilemmas.

Within the past five years, the nursing profession has experienced two major calls to action,

referenced frequently in this issue. In 2010, passage of the Affordable Care Act (ACA) identified a compelling need for more APRNs to ensure quality care for aging and chronically ill populations, including those with behavioral and mental health problems, as discussed in Jeffery Ramirez’s fine article (see page 42). It also challenged educators to prepare nurses for team-based practice, the complexity of which is captured by Ter-

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rence Cahill and Laura Cima in their discussion of facilitating teamwork in nursing (see page 62). Just months later, the Institute of Medicine (IOM) published *The Future of Nursing: Leading Change, Advancing Health*. Similar to the ACA, it recommended radical increases in the number of APRNs but, most importantly, challenged the nursing profession to lead the redesign of health care.

Why would nursing be identified for this challenge? According to Donna Shalala, chair of the IOM Future of Nursing Task Force, health care cannot afford to overlook nurses as the nation seeks to increase access, improve quality and reduce costs through primary care, preventive services and community-based health management: “The only way to understand what we’re going through in health care is by understanding people’s lives.”

Understanding people’s lives is the unique and essential contribution nurses bring to the care equation; it is the foundation for patient-centric, cost-effective, high-quality care management. Indeed, this *Health Progress* issue is replete with examples of nurses whose intimate knowledge of patients’ pathways to illness, fears about their condition and expectations of treatment became the underpinning of care redesign and health promotion: Patricia Beach’s experience that successful palliation is grounded in careful listening and respect for patients’ decisions (see page 51); Anna Hardy’s courageous, mission-driven work, informed by her knowledge of East St. Louis cul-

ture and its people (see page 33); Elizabeth Ann Scarborough's gripping narrative that we cannot address post-traumatic stress syndrome unless we understand each patient's personal "battlefield" (see page 36); Lauran Hardin's inclusion of the *situated person* in the formula to improve care and reduce the cost of frequent ED patients (see page 28); D'Anna Springer's and Kristine Todd's reliance on patients' life stories to customize evidence-based management of hospitalized elders (see page 72); and Kathy Okland's discussion of the important role of nurses in health care facility design because they know patients' need and providers' best path to care (see page 58).

In each case, they engage recipients of care in a dialogue that creates a psychological and social context for understanding their pain and planning their care. The stunning examples of three nurses described by Ann Hendrich, who assumed accountability for improving the health of their patient populations, are testimony to the readiness of nurses to lead change (see page 47). They identified opportunities, applied evidence, made the case for cost-effectiveness, convened interprofessional teams and measured outcomes for dissemination. Three amazing population health success stories, and no one had to deny or change their identity as nurses to get the job done.

#### **CONSUMERS: NURSES' BEST FRIENDS**

Independent of nurses being catapulted into leadership by the ACA and IOM, it is likely that the emerging consumerism in health care will significantly enhance nurses' influence. The relatively recent monitoring of hospital *patient experience*, for example, acknowledges that consumers' perceptions of care are important and that patients and families will not quietly tolerate indifferent care, even when medically appropriate and safe. As discerning customers informed by the Internet, patients are not hesitant to then use the Internet to tell their own hospital stories, good and bad.

Measures of patient experience work for nurses as well, providing opportunities to underscore their positive contributions and to leverage the reputation and financial incentives of good scores on behalf of patients and families. In

many ways, this measure reveals and formalizes the informal connection nurses always have had with patients. "Ask a nurse" is the way most new residents in a community determine which physicians and hospitals they will choose for their care. And when it is possible to actually plan for a hospitalization (e.g. childbirth, making up 25 percent of hospital admissions), pregnant families now consult the Internet, "get the skinny" from savvy nurses they know, and select the care site where they are least likely to have cesarean section and most likely to have a baby-friendly nursery.

Today, cost-conscious consumers with high deductible or narrow network insurance actively shop for more convenient, less expensive care venues and providers with high patient satisfac-

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tion ratings, also available on the Internet. Persons who have experienced nurses in retail clinics, travel clinics, occupational health clinics, nurse-midwife practices and behavioral health practices, as well as specialty services such as pain management, wound care, weight reduction centers, cardiac monitoring and cancer management, are impressed with the low-cost, high-satisfaction value proposition nurses offer. Successful primary care and specialty physicians have invested in risk-sharing practices with APRNs in order to offer cost-effective, interprofessional, person-centric care — enhancing patient loyalty and expanding practice volume.

Health care consumerism begs a re-examination of traditional business models in which physicians are seen as revenue centers and nurses as cost centers. Given their impact on safety, quality, patient experience and reputation, nurses are, at the least, revenue enhancers. Most hospitals and physician practices miss the opportunity to leverage high-performing nurses who also are knowledgeable and trusted members of the community. When nurses are provided the resources to do



their work well, they embody institutional integrity, inspire patient loyalty and engage physicians, pharmacists, dieticians and therapists in creating optimal, patient-centric care. Nurses know their customers — what they want, what they need, and what they do and don't get in their health care encounters.

### CREATING THE FUTURE OF NURSING

Much has happened since 1919 when the University of Minnesota started the first university Bachelor of Science degree in nursing, a milestone in a fascinating social movement that would incontrovertibly alter nursing and health care. Once exposed to other disciplines, nurse scholars began the inevitable search for new knowledge to inform practice, eventually shepherding Master's and PhD programs in nursing. Expanding nursing knowledge inevitably generated more sophisticated practice, and, in 2005, the National Academy of Science recommended the nursing profession develop a practice doctorate — not unlike the MD, DDS or DPT — to prepare nurses for clinical leadership.

Endorsed by the American Association of Colleges of Nursing, the Doctor of Nursing Practice (DNP) became the degree of choice for promoting interprofessional, team-based care and driving accountability for quality, safety and cost. There are now over 130 PhD programs and approximately 300 DNP programs in the United States that will produce the legion necessary to redesign health care.

The call for increased numbers of nurses — particularly APRNs — has created a quandary for educators and workforce planners trying to predict the number of nurses required in the future. But, as Beth Brooks suggests in her article (see page 18), the volume of nurses may be secondary to the kind of nurses required. This collection of nurse stories confirms the need to educate differently. We always will have to prepare the highest quality clinician, but the ability to lead large-scale, sustainable change demands more than clinical knowledge and expertise, as exemplified in the article (see page 55) by Coletta Barrett and Sue Catchings, who ingeniously embedded primary care and behavioral health in Louisiana school-based health centers. It requires the ability to gar-

ner the respect of a whole team, render ideas into innovation, understand and leverage economic and political imperatives on behalf of patients, expand the focus of practice from individuals to populations and translate their familiarity with what people want and need into products and services that will transform health care. Nurses must acquire a leadership persona and perhaps, most important, be able to articulate and demonstrate the value they bring to practice and to people.

As long as there are communities of human beings, we will need nurses to help them live well. Nursing, as Diane Ceravolo, Roger Griffiths and Olivia Helfer exquisitely point out (see page 24), is a fundamental and universal human relationship — both practical and spiritual in nature. Technology will expand and enhance the practical side of the nursing relationship, but it will never replace the essential affective and spiritual component to which patients resonate.

It is time to stop lamenting the alleged absence of “clinical learning sites” (usually acute care) and acknowledge that wherever we have a breathing human being, we have a learning opportunity. It also is time to let go the attempt to match the number of nurses with the number of jobs. Nurses of the future must be continuous learners and innovators, prepared not just to take a job, but to make a job.

As a nation standing on the brink of great transformation in health care, the message for all nurses is that we cannot afford to demur. There is simply too much at stake. This is not about power for its own sake. It is not even a professional issue. It is about living our profession's commitment to healthy communities, universal access and people-centered services, at a cost they can afford. The power of nurses — “the avatars of love” in Brian Doyle's breathtaking “Song for Nurses” (see page 11), always has derived from our covenant with our patients and always will.

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