

VIEWPOINT

A Failure to Rescue Ourselves

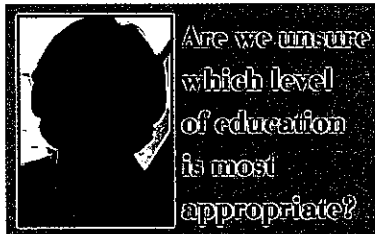
Nurses need to agree on one entry point into the profession.

A Gallup survey commissioned by the Robert Wood Johnson Foundation and released in late January found that “thought leaders” from government, corporations, health services, and universities believed nurses had less influence on the health care reform process—and would have less influence on its implementation—than all other groups, including patients, physicians, government employees, and insurance and pharmaceutical executives. Participants in the survey, *Nursing Leadership from Bedside to Boardroom: Opinion Leaders’ Perceptions*, suggested that nurses were hampered in attaining more influence and leadership by, among other factors, the perception that they’re not “important decision makers” and that they lack a “single voice” on national issues.

This should come as no surprise. Nurses may excel at individual decision making, but collectively we’ve failed to make the most basic choice of all: the level of education needed for professional practice. Allowing multiple entry points into nursing—via an associate’s, a bachelor’s, or a more advanced degree—implies that we’re unsure which level of education is most appropriate.

Despite the National Advisory Council on Nurse Education and Practice’s call in November 2001 for two-thirds of the workforce to have a baccalaureate or a more advanced degree by 2010, more than 60% of RNs still hold just an associate’s degree or diploma, according to the results of the U.S. Department of Health

and Human Services’ 2008 *National Sample Survey of Registered Nurses*. It’s time to stop arguing and gain consensus on the baccalaureate as the minimum entry point into nursing practice.



A landmark study by Linda H. Aiken, PhD, RN, and colleagues, published in *JAMA* in 2003, analyzed outcomes for more than 230,000 surgeries and found that a 10% increase in the proportion of nurses with bachelor’s degrees was associated with a 5% decrease in mortality and failure to rescue. Besides the current focus on hospital-based outcomes, nurses are faced with rising patient acuity, decreasing length of stay, patients with multiple comorbidities, new medications, and advances in technology. Kathleen Krichbaum, PhD, RN, and colleagues, writing in *Nursing Forum* in 2007, noted that the comprehensive result of these factors for nurses is a more compressed and complex workload. Regardless of position, every nurse today has been asked to do more with less.

Yet it seems that even our organizational structure prevents us from mobilizing our resources. The infighting that we privately acknowledge and publicly deny has resulted in two bodies, the National League for Nursing

and the American Association of Colleges of Nursing, that accredit disparate educational tracks. We also have different licensure requirements per state. The more energy we spend protecting our group identities, the more our collective identity will suffer.

In a 1983 article published in *Advances in Nursing Science*, Susan Jo Roberts, DNSc, RN, ANP, described nurses’ inability to unify as a symptom of “oppressed group behavior.” Overpowered by a medical model that focuses on costs and cure more than on a holistic nursing approach, historic male dominance, and a for-profit disease care business model, nurses at every level unconsciously express their perceived powerlessness by infighting. This was exemplified in February, when nurses again failed to agree on an entry-level requirement at the final *Forum on the Future of Nursing* in Houston, sponsored by the Institute of Medicine and the Robert Wood Johnson Foundation.

The term “failure to rescue” signifies that the last, best chance to avoid a tragedy wasn’t acted upon in sufficient time to prevent disaster. If we don’t stop the infighting, rally around this incredible profession, and form a single powerful governing body representing this workforce of 3 million strong, we will have failed to rescue ourselves. ▼

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