Moral Courage: Putting Ethics Into Action

by Cindy Zolnierek, MSN, RN, TEXAS NURSING Voice Contributor and TNA Director of Practice

On February 19, 2010, the Austin American-Statesman printed an article about a local Austin hero who helped rescue five people from the burning Echelon I building after it was struck by an airplane. Robin De Haven, a passerby headed for a lunch break, stopped to help and used a 20-foot ladder from his glass installation truck to assist people trapped on the second floor of the burning building to escape. According to the Statesman, De Haven didn’t think of himself as a hero. “I was just thinking about what I had to do,” he explained. The Austin community celebrated his courage to act and help others, despite the physical risk to his own safety.

Almost a year prior to that small plane crash in Austin, two other individuals engaged in a courageous act to protect the lives of Texans. Like De Haven, they did not consider themselves heroes and simply perceived their actions as their duty. Unlike De Haven, their risk was not physical and their action was not immediately celebrated. Instead, the two registered nurses, Anne Mitchell and Vicki Galle, were arrested for reporting a patient care concern and charged with a felony. High stakes indeed! These individuals ended up risking the most fundamental of our rights as American citizens: the right to liberty.

The Beginning

The Mitchell/Galle story began in a small critical access hospital in a rural West Texas town. Two long-term nurse employees of the hospital, Mitchell and Galle, identified a violent attack on patient safety purported by a physician’s practices. They appropriately brought their disturbing observations to the attention of the hospital administrator, yet no action was taken and adverse patient events continued to occur at the hands of the physician. As nurses, they had a legal duty to advocate for patient safety – a duty they never questioned.

Although an illegal hospital policy prohibited employees from external reporting, Mitchell and Galle appropriately determined rightly so that their duty to patient safety superseded that hospital policy. Together, they wrote a letter to the Texas Medical Board documenting their concerns. The letter identified patient medical record numbers so the Texas Medical Board could review specific cases and determine whether the medical standard of care was met. The letter was submitted anonymously and included:

Courage: the strength to withstand danger, fear, difficulty.

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Join the Texas Nurses Association Today!

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Sovereign immunity is the legal doctrine that the government cannot be sued. This doctrine applies to all levels of government including cities, counties, state and federal. Originating from Old English law, sovereign immunity is the legal position that the state (the sovereign) can not commit a legal wrong and therefore, is immune from lawsuits.

There are times when government actually uses sovereign immunity as a legal defense. Such is the defense of a number of defendants from Winkler County, TX, in the civil lawsuit filed against them in federal court by Anne Mitchell and Vickilyn Galle – the two nurses known as the “Winkler County nurses.” Mitchell and Galle first captured nursing’s and the public’s attention in the summer of 2009 when they were indicted and arrested by Winkler County authorities for reporting patient care concerns at their hospital workplace. They were then also fired by the Winkler County Memorial Hospital. With the state criminal trial concluded in early February of 2010 with a not guilty verdict for Mitchell (charges against Galle had earlier been dismissed), their civil trial resumes.

Defendants in the civil trial include Winkler County; Winkler County Memorial Hospital; Stan Wiley, hospital administrator; Winkler County Sheriff Robert Roberts; Winkler County Attorney Scott Tidwell; District Attorney Mike Fostel; and the reported physician, Rolando Arafiles, MD.

Waiving Sovereign Immunity

A government can waive the right not to be sued. The State of Texas can waive sovereign immunity not only for the state, but also for lower levels of government such as counties and cities. Frequently, when the government gives its permission to be sued, i.e., waives sovereign immunity, it will limit the amount and type of damages that may be recovered. For example, it normally will prohibit the recovery of punitive or exemplary damages and limit the amount of certain other damages – such as pain and suffering - that can be recovered.

The Texas Public Employee Whistleblower Act is an example of a waiver of sovereign immunity. This act gives public employees an explicit right to sue the governmental entity that is employing them if they are retaliated against by that entity for reporting a violation of law by that entity or another public employee. The act limits the amount of damages that can be recovered based on the size of the governmental entity and also does not permit punitive or exemplary damages. The Texas Nursing Practice Act provides broader whistleblower protections than the Public Employee Whistleblower Act. It not only protects nurses who report a violation of law, but also protects nurses who report unsafe care internally within the facility, and it does not place a limit on the amount of damages a nurse who has been retaliated against may recover or prohibit punitive or exemplary damages.
“I am hesitant to place a signature on this information. Administration has made it clear that there will be no reporting of any problems without Administrative, Medical Staff and Board notification. This would certainly create an opportunity for [the administrator] to remove me from employment. At the appropriate time I will speak with an investigator, should the Medical Board determine that an investigation is warranted.”

The events that followed were surreal. Mitchell and Galle were indicted by a grand jury (which only heard from prosecutors), arrested, and charged with misuse of official information – a third-degree felony punishable by up to 10 years in prison. Both nurses were told that their services were no longer needed at the hospital and their employment was terminated. Now, two nurses, fulfilling their duty to patients by advocating for their safety, were potential felons, not heroes. What!!

Advocacy
Patient advocacy is the heart and soul of nursing practice. In the hospital, it is the nurse who is physically present with the patient 24/7. It is the nurse who interacts with all the other health care team members to coordinate the patient’s care. It is the nurse who maintains surveillance of the patient and determines when an intervention may be needed to prevent a complication or untoward event. The nurse is an advocate for patient safety whether that entails calling a physician at 2:00 a.m. to report a change of condition, advising a colleague that a sterile field has been contaminated, or cancelling a procedure because a hospital-privileged surgeon is not available. It is the nurse who speaks up for the patient to protect them from harm.

Nurses understand their patient advocacy role and, when threats to patient safety are witnessed, they understand their need to report. Organizations committed to a culture of safety support and encourage the nurse’s advocacy role. In many ways, nurses are the “eyes and ears” of the organization. Nurses are in a position to inform the organization of problems that may lead to errors and negatively affect patients.

But what happens when an organization is conflicted? Where should the line on patient safety be drawn? In health care, the line is clear. It is referred to as the standard of care and it is defined by professional organizations such as the American Nurses Association that defines the standard of care for nurses, and the American Medical Association and American Osteopathic Association that define the standard of care for physicians.

Providers, such as nurses and physicians, are licensed to practice and expected to meet the standard of care of their state licensing boards – e.g., the Texas Board of Nursing and Texas Medical Board, respectively. Licensing boards are responsible for protecting the public by ensuring that those who hold a license are safe and competent practitioners. Likewise, organizations are responsible for meeting requirements defined in licensing regulations (e.g., Department of State Health Services rules) and accreditation standards (e.g., The Joint Commission) to ensure patient safety.

Reporting
What should nurses do when they witness individuals or organizations making decisions that place patients at risk? The Code of Ethics for Nurses is very clear about the nurse’s commitment to the patient first and foremost (see sidebar page 5). The nurse has an ethical responsibility to take action:

...when incompetent, unethical, illegal, or impaired practice is not corrected within the employment setting and continues to jeopardize patient well-being and safety, the problem should be reported to other appropriate authorities such as ...the legally constituted bodies concerned with licensing of specific categories of...professional practitioners (Provision 3.5).

The decision to report another practitioner is an ethical decision. Ethical decision making has been described as a four step process: 1) recognizing a moral issue; 2) making a moral judgment; 3) resolving to place moral concerns ahead of other concerns; and 4) acting on the moral concern (James Rest in Fletcher, Sorrell, & Silva, 1998). The fourth step requires moral courage, “the ability to use inner principles to do what is good for others, regardless of threat to self, as a matter of practice” (Sekerka, 2007, p.135).

The stakes are especially high when deciding to make a report external to the organization. Several authors distinguish between internal reporting and external reporting, or “whistleblowing” (Lachman, 2008; Sekerka & Bagozzi, 2007; Fletcher et al., 1998). Some consider whistleblowing a “moral action of last resort” (Fletcher et al., 1998). It is true telling to protect someone likely to be harmed (Lachman, 2008). Fletcher et al. (1998) suggests that there must be strong moral justification for whistleblowing, including:

1. A reason consisting of a grave injustice that is unresolved despite using internal channels to resolve
2. Moral justification through ethical theories or principles
3. Adequate investigation and fact-finding to ensure an accurate understanding of the situation
4. A primary loyalty to the patient
5. A determination that blowing the whistle will case more good than harm to the patient
6. An understanding of the seriousness of the action and a willingness to assume responsibility for the action

Mitchell and Galle’s reporting to the Texas Medical Board was a morally courageous act. They clearly recognized their duty to their patients, and they realized the seriousness of making a report outside the organization. Their awareness of the potential for personal negative repercussions was evident in their letter to the Texas Medical Board – if their identities were found out, they were certain to lose their jobs. Despite the severity of the consequences, the nurses did not back down.

“We did the right thing and we knew we did the right thing. We were confident it would come out in the end,” Mitchell stated at the trial. The nurses chose loyalty to their patients and professional code of ethics and put ethics in action. They demonstrated moral courage.

The backlash was worse than they could have imagined. While whistleblowers have been retaliated against in the past, we know of no situation in which a nurse has been criminally charged for patient advocacy efforts. The nurses faced a double bind: an ethical and legal responsibility to report, yet tremendous personal risk, up to 10 years in prison, for doing so.

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The health care community was outraged. Nurses, physicians, attorneys, and others throughout the nation contributed to a Legal Defense Fund established by Texas Nurses Association to assist nurses who are persecuted for advocating for patients. Besides the story being picked up by local, state and national news media, individual nurses, physicians and attorneys blogged commentaries denouncing the action against the nurses. Mitchell and Galle were “overwhelmed” by the tremendous support from colleagues. Lolly Lockhart, PhD, RN, who provided expert testimony during the trial stated, “I felt like I had a thousand nurses behind me.” The situation unified nurses on the most fundamental level: the nurse’s right and responsibility to advocate for patient safety.

The criminal case ended a grueling nine months later when the prosecutor dropped charges against Galle and a jury found Mitchell “not guilty” after only an hour of deliberation. But the story is not over. Mitchell and Galle have filed a federal civil lawsuit against the county, hospital, sheriff, county and district attorneys, hospital administrator, and physician alleging violation of civil rights and Texas whistleblower laws. A trial date has been set for November 16, 2010.

Ideally, whistleblowing would never occur. There would be no need. Organizational cultures committed to safety actively encourage internal reporting so that appropriate action can be taken to resolve the issue. Ethical organizations establish a climate that supports nurses’ ability to adhere to the profession’s code of ethics, and whistleblowing occurs as a failure of organizational ethics (Fletcher et al., 1998). When an organization fails to respond, and patient safety is threatened, outside reporting, or whistleblowing, may be the ethical action of last resort, an action requiring moral courage.

The Winkler County nurses’ story offers courage to nurses who are facing ethical dilemmas. There is tremendous support from the nursing community for nurses who are called upon to demonstrate moral courage. Mitchell and Galle are courageous heroes to be celebrated by all of us.

References
There is a nurse in West Texas who personifies the words *nursing support*, especially when it comes to patient safety and particularly when she senses a wrong. Her name is Sherrie Harris, RN. A native of Odessa with long experience in the ways of rural West Texas, Harris is a registered nurse who has worked in acute care practice for 12 years. She’s also president of Texas Nurses Association District 21, well into her second, two-year term of elected office.

When Harris first learned of the “Winkler County nurses” criminal trial, it was in early summer 2009, a day or so before the first pre-trial motions were set to be heard by the judge at the Winkler County Courthouse in Kermit, Tex. Since Kermit is a mere 30 miles or so from her home in Odessa – not all that far in West Texas parlance – Harris got in her car and drove to the Winkler County Courthouse to learn firsthand what the criminal case was all about. She wanted to understand how two nurses who advocated for patient safety could possibly end up criminally indicted. If her first suspicions proved true – that poor decisions had been made by just a few in a small town – she wanted to be a visible supporter of defendants Anne Mitchell, RN and Vicki Galle, RN, and the duty of nurses everywhere to speak out for patient safety.

By the time the criminal trial had come and gone in early February 2010, Sherrie Harris had attended nearly all of the pre-trial hearings, as well as the trial. With rural, West Texas life experiences in common, Harris found herself chatting with towns— and county folk at the cafe, in courthouse elevators and hallways, and on the streets of Kermit and Odessa, and Andrews, Tex., to where a change of venue had re-located the trial. After all, they all shared that friendly, conversational attitude of people who had lived their lives in West Texas’ small towns. And as a practicing registered nurse, Harris also found herself explaining from time to time – to a throng of news media and various citizens who asked – what the “Winkler County nurses” trial could mean to a nurse’s future ability to advocate for patients.

Now, the criminal trial is over. The lone defendant Mitchell was vindicated by a court jury verdict of not guilty. Charges against Galle were dismissed before the trial even began. For months on end since the summer of 2009, well respected news sources – national media included – dogged the story of the “outrageous” goings on in Winkler County and the criminal charges filed against two nurses who spoke out to protect patients from substandard care. The nurses had been the targets, many claimed, of vindictive prosecution in a small town. It was big news that spread way beyond the borders of Texas.

According to Sherrie Harris, the devastating fact of the “outrageous” ordeal of the “Winkler County nurses” trial is that a rural, West Texas community was caught in the middle of a firestorm of national visibility that sometimes included derogatory stereotyping of those who live in small, rural West Texas towns. The citizens of Kermit and Winkler County were all of a sudden in a spotlight of attention and controversy. Explained Harris, “Small towns are America. They are so important to our culture. It is where people actually know each other and frequently see each other …at local ball games, golf scrambles, rodeos and livestock shows, and functions at the local school gym or the church.”

In a state where 196 of its 254 counties are considered rural, Texas nurses in smaller, rural towns are generally “committed to their communities and quality health care,” confirmed Lolly Lockhart, PhD, RN. A native of Alpine, Tex., Lockhart also attended the criminal trial in Andrews County and served as an expert witness on a nurse’s duty to report. Lockhart explained to the jury of six men and six women the nurse’s duty and “moral obligation to patients and their families” to speak out for patient safety.

“Health care in smaller and rural communities is so important to local business growth and community prosperity,” said Lockhart, “and the case being given in a rural setting was a real eye opener.”

In the eyes of Lockhart, Mitchell and Galle were “humbling to be around” and the epitome of Texas nurses. The difference is, she summarized, most Texas nurses have not yet been faced with the unique kind of challenges presented in the Winkler County situation; the challenges that required the kind of individual moral courage that Mitchell and Galle demonstrated.

Clearly pleased with the “not guilty” verdict returned by the jury in the “Winkler County nurses” trial are, from left, Texas Nurses Association members Lolly Lockhart and Sherrie Harris, and TNA staffer Cindy Zolnierenk, director of practice.

Sherrie Harris called it a little differently by saying, “Doctors and nurses are precious commodities in small communities. Everyone in the community has a piece of the responsibility when it comes to quality health care,” she added, “and a nurse is the last defense for patient safety.” In Harris’ view, it’s a systems issue for communities. Referencing the trial she asked, “Where was the hospital board’s responsibility? What about the responsibility of other practitioners in the Winkler County facility?”

In the Texas Hospital Safe Staffing Law passed by the 2009 Legislature, enacted September 1, 2009, and supported by Texas Nurses Association, the Nurse Staffing Committees required of hospitals must meet at least quarterly and report at least twice a year to the hospital governing board. In a culture of safety, moral courage must extend beyond a single individual and into the entire facility. It is what can correct deficiencies and protect a quality of patient care.

Stated Harris, “I told someone last July that the county just ‘shot themselves in the foot’ because few, if any, health care providers would choose to work in an environment where reported concerns for patient safety end up getting you criminally indicted. It saddens me deeply to see the strife that has been falling on the Kermit residents.” Then Harris summarized it: “I hope the residents take a hard look at their county government and use their moral courage to correct the deficiencies.” ★
Nursing Practice Act. For example, Winkler County Memorial Hospital is subject to being fined by the Texas Department of State Health Services because its termination of the two nurses for reporting the physician violates the Nursing Practice Act. Texas Nurses Association (TNA), in fact, filed a complaint against the hospital on this very basis. However, if the federal court agrees with the County that the Nursing Practice Act does not waive sovereign immunity, the nurses will have to rely solely on the Public Employee Whistleblower Act for any damages for the hospital’s retaliation against them for reporting the physician.

TNA believes patients in public hospitals are best served if publicly-employed nurses have not only the same whistleblower protections as privately-employed nurses, but also the same right to sue for damages they suffer if they are retaliated against for advocating for their patients. In the 2009 legislative session, TNA had a legislative initiative to amend the Nursing Practice Act to add a waiver of sovereign immunity to the whistleblower provisions of the Nursing Practice Act. That initiative resulted in Rep. Donna Howard filing H.B. 2719. The bill was favorably reported out of committee but failed to pass the entire House. TNA has already begun working with Rep. Howard’s office and other stakeholders on similar legislation for the 2011 session.

It is the position of Texas Nurses Association that nurses have the same ethical responsibility to advocate for their patients regardless of their employment situation (public or private) and patients deserve no less. Nurses are best able to be patient advocates when they can fulfill their obligation without fear of retaliation. Legislation to waive sovereign immunity to the whistleblower protections in the Nursing Practice Act would ensure that all nurses share the same protections when fulfilling their duty to patients.

Sovereign Immunity continued from page 3

November 16, 2010 is the court date now set for the federal civil lawsuit of Anne Mitchell, RN and Vickilyn Galie, RN, filed last August against a number of defendants from Winkler County, TX. First, ordered the U.S. District Court Judge, all parties must attempt a second mediation by May 1, as a way to possibly resolve their differences.

Texas Nurses Association (TNA) reported Web updates continuously this past year on the “Winkler County nurses” criminal case as it drew a national following of people interested in the case. Information on the upcoming civil case is now being posted at txanurses.org. Or follow the news on Twitter @TexasNursesAssn – or #WinklerRNs.
Survey Says: Nurses’ Influence on Health Care is Untapped*

Gallup® polls usually reflect the public’s opinion. They have for more than 70 years been a standard in over 140 countries of a reliable and objective measure of public opinion on a wide range of topics. Gallup polls, conducted by the polling division of the Gallup Organization, have in the past uncovered social and economic trends, and proven over the years to have a high degree of accuracy.

In 2009, on behalf of the Robert Wood Johnson Foundation (RWJF), Gallup surveyed U.S. opinion leaders on their views of nursing and nursing leadership, particularly the role America’s nurses can and should have in improving access and quality of care, and containing costs. Results of this first-of-a-kind survey titled, Nursing Leadership from Bedside to Boardroom: Opinion Leaders’ Perceptions, were released at a news conference held January 20 at the National Press Club in Washington, D.C.

In presenting the findings, Dr. Risa Lavizzo-Mourey, president and CEO of RWJF, characterized the survey as “an action plan that will serve the nation.” She said, “Expanding the leadership of nurses is critical to health care reform. Opinion leaders recognize that we are squandering opportunities to learn from nurses and implement their ideas.”

Survey results back her up. They reflect the perspectives of opinion leaders – not average Americans – from six key groups in charge of what’s happening in health care reform: university faculty, insurance (e.g., presidents, CEOs, vice presidents, etc.), corporate, health services, government and thought leaders. The survey based on 1504 telephone interviews with national opinion leaders that averaged 11 minutes in length confirmed nurses are underutilized and they don’t have the influence in health care reform that they should. Ninety per cent of opinion leaders surveyed said they’d like to see nurses have more influence reducing medical errors, nearly 89 per cent said more influence improving quality of care, and 86 per cent said nurses should promote wellness.

Overall, explained Dr. Frank Newport, editor-in-chief of the Gallup Poll, who presented the survey findings at the news conference, said nurses are perceived as having a lot to offer. They are continually rated each year by the American public as professionals with the highest of honesty and ethics. Opinion leaders in the Nursing Leadership from Bedside to Boardroom survey ranked nurses at 42 per cent, just below doctors – the highest-ranking group at 53.5 per cent – as a trusted information source for health and health care, and way above books (29.6 percent), the Internet (13 per cent), newspapers (5 per cent) and television (2.6 per cent).

Yet survey findings place nurses at the bottom of the seven possibilities of who will influence health reform in the U.S. in the next five to 10 years. Only 13.8 per cent of responders perceived nurses as influential in health care reform; well below the government (75 per cent), insurance and pharmaceutical executives, doctors and patients.

So why the disjunction? What are the barriers that prevent nurses from contributing to improvements in planning, policy development, and managing health systems and services? The answer, according to the survey, is structural issues. There is not a structure in place, according to Dr. Newport, for people to listen and nurses to say. Key points: almost 70 per cent of opinion leaders perceive nurses as not important decision makers; 68 per cent perceive that it is doctors who generate the revenue; there is no focus on preventive care (that’s huge, says Newport); and nurses lack a single voice on national issues, no leadership opportunities, no strategic vision, and different levels of education. Structural issues.

Solutions, Survey Says

Two major suggestions came from opinion leaders on how nurses could overcome barriers and achieve more influence in key areas of health care. One, nurses must have their voice heard. It must be a single, unified voice that focuses on key issues in health policy. Nurses are perceived by opinion leaders as lacking the interest to be in that role.

Second, there must be higher expectations by society and by nurses around what nurses can achieve. “Nurses should be held accountable for not only providing quality direct patient care, but also for health care leadership.”

Noted Participants

At the news conference, expert responders to survey findings included: Pennsylvania Governor Edward G. Rendell; Dr. Reed Tuckson, executive vice president and chief of medical affairs, UnitedHealth Group; and Dr. Gail Wilensky, senior fellow at Project HOPE, former administrator of the Health Care Financing Administration.

A panel discussion by nurses over the survey findings followed the news conference. Panelists included: Dr. Susan Hassmiller, senior adviser for nursing at RWJF; Dr. Patricia Gerrity, associate dean, College of Nursing and Health Professions, Drexel University, and director of the School of Nursing at the Bedside partner; Dr. Beverly Malone, CEO of the National League for Nursing; and Dr. Mary Naylor, professor at the University of Pennsylvania, School of Nursing.
Texas Board of Nursing
At its January meeting, the Texas Board of Nursing (BON) adopted rules regarding requirements for physical and psychological evaluations, and approved a recommendation to proceed with a pilot program for deferral of disciplinary action.

- House Bill 3961 clarifies the BON's authority to utilize physical and psychological evaluations as part of the licensure and disciplinary process to determine fitness to practice. While the BON has the authority to request voluntary evaluations, HB 3961 establishes specific circumstances in which the BON can require a psychological or physical examination. The BON adopted rules to implement the new statute.

- In accordance with Senate Bill 1415, the Board of Nursing completed its study of the feasibility of implementing a pilot program regarding deferral of final disciplinary action. The BON determined that such a program was feasible. The pilot program would allow the Board to defer disciplinary action against an individual who is considered to be a low risk to the public and who complies with probationary conditions of the Board order. Once the individual completes the deferred disciplinary action, the order would become confidential. SB 1415 was intended to provide the Board with less punitive options when considering disciplinary action for individuals who are not considered to pose a threat to public safety.

Hospital Safe Staffing Law and Prohibitions on Mandatory Overtime
The Texas Department of State Health Services has indicated that the timeline for adoption of new rules will most likely be late summer or early fall 2010. Stay tuned...

What Nurses Need to Know
— a new information series from Texas Nurses Association

Information is the key to effective advocacy. With new research about safety and practice, and the constant changing of Texas laws and hospital rules that govern nursing practice in hospitals, there’s a lot to keep up with. That’s why Texas Nurses Association has launched its new advocacy guide series, What Nurses Need to Know.

The series’ topic-specific guides provide relevant, netted-out information in a pocket-hand size. The newest guide – Fatigue is a Workplace Hazard – presents information and strategies for guarding against fatigue-related risks to patient and nurse safety.

The Texas Hospital Safe Staffing Law – another title in the series – offers direct care nurses information on how they can participate proactively with their hospitals to achieve appropriate nurse staffing.

Grab yourself a copy of either guide at texasnurses.org > store! Individual copies are $4.75 each. Or order 30 or more copies to receive volume discounts and a special, FREE 10-15 minute PowerPoint® presentation to share information with colleagues or staff.
Call to Collaboration: TNA Helps Sponsor the Texas State Health Plan Meeting

by Laura Lerma, MSN, RN, Texas Nursing Voice Contributing Editor and CNF Program Manager for Texas Nurses Association

On February 19, the Statewide Health Coordinating Council (SHCC) hosted the 2010 Statewide Workforce Symposium to unveil a preliminary draft of “A Roadmap to a Healthy Texas” – the 2011-2016 Texas State Health Plan. The Austin gathering provided an opportunity for state experts and stakeholders to review the SHCC’s preliminary findings and provide input into the final plan.

The state health plan is mandated by law and is submitted to the governor and the legislature every six years with updates every two years. This year’s plan is the third six-year plan to be developed for the State of Texas. The plan is based on the philosophy that “a healthy Texas is a productive Texas.” It envisions “a Texas in which all are able to achieve their maximum potential and are healthy, productive and able to make informed decisions.”

Since the state health plan has its foundation in data and research, symposium attendees received a demographic overview of the population trends in Texas and of the Texas health professions workforce. It was probably not surprising to those in attendance that the following trends emerged from the data:

- Prevention and education are the primary approaches for achieving optimal health.
- All have equal access to quality health care.
- Local communities are empowered to plan and direct interventions that have the greatest impact on the health of all.
- We, and future generations, are healthy, productive and able to make informed decisions.

Three Key Areas of the Plan
From the review of the data, three key areas of focus for the health plan emerged: 1. access to care; 2. technology; and 3. prevention and education. Prior to the February 19 meeting, work groups had convened to brainstorm about these three key areas. Those results were also shared with the symposium attendees.

Access to Care – the work group addressing access to care outlined four areas of concern that its members believed had implications related to the health plan and the overall health of Texans. The four areas are:
- The increasing number of uninsured and the impact their increased demand for health care will have on an already stressed health care system.
- The social and economic disadvantages linked to health disparities across the state and the need for a health care workforce that is culturally competent.
- The need to focus resources on primary care (health promotion, disease prevention, health maintenance, patient education, etc) and access to a wide range of potential primary care providers.
- The barriers that various populations – persons with disabilities, people living in rural areas of the state, children and adolescents, and the elderly – have to access care.

Technology – the purpose of the work group looking at technology was to review current health care and technology data and identify what is currently being used in Texas. The group found that, despite there being both a need and an interest in developing public/private collaborations among technology stakeholders, Texas is far behind other states in adopting and embracing health care technology. Current telemedicine and health information technologies require more development, marketing, adoption, communication and training while understanding that the next generation of these technologies will be vehicles used for personalized health care to include cell phones and Internet-based telecommunications for remote care. And, ultimately, with the ever changing needs of the health care population, these complex systems must move toward functionality, integration, outreach, and quality.

Prevention and Education – the prevention and education work group set its purpose as “change or die.” It is human nature to know what to do to stay healthy – don’t smoke, don’t drink and drive, do exercise, eat healthy, immunize, etc – but not to always do what we are supposed to do. Change is hard. So, instead of having to change unhealthy behaviors once established, the research indicates starting early, when the brain is developing, might be the best time to instill healthy behaviors. This work group proposes that more resources be put into good pre-natal care and nutrition; early childhood growth and development programs; family support through home visits; quality child/day care; and the use of social media to promote public awareness of healthy life styles.

This symposium ended Phase I of the state health plan development. Phase II calls for the draft to go for approval at the April SHCC meeting. In Phase III, the proposed plan will be published for a 30-day comment period. The final 2011-2016 State Health Plan will be presented to the SHCC in July for approval. In October, Phase IV will be completed when the plan is submitted to the governor and the legislature.

The Texas Nurses Association, in conjunction with many other organizations, was a proud sponsor and participant in the symposium. TNA looks forward to the release of the final plan and its implications for nurses and nursing, and the citizens of Texas.
A Brief History of National Nurses Week

1953: Dorothy Sutherland of the U.S. Department of Health, Education, and Welfare sent a proposal to President Eisenhower to proclaim a “Nurse Day” in October of the following year. The proclamation was never made.

1954: National Nurse Week was observed from October 11 - 16. The year of the observance marked the 100th anniversary of Florence Nightingale’s mission to Crimea. Representative Frances P. Bolton sponsored the bill for a nurse week. Apparently, a bill for a National Nurse Week was introduced in the 1955 Congress, but no action was taken. Congress discontinued its practice of joint resolutions for national weeks of various kinds.

1972: Again a resolution was presented by the House of Representatives for the President to proclaim “National Registered Nurse Day.” It did not occur.

1974: In January, the International Council of Nurses (ICN) proclaimed that May 12 would be “International Nurse Day” (May 12 is the birthday of Florence Nightingale). Since 1965, the ICN has celebrated “International Nurse Day.”

1974: In February, a week was designated by the White House as National Nurse Week, and President Nixon issued a proclamation.

1978: New Jersey Governor Brendon Byrne declared May 6 as “Nurses Day.” Edward Scanlan of Red Bank, N.J., took up the cause to perpetuate the recognition of nurses in his state. Scanlan had this date listed in Chase’s Calendar of Events (a comprehensive, authoritative reference of holidays, special events, birthdays of the famous, and civic observances) and promoted the celebration on his own.

1981: American Nurses Association (ANA), along with various nursing organizations, rallied to support a resolution initiated by nurses in New Mexico, through Congressman Manuel Lujan, to have May 6, 1982, established as “National Recognition Day for Nurses.”

1982: In February, the ANA Board of Directors formally acknowledged May 6, 1982 as “National Nurses Day.” The action affirmed a joint resolution of the United States Congress designating May 6 as “National Recognition Day for Nurses.”

1982: President Ronald Reagan signed a proclamation on March 25, proclaiming “National Recognition Day for Nurses” to be May 6, 1982.

1990: The ANA Board of Directors expanded the recognition of nurses to a week-long celebration, declaring May 6 - 12, 1991, as National Nurses Week.

1993: The ANA Board of Directors designated May 6 - 12 as permanent dates to observe National Nurses Week in 1994, and in all subsequent years.

1996: ANA initiated “National RN Recognition Day” on May 6, 1996, to honor the nation’s indispensable registered nurses for their tireless commitment 365 days a year. The ANA encourages its state and territorial nurses associations and other organizations to acknowledge May 6, 1996 as “National RN Recognition Day.”

1997: The ANA Board of Directors, at the request of the National Student Nurses Association, designated May 8 as National Student Nurses Day.
Anna Pearl Rains (1935-2010)

Ms. Anna Pearl Rains, legendary figure in Texas nursing, died peacefully on January 13, 2010 in Clifton, Tex. She was 74.

Highly respected and widely recognized for her contributions to nursing, Anna Pearl Rains, MSN, RN was a long-standing member of Texas Nurses Association and served as its president from 1985 to 1989. A graduate of UTMB School of Nursing, Ms. Rains received her master’s degree from Yale University, and completed doctoral courses at the UT School of Public Health in Houston.

During her career of a lifetime, Anna Pearl Rains was an associate professor of nursing at The University of Texas Medical Branch in Galveston, Tex., with a particular interest in maternal-child health and midwifery. She held a number of leadership positions during her 50 years at UTMB including chief nursing officer and associate professor of nursing.

In 1993, Rains was named the recipient of the UTMB School of Nursing Distinguished Alumni Award. That honor is presented yearly to one alumnus who “has made a significant impact on health care in addition to making significant contributions to the nursing profession in clinical practice, education, administration or organization work involving health care or innovation in health care delivery systems.”

In the early to mid-2000s, Rains contributed her years of nursing education experience and wisdom to a number of state-wide efforts that began to address the nursing shortage. She co-authored the 2000 Texas Schools of Nursing Capacity Study — work that became instrumental in focusing attention on the need to increase RN graduates in Texas. In 2004, she served on TNA’s Nursing Education Redesign Task Force which examined how a nurse of the future might need to be educated for a role that, at the time, was yet to be defined. Recently, Anna Pearl was a member of TNA’s Task Force on Continued Competence, an effort that examined over several years how nursing could assure the continuing competency of nurses, not just their continuing education. Nursing in Texas has lost a champion.

Well known for her leadership in various Texas Nurses Association and Texas Board of Nursing sponsored initiatives that furthered the nursing profession, Rains’ contributions to nurses and the nursing profession is a legacy that will certainly extend well into the future.

In the earlier 1980s, before the Texas Peer Assistance Program for Nurses was created by the Legislature in 1987, Ms. Rains was a stalwart supporter of nurses who sought recovery from their dependencies and a pathway back to practice. She stretched the vision of what could be for their return to work beyond the hospital unit and setting. She was a nursing champion who grasped the greater issues at hand and challenged her nursing contemporaries to see beyond the obvious. TPAPN was fortunate to have Ms. Rains as an initial member of its Steering Committee and later of its Advisory Committee.

Aside from professional interests, Anna Pearl Rains was an active member of the Broadway Church of Christ. There she conducted bible studies and made many compassionate contributions to the welfare of the homeless in Galveston. Anna Pearl Rains will be missed by all of those whose lives she touched. ✪

Texas Nurses Association is pleased to announce the launch of a new program designed to prepare Nurse Advocates: nurses who can guide other nurses in advocating for patient safety within existing Texas laws and regulations. In Texas, nurses have strong protections when advocating for patient safety. Too often, nurses are unfamiliar with what protections exist and how to effectively utilize them to improve patient care.

The Nurse Advocate is a hospital-based expert on available protections for nurses when they engage in patient advocacy activities. The Nurse Advocate supports individual nurses in advocating for patient safety (e.g., using existing communication/reporting channels, expressing/documenting concerns effectively, invoking Safe Harbor appropriately) and acts as a resource to the hospital in creating an environment conducive to patient advocacy efforts (e.g., consultant in the development of policies and procedures regarding Safe Harbor Nursing Peer Review and the Nurse Staffing Plan).

The Nurse Advocate Certificate Program includes an intensive two-day training workshop for select individuals who have the support of their employing facility to implement the Nurse Advocate role in their hospital. The workshop covers information on Safe Harbor Nursing Peer Review, patient advocacy protections for nurses, and conflict resolution and problem-solving skills. Upon successful completion of the workshop and competency validation, participants will receive a certificate recognizing their expertise as a Nurse Advocate.

The first Nurse Advocate training workshop will be offered in May 2010. Attendance will be by invitation based on an application process. Individuals completing the workshop training, and their employer organization, will be expected to participate in an ongoing program implementation and evaluation process so that the benefits and opportunities for improving the program can be identified. For more information, please contact gbirdwell@texasnurses.org. ✪
Test Texas HIV Coalition Holds Summit in Austin

With the threat of a major winter storm hanging over it in December, the Test Texas HIV Coalition, of which the Texas Nurses Association is a member, held its first summit—“Finding Direction: Your Way to Routine HIV Testing.” The goal of the summit, as is the goal of the Coalition, was to provide information to health care providers in public health, emergency departments, primary care and correctional facilities on how to integrate routine HIV testing into daily practice.

The summit featured several state and national speakers well-known for their work in HIV and AIDS. Ann Robbins, PhD, manager of the HIV/STD Prevention and Care Branch of the Texas Department of State Health Services, spoke on the current trends in epidemiology of HIV and AIDS in Texas, and how those statistics support the need for routine HIV testing in health care settings.

Bernard Branson, MD, associate director for Laboratory Diagnostics, Division of HIV/AIDS Prevention for the CDC, reviewed the most current HIV testing technology and its potential influence on the implementation of sustainable routine HIV testing programs.

John Carlo, MD, MS, medical director/health authority for the Dallas County Health and Human Services, challenged the attendees by asking: With all we currently know about routine testing, is there an ethical argument still to be made to not test? And, Marlene McNeese-Ward, BS, bureau chief, Bureau of HIV/STD and Viral Hepatitis Prevention for the Houston Department of Health and Human Services, summed up the summit by addressing the current public attitudes towards routine testing: the barriers, challenges, and opportunities for implementation; and the lessons learned by those who have gone forward and implemented routine testing.

A truly touching presentation was given by three guest speakers from the Women Rising Project of AIDS Services of Austin. These women shared their personal experiences about testing positive for HIV. Their stories reinforced the impact that a delayed HIV diagnosis can have on overall health, medical treatment, and progression of the disease.

Their message to health care providers was very clear:
1. Know the signs and symptoms – ignoring or denying them will not make them go away.
2. “Step up to the plate for your patients.” Missed opportunities delay diagnosis and treatment.
3. “It’s not about the look; it’s about the test.” Routine testing is the key to prevention and early detection and treatment of those who are positive who may never have known before.
4. Patients are still scared, embarrassed and confused. They feel guilty and ask “why me?” when they are first diagnosed. Society and families can still be cruel and judgmental. As the health care provider, be the advocate and help to reduce the stigma.

The breakout sessions associated with the summit focused on the obstacles and avenues to implementing a routine testing plan in a variety of settings. Topics included how to implement a routine testing program, who pays for the testing, what to consider when deciding on what testing methodology to use, and how to get staff on board.

A common question that is asked by staff and health care settings alike is – “Now that I have a patient with a positive test, now what?” The “safety net” is out there. Health care providers do not need to know all the answers, they just need to know the next step in the continuum of care that Texas provides to its citizens who have been diagnosed with HIV or AIDS. Through the Texas Department of State Health Services there is the Partners Services Program, HIV care services, the Texas HIV Medication Program, the Mental Health Substance Abuse program, and prevention services for both HIV positive patients and those that test negative but may be at-risk. They are all quality programs just waiting to help.

Though the snow never really materialized in Austin, leaving some disappointed, the Test Texas HIV Coalition Summit left no one disappointed. The Coalition continues its work with its next meeting scheduled as a webinar on March 16. Interested in more information about the Coalition and its work? Go to: www.testtexasHIV.org.

Texas Nurses Association announces its Spring 2010 schedule of continuing nursing education workshops.

Individual Activity Workshop – Uncovering the Mysteries of the CNE Activity

- April 15 • May 11 • June 14 • June 30

The TNA Individual Activity Workshop is designed for all who are new to the CNE process, who are interested in providing single activities or who are taking the first step toward becoming an approved provider. The focus of this workshop is the development of a single CNE activity.

Approved Provider Workshop

- April 28 • May 3 • June 10 • June 22

The TNA Approved Provider Workshop is designed for lead nurse planners who seek initial or renewed approved provider status. The focus is on the development of approved provider status application with limited discussion of the CNE activity.

Complete information can be found at texasnurses.org > Education or by phoning the TNA CNE Department, 512-452-0645 ext. 3.

The Texas Nurses Association/Foundation Provider Unit is accredited as a provider of continuing education by the American Nurses Credentialing Center’s Commission on Accreditation.
“I’m busy trying to keep people alive and you want me to attend a meeting?”

I DON’T HAVE THE TIME.

WHILE YOU TAKE CARE OF PATIENTS, WE TAKE CARE OF YOU. TNA has been working hard for Texas nurses for more than 100 years, helping to pass legislation on personal protection rights, workplace safety and safe patient handling, negotiating rules affecting mandatory overtime and floating, and assisting in securing $50 million for nursing schools to address the shortage. And you don’t have to attend meetings to be a part of TNA. Convenient tools such as email alerts, online forums and surveys make it easy to stay informed and give feedback. TNA membership is not only easy it’s essential.
RESERVE YOUR SEAT.

Pain Management
and Palliative Care

½ Day CNE Conferences
for Nurses in All Fields of Practice

In San Marcos: May 15
In San Antonio: June 12

- Components of Pain Assessment
- Pharmacologic and Non-pharmacologic Management of Pain
- Symptom Management at the End of Life
- Psychosocial, Spiritual, and Cultural Considerations

For information or to register, go to www.noep texas.org.

The Texas Nurses Association/Foundation Provider Unit is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

The Nurse Oncology Education Program (NOEP) is part of the Texas Nurses Association/Foundation Provider Unit and funded by the Cancer Prevention and Research Institute of Texas.

This program was made possible by LIVESTRONG.
Meet the Emerging Nurse Leaders, 2010

Mentoring is actually a two-way street. Even though fairly new-to-career individuals are often considered the benefactors of a professional mentoring program, Texas Nurses Association and Texas Nurses Foundation see it differently. They believe it is the future of nursing and, ultimately, patient care that will benefit from the Emerging Nurse Leader Program of Texas Nurses Association/Foundation.

Created in 2008, the Emerging Nurse Leader Program is intended to cultivate budding leaders of the nursing profession. Through this bi-annual, multi-part program, younger nurses interact with recognized, mature nurse leaders from across Texas in a series of events designed to connect nurse leaders from across generations. Nurses of all ages – and generations – have a great deal to learn from each other.

This year, 10 fairly new-to-practice (less than 10 years) nurses were selected to participate in the program from nominations received throughout Texas. The meeting of program criteria drove the selections and included demonstrated leadership in and beyond a nominee’s place of employment, service to their communities, and being a compassionate care giver. Membership in Texas Nurses Association was not a criterion.

This year’s participants in the Emerging Nurse Leader Program are:

- Antwoin Smith, BSN, RN, Baylor All Saints Medical Center – Fort Worth
- Serena Bumpus, BSN, RN, Seton Family of Hospitals – Austin
- Kevin Keith, BSN, RN, Terrell State Hospital – Terrell
- Neal Garrett, MBA, RN, The Methodist Hospital – Houston
- Robin Francis, BSN, RN, PCCN, St. Luke’s Baptist Hospital – San Antonio
- Ashley Kellogg, RN, St. Luke’s Episcopal Hospital – Houston
- Ruben Molina, BSN, RN, MHA, San Jose Clinic – Houston
- Tanya Klinegardner, MSN, RN, FNP, Brazosport College – Lake Jackson
- Pablo Vasquez, MBA, BSN, RN, The Methodist Hospital – Houston
- Stephanie Garee, RN, The Methodist Hospital – Houston

Emerging Nurse Leader Program participants have already experienced two encounters as a group. The first which took place in late February brought the emerging leaders together with some of the recognized, more mature nurse leaders of Texas, to share challenges and experiences all faced in their careers.

“Each generation brings specific characteristics to the leadership experience,” explained Susy Sportsman, PhD, RN, president of Texas Nurses Association. “It was clear from discussions in the first workshop how many of the nursing issues of today have been developing or re-emerging for years. It is our hope,” she summarized, “that this program will better prepare next-generation nurses to face – and solve – the future challenges of health care.”

The 2010 Emerging Nurse Leaders will next receive exposure to furthering nursing and health care policy through legislation in a series of upcoming, planned workshops.
selecting YOUR MEMBERSHIP

When joining Texas Nurses Association, you can choose from two membership options:

- **TNA Tri-Level Membership** that includes a state membership in Texas Nurses Association (TNA), national membership in American Nurses Association (ANA), and a more local District membership.
- **TNA Direct Membership** that is state wide Texas only.

**TNA TRI-LEVEL MEMBERSHIP**

Tri-Level Membership in ANA/TNA/District gives you the opportunity to influence nursing at every level – state and local. TNA Tri-Level members receive full voting privileges; opportunities to grow and connect beyond the workplace through service on committees, task forces and coalitions; unique pathways to professional development; a network of like-minded colleagues; and member discounts on a variety of conferences/forums, publications and resources, goods and services, as well as ANCC certification.

Dues in TNA Tri-Level Membership are determined by your TNA District, the type of membership that best describes you (i.e., full) employed, full-time student, retired, etc.), and preferred method of dues payment. See Steps to Tri-Level Membership below.

**STEPS TO TRI-LEVEL MEMBERSHIP**

1. Find your TNA DISTRICT. Within the Texas map, locate your county of residence OR county of employment. The large circled number within the indicated boundary is your TNA District.
2. Select your TYPE of Tri-Level Membership:
   - **M-Full Membership** – for RNs employed more than an average of 20 hours a week.
   - **R-Reduced Dues Membership** (50% of annual dues) – for RNs who are unemployed or working less than 20 hours a week, licensed RNs who are full-time students, new graduates from basic nursing education programs joining within 6 months of graduation, and RNs 62 years-of-age or who are working and receiving Social Security.
   - **S-Special Membership** (25% of annual dues) – for RNs over 62 years-of-age and not employed, or 100% disabled.

**TNA DIRECT MEMBERSHIP**

For many registered nurses, influencing nursing in Texas where they practice is their main interest. That's why TNA offers the TNA Direct Membership. Preferred to everyday practice in Texas, TNA Direct is a great membership choice for RNs who are interested in influencing nursing practice but have limited time or resources for full involvement.

A $99 annual dues rate (or monthly payments of $8.75 through the Electronic Dues Payment Plan) makes this Texas only involvement the perfect connection to professional nursing in Texas, and still provides many of the same personal benefits of Tri-Level ANA/TNA/District membership.

**PAYMENT METHOD**

1. Annually – in a single, annual payment by check or credit card.
2. Monthly – by credit card draft or through the Electronic Dues Payment Plan (EDPP) where dues are automatically paid from your checking account. See “Select Payment Method” in Application for Membership.

**MEMBERSHIP ELIGIBILITY**

To be eligible for TNA Tri-Level or TNA Direct membership, you must have been granted a license to practice as a registered nurse in a state, territory, possession or District of Columbia of the United States, and not have your license under suspension or revocation at any time.