VIRGINIA

NURSES TODAY

THE OFFICIAL PUBLICATION OF THE VIRGINIA NURSES ASSOCIATION

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In Memory Of Evelyn Bacon

This obituary was adapted from the Richmond Times Dispatch, October 25, 1997.

Evelyn Crary Bacon, 81, of Charlottesville, died Friday, October 24, 1997 at a Charlottesville Hospital. She was born September 27, 1916 in Grundy Center, Iowa, daughter of the late Elisha Avery Crary and Gertrude Elizabeth Minor Crary. Mrs. Bacon was a graduate of the University of Iowa and the University of Chicago. She served as a captain in the US Army Nurse Corps from June 1942 to January 1946, where she was a head nurse supervisor and instructor in the European Theatre of Operations. She was in the battles and campaigns of Normandy, Northern France, Ardennes, and Rhineland Central Europe and was awarded the European Theatre Ribbon with Silver Battle Star and six Overseas Service Bars. The majority of her Army work was in post operative care of neuro surgical cases both in General and Evacuation Hospitals overseas. On the 50th anniversary of the landing in Normandy, she was recognized along with military personnel from other participating countries with a ribbon and gold medal "Liberte" from the Council of Normandie in 1994. She was the most recent recipient of the Nancy Vance award for her contributions to nursing in Virginia.

EVELYN CRARY BACON

Mrs. Bacon was a member of the American Nurses Association since 1940 and Virginia Nurses Association; National League for Nursing, Sigma Theta Tau; and first woman chairman of Richmond, Va. Chapter, American Red Cross and a member of the Virginia Council on Health and Medical Care Committee on Nursing. She was board member and president of the League of Women Voters, Richmond League of Women Voters of Va. and Education Chairman, 1965-66 Commission on Status of Women, Sub-committee on Health, Vice-Chairman Citizen's Committee on Status of Women. She served on the executive Committee Governor's Advisory Council on nursing training, Chairman, Board of Managers for Virginia Diocesan Home, Richmond Area Community Council and on the City of Richmond Technical Committee, Model City Task Force. For many years she also served on the Health Services Agencies Board of the Tidewater and North Central Virginia.

Mrs. Bacon was a member of Grace and Holy Trinity Church of Richmond, where she was also a choir member, and a member of Richmond Choral Society. She was one of three women and 39 men selected from the Richmond Metropolitan area to participate in the two year Urban Policy Conference Seminar program presented by the Brookings Institution and University of Richmond in 1964 and 1965.

Mrs. Bacon's career in Virginia included faculty positions at the University of Virginia and Virginia Commonwealth University. She served as a consultant to the Board of Nursing. In 1972 Evelyn planned and directed the associate degree program at J. Sargeant Reynolds Community College, including recruitment of the faculty. In 1983, Evelyn began a major volunteer activity for VNA: "The VNA Archives were given to Virginia Commonwealth University Libraries. They are now located at the Tompkins-McCaw Library on the Medical College of Virginia Campus in Richmond, Va. Under the direction of Jodi Koste, the Archivist in Special Collections. Evelyn began processing and organizing the records of the Association and the personal papers of the early nursing leaders. Evelyn felt that the opportunity opened a career for her in historical research, especially in the early development of health care in Virginia.

At the time of her death, Evelyn was co-chairman of the VNA History Committee and was involved in updating the history of the association to be ready for the centennial of VNA in the year 2000.

Surviving are her husband, Franklin Bacon; two nephews, Elisha Avery Crary, and Oliver N. Crary, both of Newport Beach, Calif.; and a niece, Julie Ann King of Weiser, Idaho. A memorial service took place on Wednesday, November 12, 1997, at Grace and Holy Trinity Episcopal Church, with the Rev. Hill Brown officiating. Interment was at Arlington National Cemetery with full military honors, on Thursday, November 13, 1997. In lieu of flowers, the family suggests contributions be made in her memory to your favorite charity or to Virginia Nurses Foundation. ◆

Voucher Value

Your VNA is offering not only the value of membership through its activities to "improve nursing for the profession and our patients," but by extending VOUCHER VALUE as an incentive.

We all look for value in our lives, but where can you get value on a membership that provides you with the tools to become a better professional? Subscribe to a **new** membership and sponsor yourself or be a mentor through the sponsorship of a non-member colleague. These are two ways you can show that nursing is a proud profession. Ways to use the voucher include:

* 1998 Dues
* 1998 Legislative Day
* 1998 Annual Meeting
* Virginia Nurses Foundation donation
* Quality Indicators Research Project donation

The financial arm of your organization is constantly striving to bring you, the member, the most benefit for your membership dollar. This $25.00 VOUCHER can provide you, the VNA member,

* Benefits
* Distinction
* Marketability
* Quality
* Desirability
* Excellence
* Power
* Superiority

VNA membership is a value in itself—even more so with

VOUCHER VALUE

Call your VNA office at 1-800-868-6877 for further details, or see the last quarter 1997 *VNT* for information.

Each new voice for the Virginia Nurses Association provides power for you and your profession.

Barbara Tiffany Courtney, MSN, RN
Treasurer ◆

13TH ANNUAL NURSES' DAY AT THE VIRGINIA GENERAL ASSEMBLY

POLITICAL HEALTH AND NURSING: ISSUES AND ANSWERS

FEBRUARY 4, 1998
at the
RICHMOND CENTRE
and the
CAPITOL GROUNDS

VNA is very excited to have Beverly L. Malone, PhD, RN, FAAN, current President of the American Nurses Association, as this year's keynote speaker.

Beverly L. Malone, President
American Nurses Association

Virginia Governor James Gilmore has been invited to address the Nurses' Rally on the Capitol Grounds, following our March to the General Assembly.

See inside this issue for Legislative Day program schedule, registration form, and preparatory materials. Some details are also available on the VNA web page at http://www.nursingworld.org/ . ◆

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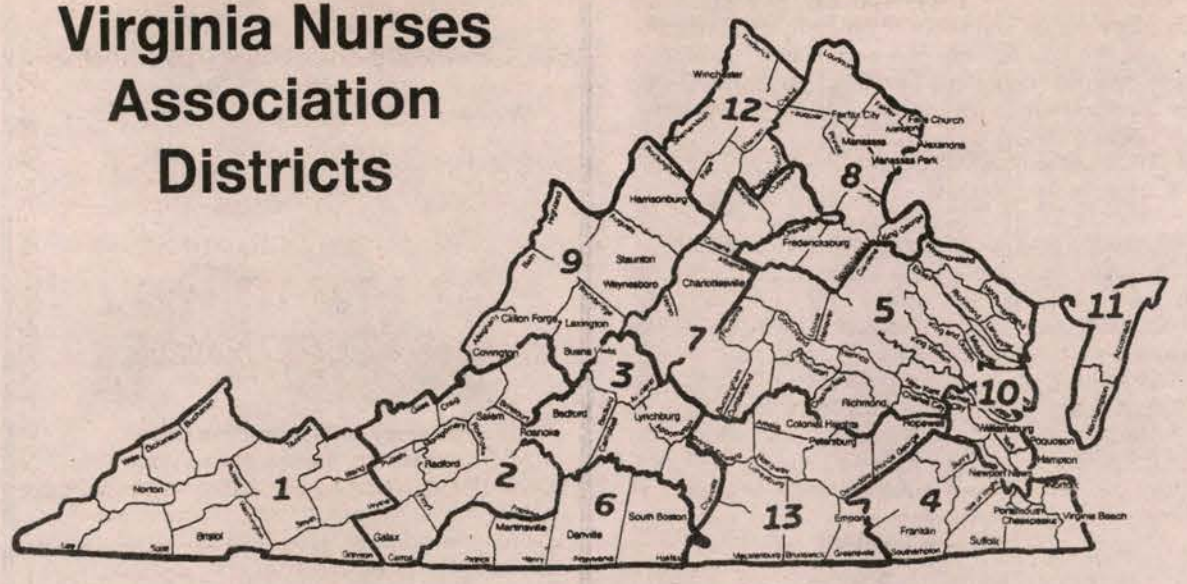

WHOM DO I CALL?

Quite often we receive telephone calls and inquiries for information not provided by the Association.

Below is a list of names and numbers to call for various kinds of information:

Licensure, nursing guidelines, practice requirements, etc.	Virginia Board of Nursing	(804) 662-9909
Physicians or physician assistants	Virginia Board of Medicine	(804) 662-9908
Certification	ANA Certification	(800) 284-2378
Licensed Practical Nurses	Virginia Board of Nursing	(804) 662-9909
Certified Nurse Aides	Virginia Board of Nursing	(804) 662-7310

PRESIDENT'S MESSAGE

REBECCA B. RICE, EDD, RN

As I write this, the leaves have almost completed their autumnal journey, and the trees are preparing to lie dormant until spring. But by the time you read this column, the wintry winds will be blasting away at our Commonwealth—another season has passed. So, it seems appropriate that I reflect on the themes that resonate from the life of our colleague Evelyn Bacon, who died in October, 1997. Evelyn's obituary lies elsewhere in this edition of the *VNT*, and I encourage you to read it. As the current holder of the Nancy Vance award, the highest honor our association bestows on its members, Evelyn Bacon served as a role model for many of us, and I know that her legacy will continue.

When I think of Evelyn, I think of how her life epitomizes our profession—caring and courage in the midst of uncertain and continuous change, commitment to the profession and to the patients we serve, and a sense of history. I can only speak from my interactions over the years with Evelyn, so my story is flawed with gaps but not with the warmth I hold in my heart for her and her husband, Franklin (or "Bake," as he had us call him on occasion).

Evelyn's caring for others led her into nursing, and her courage propelled her to the beaches of Normandy after D-Day. Through the years, Evelyn cared for us all as she developed and nurtured diverse educational programs for nurses in Virginia. She was deeply committed to our profession, and she believed that each of us had worth and value to ourselves, our colleagues, and our patients, regardless of our educational preparation. Since Evelyn's death, I have participated in several discussions about entry into practice, and I listen to the arguments for and against certain educational programs. On these occasions, I have been reminded of Evelyn's commitment to our diversity. I believe, as Evelyn did, that there is room for all of us at the table. On the other hand, I also believe that we should all continue to learn, whether our education be formal or informal, so that we can all serve our patients in the best manner to which we are able.

Evelyn was totally committed to our profession. She was an active member of the VNA and of the Virginia League for Nursing, having served most recently on the History Committees for both organizations. Her ability to turn words into actions serves as a model for us. Belonging to the professional organization is an important component of our commitment; contributing one's time and talents is a second factor to which we should aim.

Finally, I will always cherish Evelyn's sense of history and her devotion to communicating its message to us. When I was a young nurse, I thought history was something to be relegated to the textbooks. As I've aged, I have grown to appreciate the value of knowing history and (hopefully) learning from our past endeavors, successful or otherwise. Evelyn helped us all remember those moments of our courageous foremothers.

We'll miss Evelyn, but we know her work will go on. Our history rests in the archives at the library of the Medical College of Virginia, and it is being made today. New committee members will work on historical perspectives. Let's all continue to commit ourselves to caring, to the profession, and to creating our own pages of history of nursing in Virginia. ◆

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Richmond, Virginia 23226

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The opinions contained herein are those of the individual authors and do not necessarily reflect the views of the Association.

VIRGINIA NURSES TODAY reserves the right to edit all materials to its style and space requirements and to clarify the presentation.

VNA Mission Statement
Our mission is to improve nursing practice, promote access to nursing care, provide consumer advocacy by influencing public policy, supporting optimal standards of health care and providing continuing education, thereby increasing the overall quality of health care.

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Coleman

Evelyn Byrd Coleman died Tuesday, September 23, 1997, at her home at Westminster-Canterbury House, Richmond. Miss Coleman was born June 2, 1899 in South Boston, VA. Miss Coleman was a member of Emmanuel Episcopal Church, Brookhill. She graduated in 1921 from Stuart Circle Hospital. Miss Coleman also studied at RPI and obtained a BS degree from Marquette University. She served in public health nursing in six states, and served as Education Director of the combined IVNA and City nursing services, as well as a member of the IVNA Board. A memorial service was held in the chapel of Westminster-Canterbury on Friday, September 26, 1997. She is survived by two nieces, one nephew and several cousins. ◆

EXECUTIVE'S COMMUNIQUÉ

Nurse Power: An Invitation

Jan Marshall Johnson, MS, RN
Executive Director

Recent market research done for the American Nurses Association uncovered some interesting contradictions. Each "type" of RN thinks that ANA is for another kind of nurse. Another is this basic Catch-22: RNs want a powerful group (and see the ANA as that group) but aren't compelled to join until it's powerful. But if people/nurses = unity = power, all parts of the equation have to be present in order to be effective. Anyone for the challenge of balancing these competing assumptions?

Belonging to an association proves the old adage that numbers mean power, period. If an association doesn't do what you want it to do, you fix it, or tell the leaders what would fix it, and make it possible with your voice, vote, and support. The corresponding challenge goes to the leadership which must hear what people/nurses want and need. Together an organization can effect change and work to strengthen its positions.

"Nursing suggests the difficulty of trying to forge a basis for . . . unity when heterogeneous experiences, classes, and beliefs divide a group." (Susan M. Reverby in ORDERED TO CARE). Unquestionably, nurses are divided by clinical, educational, political, gender, generational, geographical and philosophical differences. But fundamentally, nursing is centrally focused on patient care. The research identified that ANA represented "nursing ideals, standards/practices, and provided a political "voice." The groups felt that a national association for all nurses has to exist, and that ANA was that association.

So where is the disconnect? I invite you—member and non-members—to tell VNA how to maximize our power. Write to VNA or the *VNT*; a contact with any VNA leader listed on the directory page may be the most effective communication channel. The invitation is for you to tell us how to implement current programs and activities, what to consider doing in the near future, and **(this is crucial)** how you can/will help.

Please consider just some of the ways VNA does business when developing your remarks.

- — Through the representative organizational members of the Legislative Coalition of Virginia Nurses
- — Via our legislative platform, paid lobbyists, Annual Nurses Day at the General Assembly.
- — By producing *VNT*, sent to all Virginia RNs.
- — Offering continuing education accreditation for programs, and the approval process for facilities and groups for over 15 years. Accreditation is awarded by the American Nurses Credentialing Center.
- — Efforts to assist nurses in the workplace (recent activities include career counseling clinics, local membership/educational meetings, co-sponsored sessions on delegation, newly formed partnerships with GlaxoWellcome and Eli Lilly pharmaceutical companies, and a quality indicators research project (coming soon to a hospital near you!).

Member/RN power through membership is being recognized and rewarded through the VNA Vouchers campaign—a $25 voucher redeemable on dues or registrations (see *VNT*, Oct/Nov/Dec 97 or the Treasurer's article in this issue.)

1997 CONVENTION—IN BRIEF AND IN PICTURES

Election results for new officers and delegates to ANA are below (see also the directory on page 2). These individuals will serve for two years, the president-elect the sole exception. VNA and the Nominations Committee appreciates the willingness of all the candidates to provide leadership to the Association.

PRESIDENT-ELECT
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Judy Carlson-Catalano
Esther Condon
Marcia DiTrapani
Marva Banks Fretheim
Florence Jones-Clarke
Georgine Redmond

DELEGATE ALTERNATE
Jan Johnson

Membership awards given by the Arthur L. Davis Agency, publisher of *VNT* were presented by managing editor Mark Miller to **Districts 6 and 12.** Each district received a check to recognize their numerical increase since October 1996. The publisher also announced that awards will be given next year for greatest growth.

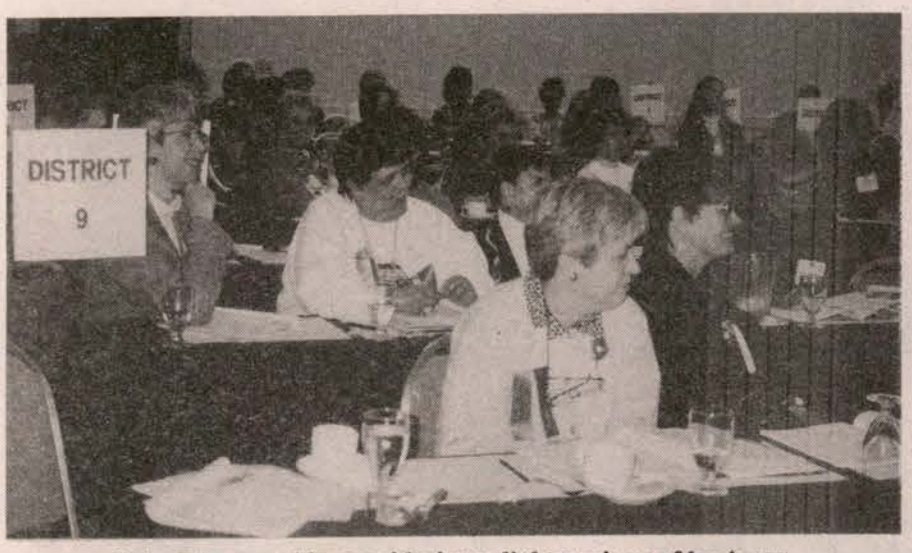
District 1 received the VNA Membership award for largest percentage of membership growth.

Two members were acknowledged at the banquet for outstanding service to the Association. **Rebecca Bouterie Harmon/District 9,** chairman of the Continuing Education Approval Committee, and *VNT* editor, **Veronica Phillips-Arikian/District 5** were cited for excellent work and contributions to the profession in their respective areas. VCU Archivist, **Jodie L. Koste**, was awarded a special recognition for 15 years of outstanding assistance to the History Committee and VNA. ◆

Opening Session: Welcome remarks from Mayor of Charlottesville.

Keynote Speaker and VNA President—(l) JoEllen Koermer and (r) Becky Rice.

1997 CONVENTION—IN BRIEF AND IN PICTURES



Delegate assembly considering a lighter piece of business.

Quality Indicators Research Project Forum (l-r) Jeanne Sorrell and Georgine Redmond (project directors); Gretchen Kelly District 7 President; Becky Rice, VNA President.

VNA-PAC Reception: (l) Sandra Ryals, PAC Chairman; Mitch Van Yahres (D) Charlottesville; and District 7 members and constituents.

VNA and UVa participants at the Annual Bice lecture and reception at UVa.

1997 CONVENTION—IN BRIEF AND IN PICTURES

President's Reception on Friday evening (l-r) Leslie Durr, Gretchen Kelly, Becky Rice, Jean Gilmon, Jan Johnson, Catherine Courtney, Ellen Seal.

VNF President, Lorna Facteau "building the future" for nursing in Virginia.

Installation of new members of the Board of Directors and Nominations Committee: (r to l) Dynese Wenthold, Karin P. Harris, Barbara Courtney, Marcia Ditrapani, Marva Fretheim, Arlene Wiens (N.C.), Melanie Harris (N.C.).

VCNP Vision

The Fall board meeting of the Virginia Council of Nurse Practitioners was held on October 25th in Charlottesville, in conjunction with the 1997 VNA Convention. At this meeting, the major topics for discussion and action were:

Adoption of Slate of Officers for the 1998 election

- President-elect
  - Susan Donckers - Blue Ridge Region
  - Elaine Ferrary - Richmond Region
- Treasurer
  - Iris Woodard - Northern Virginia Region

Appointment to position of President-elect for 1997-98

- On October 25, 1997, Veronica Griffith, Tidewater Region, resigned from her position of President-elect due to her relocation to Florida.
- Micah Scott, Tidewater Region, was appointed to fulfill the remainder of the term for the position of President-elect for 1997-98 and assume the office of President in April 1998.

Centralization of Membership

Current membership is 825 members (this includes student members).

- All Regions will have
  - Same member definition
  - Nurse Practitioner students
    - Affiliated members until qualified or licensed as an NP in Virginia
  - Dues structure
  - Mechanism for membership renewals to be initiated by the VCNP Administrative Assistant.

Appointment of Task Force to explore Regional Redistribution and the formation of additional VCNP regions.

- Goal is to redefine regions to better serve NP's in Virginia
  - Currently there are 7 VCNP Regions
  - Members of Task Force:
    - Nancy Harvey - Blue Ridge Region
    - Nancy Lutz - Piedmont Region
    - Micah Scott - Tidewater Region
  - Define 10 VCNP Regions

Next meeting will be January 10, 1998.

RULES and REGULATIONS UPDATE

The latest revision of the Rules and Regulations for Nurse Practitioner Practice has been approved by the Joint Committee of the Boards of Nursing and Medicine. Most of the changes were minor and were primarily to clarify and update language. They will be sent to the Board of Nursing and Medicine for approval. A Public Hearing will be held to allow for public comment.

MEDICARE REIMBURSEMENT UPDATE

The Health Care Financing Administration is writing the regulations for Nurse Practitioner Medicare Reimbursement. The Grassroots Task Force is requesting input from NP's and answers to the following questions.

1. In which state do you work?
2. What is the nature of your practice agreement, i.e., supervisory, collaborative or independent? Briefly explain your scope of practice.
3. Are NP's on provider panels? If so, name the MCO/HMO.
4. If you are not on provider panels now, are discussions going on within your organization or state to put NP's on provider panels? Please describe what you know.
5. Depending on the practice arrangement (supervisory, collaborative or independent), is there a difference in the capitation rate for NP's vs MD's?
6. What is the arrangement for NP's who are on provider panels for hospital admission? What has been done by the MCO to accommodate the practice agreement between the NP and the MD for the purpose of hospital admissions?

You can reply to the Grassroots Task Force at: mcare-team@nurse.net or bsmithing@wizards.net

NP's must be diligent and well-informed as these regulations are being written and implemented.

CONFERENCE

The Virginia Council of Nurse Practitioners Annual Conference (formerly the Mid-Atlantic Nurse Practitioners Conference) will take place March 14-17, 1998 in Williamsburg.

The conference will offer a variety of clinical and pertinent professional issues topics.

Early Bird tuition $175; students $100.

Earn up to 23 contact hours.

Hotel rates $86/night; call 757-220-2500 by February 20, and identify yourself as a VCNP Conference participant to receive the conference rate.

Conference brochures will be mailed in January. If you were licensed as of October 15, 1997 you will receive the brochure. If you would like to be added to the list please call 1-757-683-4256 or e-mail sglover@odu.edu.

The conference is open to all. You need not be a NP in VA to attend. ◆

LEGAL ISSUES

PROFESSIONAL INSURANCE—WHO NEEDS IT???

ANDREA J. SLOAN, RN, ESQ.

"Do I need to carry my own insurance?"

I teach many seminars on medical/legal topics for nurses and other health care professionals. Regardless of the group or the topic, one of the most frequently asked questions is, "Do I need to carry my own professional insurance?" My answer is always concise and consistent: "It depends . . ."

Your Status

In order to understand whether or not you need insurance, you first need to do an assessment of your actual or potential liability. This requires an understanding about the actual or potential risks based on your employment status, the type of employer and the type of work you are doing.

Who are you?

Given the great diversity of practice settings it is easy to understand that there is great variance in actual or potential liability a nurse may face. One of the first questions I ask in evaluating liability is whether the nurse is an employee, a "borrowed servant" or an independent contractor.

An *employee* is defined in a variety of ways in Federal and state laws. For purposes of this discussion, an *employee* is one who works for any type of employer, who is paid a wage or salary by that employer and for whom the means and end of doing the job is largely controlled by the employer. The issue of control is important. The employer tells the *employee* when, where and how to do the job through numerous means including policies, schedules, manuals and direct supervision.

An *independent contractor* is an individual contracted to do a particular job. This individual has considerably more latitude in determining the when, where and how to accomplish the agreed upon end product.

A *borrowed servant* is an individual who is employed by one employer, who, through a contractual agreement with a second employer allows the employee to perform services for the second employer.

The employer of an employee has the highest degree of control over the employee and, logically, has the greatest degree of responsibility for the conduct of the employee. ***Respondent superior*** is the Latin phrase meaning "let the master answer." The important legal doctrine means that the employer is responsible for the acts of the employee done within the course and scope of employment. Nurses need to understand this important concept and its direct impact on their personal liability and needs for insurance. Nurses without a "master" (employer) exercise the greatest control over their work, but also assume the greatest risk.

Who is your employer?

Working for some employers is riskier than working for other employers. As an *independent contractor*, a nurse is self-employed and assumes all the risk as there is no other master to answer. The same is true for nurses volunteering in some circumstances.

As an *employee*, a nurse might face less risk in knowing that the employer is held responsible for her actions, under *respondent superior*. Most lawyers will sue the responsible party with the deepest pockets, which, in most cases, is the employer. However, this does not mean that the nurse automatically avoids being named in the lawsuit. Nor does it mean that the employer will pay for the nurse's defense or any judgment against her. As a *borrowed servant*, the nurse may find that two masters must answer for her actions, but, that the two disagree as to liability and try to shift the blame on the other party.

The type of employer plays a significant role in the relative risk faced by an employed nurse. A large, multi-facility health system is most likely well-insured. Contrast that employer with a small physician group struggling to grow and maintain a practice. The cost of sufficient coverage for physicians and staff may be prohibitive. Nurses working for the government, state or Federal, may realize the protection of sovereign immunity. In this situation, the individual claiming to be harmed must have the permission of the government entity in order to sue or, in some cases, suit may be barred altogether. Certain charitable organizations may be allowed "charitable immunity." Employers who are undergoing financial hardship may be under-insured or not insured at all.

What is your job?

Some practices are riskier than others. Just as certain specialty physicians, such as neurosurgeons and obstetricians are more frequently sued, so are nurses in some settings. Critical care areas including emergency room pose an increased risk. Nurses in advanced practice settings, such as CRNA's and nurse practitioners, who have increased independence and responsibility also face increased risk. Nurses who work in certain jurisdictions which are more favorable to lawsuits may have increased exposure as is the case with any nurse practicing in a "non-traditional" setting. Finally, the type of patient may contribute to the risk. Very sick patients, children, prisoners and doctors, nurses or lawyers as patients can increase potential liability.

Evaluate the Risk

Consider the following nurses and evaluate their insurance needs.

Kate is employed as an Emergency Department nurse in a hospital owned by a large regional health system.

(continued on page 10)

Legal Issues

(continued from page 9)

Lynn is a nurse with 15 years experience in critical care and PACU nursing. She works for an agency rotating to as many as five different hospitals in a month.

Miranda is a pediatric nurse practitioner. She has a contract with a group of physicians, which includes doing telephone triage. Because the office is in northern Virginia, she sometimes takes calls from patients who live in Maryland, DC or West Virginia.

Neil is a geriatric case manager. He has his own business and gets referrals from physicians and social workers.

Ophelia is a happy, "stay-at-home mom" with two children, ages 1 and 3. She had previously worked for six years as a labor and delivery nurse. To "keep her hands in nursing," she volunteers several times per month at a privately run charity pediatrics clinic. As a nurse, she is always sought after at her children's play groups for advice on breast-feeding, rashes and other common questions from the other moms.

Paula is the Vice President for Nursing in a large community hospital. She makes it a practice to take one shift per month as evening supervisor to keep in touch with her staff.

Quinn is a nurse anesthetist, working in a busy OR in an inner city hospital He also works as a traveling nurse, escorting individuals all over the world for a medical transport service.

Rose is a recovering drug user, who has had some practice problems in her job as a Home Health nurse, as a result of her abuse.

Sally is a nurse for a large suburban public school system. She is responsible for three schools and oversees many unlicensed "aides" working in the "clinics" there when the nurse is not on duty.

Terry is licensed in another state. Her next door neighbor is dying of cancer and has asked her to give her injections until the neighbor's husband learns to do so and is comfortable with the home treatment regimen.

Risk Assessment

Employee/Contractor/Borrowed Servant/Volunteer

Kate is an employee, as are Rose and Sally. Miranda has a contract, but it is an employment contract. Their respective masters will answer under *respondent superior.* Lynn, as an agency nurse, has two masters,the agency by whom she is employed as well as the hospitals to which she is sent by the agency. They will apportion liability. Some agency nurses are independent contractors, who assume even greater personal responsibility. This status is set out in their agency contract. Here again, however, the hospital using Lynn's services may be held liable under the doctrine of *vicarious liability.* This doctrine holds the hospital responsible for providing competent providers whether they are employed, borrowed servants or independent contractors. Neil is self-employed and shoulders full responsibility as an independent contractor. The volunteers, Ophelia and Terry, likewise may have no master to share the responsibility for their actions. Some organizations do provide liability coverage for volunteers, but many do not.

The Type of Employer

Paula and Kate both work for large, well-insured employers. Miranda's small group is struggling and is under-insured. Sally works for a school system that benefits from governmental immunity from civil suits. Quinn's inner city, quasi-public hospital is chronically teetering on the brink of closing due to lack of funds, but does not enjoy any governmental immunity.

The Nature of the Job/The Location/The Patient

Kate, Lynn, and Quinn are in high-risk specialty areas (E.R., CCU/PACU and CRNA), as is Miranda, an advanced practice nurse. Paula has a different type of liability as a supervisor and as an officer of her organization. Sally, too, supervises many unlicensed individuals in an outpatient setting with a high risk patient group (minors). Neil is in a relatively new type of independent practice, with a wide divergence in tasks and responsibilities among practitioners and a standard of practice that is currently in the developmental stages. Rose practices in the highly uncontrollable environment of her patient's homes and must deal with families to a greater extent than many of her colleagues. She works in some very rough neighborhoods, too. Ophelia, our "stay-at-home" mom, is giving out a lot of nursing advice. The fact that she is not getting paid for it does not give her immunity from risk, likewise Terry's acts of kindness may not shelter her from civil suit. She may not be covered under the state's Good Samaritan laws if she takes on the legal duty of administering the medications, even though she is unpaid. Quinn is roving from state to state or country to country and there's no telling whose law will apply. Miranda's telephone triage duties raise the same question.

What kind of insurance?

Most nurses think of insurance only in the malpractice context, that is, insurance to provide coverage for negligence in practice. If the nurse makes a practice mistake, the insurance covers defense and any judgment against the nurse.

However, professional liability insurance is not quite that simple.

First, the nurse should consider that most professional liability insurance available today is "claims made" rather than "occurrence" insurance. This means that the nurse must have coverage with the same company both at the time the incident occurs as well as when the claim or suit is made. This differs from "occurrence" coverage which insured the nurse whenever the claim occurred as long as the insurance was in effect at the time of the incident.

Nurses who get insurance for the first time will not be covered for acts occurring prior to the insurance unless they buy special "prior acts" coverage and advise the company of any known claims. Nurses who drop insurance coverage because they are no longer practicing are at risk under "claims made" for any claims which may occur after they have discontinued practice. Miranda (PNP), Ophelia (former L & D nurse) and Sally (school nurse) all worked with minors. Minors have a longer period of time to file claims, as long as eight years in Virginia and even longer in some states. The risk may last long after these nurses leave their practice. "Tail" coverage may be necessary to protect them against such claims after they leave the practice.

Second, the nurse should consider that the insurance she purchases may be secondary coverage. That is, any policy of insurance, such as that of the employer, which provides coverage for the nurse must first be exhausted before the nurse's private policy is effective.

Third, the coverage may include certain acts of negligence, but may exclude the intentional torts. Such intentional torts include false imprisonment, (e.g. preventing a patient from leaving the unit) battery, (any unwanted or offensive non-consensual touching), defamation (libel and slander) and the intentional infliction of emotional distress. Such intentional tort claims are not unusual where the underlying claim is, for example, lack of consent or improper use of restraints or the increasingly popular patient abuse claim. Read the policy carefully and look for exclusions.

Fourth, the insurance may exclude acts of a criminal nature. This is particularly worrisome where some claims, such as patient abuse, have criminal consequences.

Should I Buy Insurance?

Analyze Your Practice and the Products Available

Do a risk evaluation of your nursing practice. Are you in a high risk practice or do you work for an under-insured employer? Is insurance mandatory? Many nurses, such as CRNA's and other advanced practitioners must have proof of insurance in order to get staff privileges. Independent contractors should strongly consider insurance. If insurance is not mandatory, determine what is your level of comfort with your employer and with the risk of your practice.

Contact several companies to see what products are offered. Not all insurance is the same. Read the policy carefully and ask questions so that you are sure you understand what coverage you are getting and what coverage you are not getting (the

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Legal Issues

(continued from page 10)

exclusions). Compare the cost of the various policies.

Protect Your License

Obviously, malpractice insurance will protect your assets and will protect your ability to practice your profession. But, there is an additional component of protection that you may want to consider.

Many nurses are unaware that insurance can be purchased which will offer the nurse protection in the event of a disciplinary claim. What if you are accused of professional misconduct and must appear before a licensure or other disciplinary board? In the above examples, could Terry get in trouble for practicing nursing without a license? Is interstate telephone triage risky if your patient is in a state in which you are unlicensed? Disciplinary investigations may result from patient complaints, termination by your employer, or as a result of personal problems, such as drug or alcohol abuse. Is Rose more likely to be disciplined because of her abuse history? Defending a disciplinary action may require a lawyer and may result in lost time from work and loss of income. This type of coverage is not usually included in standard policies and you may want to consider it.

To Buy or Not to Buy. That Is The Question

Have you done a risk evaluation of your practice lately? Have you given serious consideration to your needs and the available options? Have you ever considered the potential cost of not having insurance? Only you can answer this question, and you would be well-advised to do it now and to re-evaluate your needs on a regular basis. ◆

***Andrea J. Sloan** is a nurse and an attorney whose practice includes healthcare law, employment law (including representation of professionals in disciplinary proceedings) and bioethics. Comments and questions are invited. 1.800.84RNLAW or P.O. Box 419, McLean, VA 22101-0419 or em-mail at asloancat@aol.com.*

ALTERNATIVE APPROACH

A COLUMN ABOUT TRUE STORIES OF UNCONVENTIONAL HEALTH

True documented stories are requested for this column from our readership. Please send to Mary Anne Noble, DNSc, RN; or Jeanne Sorrell PhD, RN: College of Nursing and Health Science, George Mason University, 4400 University Drive, Fairfax, VA 22030.

Natural Remedies For Nausea

Mary Anne Noble, DNSc, RN

There are a number of good remedies for nausea (nausea from seasickness, motion sickness, morning sickness, chemotherapy, and inner ear problems) which are easy to take and eliminate the need for drugs such as dramamine, bonine, marazine, and compazine which have a number of side effects such as sleepiness and lethargy.

Perhaps the simplest and easiest remedy is use of a wristband, one type of which is marketed under the name "Seabands." These elasticized bands are worn on both wrists about three fingers above the wrist. A button on the inner side presses slightly into the P-6 or Neiguan point. The bands should be tight enough to be just slightly uncomfortable or what might be called gentle pressure. This procedure is based on the principles of acupressure, and was invented by a Chinese sailor who suffered from seasickness. Initially, he simply held his wrist, but obviously he couldn't sail at the same time so he invented the bands. These bands can be purchased at pharmacies such as CVS or Rite Aid for about $7. They can also be ordered from various catalogs for even less money. The principle is so simple that they can be made from elasticized materials. Personal experience proves that the bands work like a charm for seasickness, and reports from patients indicate that they also help for morning sickness, and nausea from inner ear problems and chemotherapy.

Another excellent remedy is ginger. Ginger is believed to work on the digestive system directly and not on the nervous system as is the case with some medications. Ginger is effective for the nausea and vomiting which occurs after surgery as well as for morning sickness, seasickness, heartburn, and other conditions associated with upset stomach. Ginger comes in a variety of forms—extracts, tinctures, syrups, capsules, tea. One patient with nausea from an inner ear problem used a piece of ginger root rolled in sugar as an effective remedy. Ginger can also be purchased in the crystallized form (in stores such as Safeway); it can then be sucked as candy. Incidentally, crystallized ginger is also helpful for sore or scratchy throats.

Peppermint and flat Coke (especially Coke syrup) have long been used for nausea. These were favorite remedies recommended by many "old time" country doctors, and both are popular remedies even today.

Lastly, the essential oils of ginger, lavender, orange, peppermint, and petitgrain are known to be useful for nausea. Essential oils should be put on a cotton ball or handkerchief and inhaled. Some nurses use a similar strategy for their patients by putting saturated cotton balls in crucial places in the critical care or postsurgical environment to aid in calming their patients. Essential oils can be added to the oil mixture in oil lamps for permeating the total environment. ◆

1. Fugh-Berman, Adriane. (1996). *Alternative Medicine: What Works*; Tucson: Odonian Press, pp. 30-31.

2. Fugh-Berman, pp. 113-114.

3. Mayell, Mark. (1997). "25 Power Herbs," *Natural Health*, September-October 1997, pp. 115-120, 122, 124, 126, 128-130, 132, 164-175.

4. Vukovic, Laurel. (1997). "99 Home Remedies," Natural Health, May-June, pp. 86-95, 148, 150, 152.

Discount on Liability Insurance is New Benefit of Certification

ANCC-certified nurses can now receive a 10% discount on their risk management insurance premium from Maginnis & Associates, the liability insurer recommended by the American Nurses Association. According to Maginnis Senior Vice President Joan O'Sullivan, the company is offering the discount to nurses certified by ANCC because "we realize the value of certification in raising the levels of competency in the nursing profession and believe ANCC-certified nurses deserve a discount for their efforts."

ANA recommends that all nurses carry their own liability insurance to protect themselves and their assets if they become involved in a malpractice case. Nurses should realize that any employer-provided coverage they have is limited to professional acts performed on behalf of the employer. Nurses are nurses 24 hours a day, 365 days a year, however, and any advice or care they give outside their employment can lead to malpractice claims. Maginnis' insurance protects a nurse for actions performed both on and off the job, and it is also "occurrence-based," meaning that it continues to protect the nurse for actions performed during the policy period even after the nurse has discontinued coverage. The insurance thus protects against malpractice claims that are filed long after an incident has occurred.

The Maginnis program also offers a broader-than-usual choice of risk management training. While some insurers require nurses to attend insurer-designed risk management seminars to qualify for reduced premiums, an ANCC-certified nurse can attend any risk management seminar to qualify for Maginnis' 10% discount. Another unique feature of the program is Maginnis' policy of seeking a nurse's written consent before settling any claim. The Maginnis program is the only liability insurance program that automatically reduces a nurse's risk management premium on the basis of ANCC certification.

It is not necessary to be a member of a state nurses association to qualify. Nurses who are interested in applying for the insurance and receiving the discount (or who are already insured by Maginnis and qualify for the discount) should call the company at 1-800-621-3008, ext. 105. ◆

Addressing Spiritual Needs

Reprinted with permission from ***Nursing Spectrum,*** *September 22, 1997*

Eileen R. Giardino, PhD, RN

When providing holistic nursing care, it is important to address the spiritual dimension of patients and their families by considering the whole person—physical, psychological, social, and spiritual. Although definitions of "spiritual dimension" vary, it can be described as "a quality beyond religious affiliation that is used to inspire or harmonize answers to questions regarding infinite subjects, such as the meaning and purpose of life and one's relation to the universe." People of all cultures, nationalities, and faiths have a spiritual side that becomes the lens through which they view the world and interpret events. Within the context of spirituality, people are able to face illness, disease, and their own mortality.

Some nurses contend that unless they address the spiritual nature of a patient they have not given nursing care at all. Others argue that the spiritual dimension is important, but competent physical care is primary. Most people want nurses who deliver excellent care and who are competent in technical skills. But within a holistic perspective, melding technical competence with humane, sensitive, and respectful care is the ideal and the essence of spiritual care.

How Can Spiritual Care Be Addressed?

Nurses are in an excellent position to address all dimensions of a person's care because they interact with people in the most intimate of human experiences. We care for people when they are physically and emotionally vulnerable. Helping people deal effectively with difficult situations, such as the onset of a new disease, failure of a promising treatment course, or death of a family member, requires that the nurse be able to help them transcend their distress and anguish. There are many accounts of people and their significant others who have had devastating news delivered by a nurse or healthcare provider only to be immediately left alone with the consequences of that difficult announcement. Although there are often both internal and external limits to the depth and extent of care that nurses can deliver, holistic care helps patients and families go beyond the physical to the psychological, social, and spiritual. What then does the spiritual nature involve and how can nurses address this?

To some patients, the spiritual nature is intertwined with their religious beliefs. Therefore, to care for the whole person is to recognize how important such convictions may be and that decisions regarding healthcare and treatment may be connected to those beliefs. Recently, I met an elderly gentleman in a primary care setting who refused to even consider renal dialysis for impending renal failure because he, his wife, and church community believed strongly that God could heal him of his disease. From the rational and scientific perspective of his healthcare providers, his decision is foolish, ill-fated, and unwise. However, when I spoke with him about this treatment path, he and his wife were confident that he would receive "healing."

In this case, the couple knew the medical rationale for treatment and explaining the concerns with their decision again would not make them reconsider. So, by acknowledging the depth of their beliefs and not dismissing them as foolish, I kept the door open for future reconsideration of their options. There was also an opportunity, in this atmosphere of mutual respect, to share more content-based information related to kidney disease and dialysis.

Nurturing Humanness

Another aspect of spiritual care is to consider the dimension of humanness. A nurse can deliver excellent, competent physical care and never deal with the person's emotional well-being. The foundation of dealing with spiritual well-being is to treat patients with dignity and respect and recognize them as whole beings.

A clinical environment, such as an acute care hospital setting, is filled with technology, scientific knowledge, and medical interventions that need to be delivered in an expedient time frame. Within this framework lie patients whose lives and recovery are dependent on physical resources. But to care for only the physical side may lose sight of the person's dignity and the values that are the true nature of a person.

Early in my career, I had an instructive experience with a physically healthy young woman admitted to a medical intensive care unit (MICU) for a suicide attempt by drug overdose. While intubated, and then during the remainder of the MICU stay after extubation, I asked her how she was doing, paid attention to her, and expressed interest in what was an embarrassing situation for her while attending to the physical aspects of her medical and nursing care. Before discharge from the hospital, she and her mother asked me to visit them. They thanked me for treating her kindly and talking with her as a person. They said that although every nurse in the MICU delivered competent physical care and asked her appropriate questions regarding her physical condition, few addressed her as an emotionally hurting person. Although I do not remember what we talked about or exactly what happened that made an impression on her, the situation showed me how addressing that person's humanness made the greatest impression on her.

Family Circles

The nurse who addresses the spiritual needs of patients often extends that care to the family and significant others who live with them through the illness and its consequences. The nurse may recognize what the family wants and directly or indirectly provide spiritual intervention. Joanne Serembus, RN, MSN, a faculty member at LaSalle University's School of Nursing, described an indirect spiritual intervention in which the Mennonite family of a woman severely injured in an automobile accident asked to have time alone in the hospital room with the patient and each other to pray for their ill family member. Providing privacy is not always easy to do in an ICU setting where close patient monitoring and open rooms are essential for continual observation of critically ill people. But for this family, having private time with their dying loved one was a component of a spiritual need. The family explained to the nurse that they wanted to pray that God would "take her," as they had watched their loved one deteriorate and were told there was no hope for recovery.

Serembus provided privacy for them in the midst of a busy unit and encouraged them to be with their loved one and pray for her. Within 20 minutes after the family finished, the woman died peacefully.

Keep Talking

Nurses can help family members deal with the spiritual needs of their ill loved one by encouraging significant others to deal appropriately with difficult topics. In one scenario, the mother of a 33-year-old who was dying of breast cancer would not let her daughter talk about dying. Although the mother was a leader in a Pentecostal church and was used to dealing with people in spiritual need, she felt that her daughter was giving up by mentioning death or dying.

Months after her daughter's death, the mother talked with me about her lack of sensitivity towards her daughter's need and lamented that she discouraged such disclosure. She told me that whenever her daughter brought up the subject, she told her not to "talk like that" and implored her to keep praying and fighting. Although her intentions were good, the mother later realized that her daughter needed to talk about her death and wished that she had encouraged the conversation, rather than cutting it off.

Nurses who run into a situation like this in their own practice might encourage family members to listen to what the patient has to say, even if it is not what they want to hear. Similarly, the nurse can address the spiritual dimension by encouraging a person to express individual views of life and death. Nurses sometimes discourage patients from talking about difficult subjects in an attempt to be the cheerleader and hope-giver. While instilling hope is certainly an appropriate intervention, there are times when a person wants to verbalize inner thoughts and concerns that may be considered morbid.

When giving care, nurses often tell patients what they should feel, how they should respond to circumstances, or what they would do in their situation. When this happens, the nurse fails to listen to what the patient is saying and closes off further interaction. It is better for the nurse to encourage the patient to verbalize inner thoughts and feelings that family members aren't willing to hear. If the nurse is not comfortable with this, then she can find other persons on the team who can listen to the patient's concerns or thoughts.

By addressing the whole peron, nurses can meet the spiritual needs of patients and their families. ◆

Eileen R. Giardino, *RN, PhD, is the interim director of undergraduate programs and an associate professor at La Salle University School of Nursing, Philadelphia, PA.*

Reference

* Emblem JD. Religion and spirituality defined according to current literature used in nursing literature. *Journal of Professional Nursing.* 1992; 0(1):41-47.

N-STAT—TAKE THE TIME

The Nurses Strategic Action Term (N-STAT) is the nurses' grassroots network coordinated by the American Nurses Association (ANA) in conjunction with State Nurses Associations (SNAs) to make nurses' voices heard on Capitol Hill. Tens of thousands of nurses across the country comprise the N-STAT Rapid Response Team, which plays a critical role in advancing nursing's legislative and political agenda.

Grassroots actions are needed to protect gains nursing has already made in Congress, as well as advocate for new initiatives. Nurses must speak in a united voice to shape the future of public policy issues impacting nursing, rather than letting it be shaped by people who do not understand the nursing profession.

To join N-STAT, you must first belong to your SNA, a constituent member of the ANA. If you are a member of your SNA, complete the attached form and return it to ANA. There is no initiation fee to join N-STAT.

When you become a member of the N-STAT Rapid Response Team, you will receive a grassroots orientation kit including N-STAT's *Legislative Action Handbook.* ◆

Yes, I would like to be part of a united voice for nursing. Please sign me up as a member of N-STAT's Rapid Response Team.

Name: _____

Address: _____

City: _____

State: _____

Zip Code: _____

SS#: _____

Home Phone: _____

Work Phone: _____

FAX #: _____

Internet Address: _____

Mail to:
N-STAT Rapid Response Team
American Nurses Association
600 Maryland Avenue, SW, Suite 100 West
Washington, DC 20024-2571

THIRTEENTH ANNUAL NURSES' DAY AT THE GENERAL ASSEMBLY

Political Health and Nursing: Issues and Answers

February 4, 1998

Program Agenda

Program: The agenda is designed to prepare participants to speak knowledgeably with their legislators about current bills before the General Assembly and nursing issues which will be the focus of the morning sessions. The keynote address and concurrent sessions will expand on the knowledge needed by nurses to continue to dialogue and to assess environmental forces influencing health care policy decisions.

AGENDA	EVENT
7:00-8:00 AM	**Registration** Coffee Service
8:00-8:15 AM	**Welcome & Introductions** *Rebecca Rice, EdD, RN* *President, Virginia Nurses Association* *Ray Zakhari* *President, Virginia Nursing Students Association* *Marva Fretheim, MSN, RN* *Commissioner on Government Relations*
8:15-8:45 AM	**Creating a Dialogue with your Legislator** *Delegate Robert F. McDonnell, (R) 84th District*
8:45-9:15 AM	**What to Expect from the 1998 General Assembly** *Mark Rubin, Esquire* *Shuford, Rubin & Gibney* *VNA Lobbyist*
9:15-9:45 AM	**Tips and Techniques for Talking to your Legislator** *Stephanie Ferguson, PhD, RN* *White House Fellow*
9:45-10:00 AM	**Break**
10:00 AM	**March to the Capitol**
10:15 AM	**Greetings** *Governor James S. Gilmore, III (invited)*
10:25-11:15 AM	**Visit Individual Legislators**
11:30 AM-12:30 PM	**Lunch** *and* **Exhibits**
12:30-1:30 PM	**Keynote Address** *Beverly Malone, PhD, RN, FAAN* *President, American Nurses Association*
1:45-2:45 PM	**Concurrent Sessions** *Select One* **Building Coalitions for Political Action** *Amanda Wellman* *N-STAT Regional Director,* *American Nurses Association* *(Nurses Strategic Action Team)* **Home Health Care Issues** *Bobbye Terry, BA* *Va Association for Home Care* **Joint Commission on Health Care** *Patrick Finnerty* *Associate Director* *Joint Commission on Health Care* **Defining Delegation** *Nancy Durrett, MS, RN* *Executive Director, Virginia Board of Nursing* **"No Wonder There's Chaos, No One's in Charge of Our Health Care System"** *Jean Donovan Gilman, PhD, RN* *Mary Baldwin College* **Impaired Professionals: Legislation & Treatment** *Rebecca Mason, MSN, RN* *University of Virginia, Employee Assistance Program* **"Legal Issues and Regulatory Requirements: Joint Communication on Accreditation for Hospitals" (JCAHO)** *Mildred Sawyer, MPH, RN* *JCAHO Survey Trainer and Facilitator* **Creating/Strengthening Political Action: The VNA-PAC** *Sandra Whitley Ryals, MS, RN* *Chairman, VNA-PAC* **Advanced Practice Nursing: Implications of Medicaid Reimbursement** *Ann Cary, PhD, MPH, RN, A-CCC* *Member of the ANA Congress on Nursing Practice*
3:00-4:00 PM	**Concurrent Sessions continued** *Select from above topics.*
4:00 PM	**Adjournment**

Registration/General Information: To register, complete and return the registration form to the Virginia Nurses Association. Late registrations, sent after January 30, please add $10.00 to appropriate fee. On-site registrations do not include lunch. Parking is available adjacent to the Richmond Centre and in nearby city and private lots on Marshall Street.

Location: The Richmond Convention Centre; 400 E. Marshall Street, Richmond, (one block off Broad Street).

Continuing Education/Preparation: Certificates will be available at the completion of the program for registered nurses and licensed practical nurses. An appointment in advance with your individual legislator is recommended. ◆

Registration Form
Thirteenth Annual Nurses' Day At The General Assembly

_____
Name

_____
Social Security Number

_____
Address

_____
City *State* *ZIP*

_____
Home Phone *Work Phone*

Registration Fee
Mail To: *VNA*
7113 Three Chopt Road, Suite 204
Richmond, VA 23226
Make checks and money orders payable to VNA Legislative Day
Fee includes: VNA Health Policy Facts Book
Legislative packet and coffee/lunch

☐	VNA Member	$55
☐	VNA Non-Member	$65
☐	Retiree (Age 62+)	$50
☐	Full Time Student (w/lunch)	$25
☐	Full Time Student (w/o lunch)	$15

_____
Name of School

We accept VISA and MASTERCARD (Circle One)

_____
Credit Card Number *Expiration Date*

_____
Signature for credit card authorization

On site registration will not include lunch.
Late Fee—After January 30, add $10.00

Refund Policy
Full refund minus a 25% administration fee if canceled by January 30, 1998.

NO REFUNDS AFTER JAN. 30, 1998
Registration forms can also be downloaded from the VNA Web page at ***http://www.nursingworld.org (See SNA Section).***

Welcome to Our New Members

Janice Adams
Kay Ashbrook
Debra Bagwell
Renee Barnes
Marie Barthelemy
Susan Belknap
Katherine Benton
Joyce Brors
Penny Burlington
Jennifer Collie
Louise Compton
Susan Conaty-Buck
Robert Cox
Susan Cutchin
Marjorie Diehl
David Downing
Diane Downing
Mary Dunford
Aurora Edmunds
Angelica Fletcher
Carolyn Friedman
Lynette Fuller
Carrie Goodwin
Monica Gutierrec
Bettina Graham
Vivienne Hess
Karen Hoffstetter-O'Hara
Eunice Howell
Suzanne Hunter
David Irby
Rita Jablonski
Donna Jarvis
Linda Kuchera
Marilyn Lieber
Antonietta Lucier
Elena Lunt
Kristin McGraw
Virginia Melton
Kathy Ann Merone
Suzanne Milas
Jane Milligan
Johnie Millner
Rhonda Morrissey
Judith Mosher
Jacqueline W. Mothena
Donna Neri
Maura O'Grady
Denise Oppenhagen
Barbara Pasternak
Bonni Payne
Marlene Pratt
Robert Rankel
Jennifer Reilly
Joyce Richards
Rebecca Rimel
Phaedra Rodgers
Maureen Running
Kimberly Saunders
Diana Seighman
Karen Stringer
Nancy Swanson
Nancy Van Beek
Daniel Veit
Laurie Walker
Anne Weiss
Cynthia Westley
Donna Whitford
Lewis Williams
Martha Wilson
Sonja Wintermantel
Laura Wright
Roberta Wright
Janet Wyatt
Carol Zasler
Toni Zito ◆

MONEY MATTERS

Getting Your Records Organized

by Nora P. Gillespie, CFP

NORA GILLESPIE, CFP

When it comes to keeping and organizing personal financial records, methods range from keeping every piece of paper in meticulous files "just in case" to one which can only be called chaotic, such as when records are kept sporadically and maintained haphazardly. The best system is one which works for you and which is simple and organized, with records maintained in locations consistent with their importance.

The benefits of good record keeping are primarily twofold: it saves you time when you need to find a document or record, and, in the event of an emergency, it helps the person you designate to step into your place (financially speaking) by making it easier for him or her during what may be a stressful time.

Start your organizing by making lists. Prepare an inventory of your possessions in the event of loss by fire, theft, etc. This can be on paper, but photographs or videos are recommended. Make a list of your advisors. An advisor may be your attorney, tax preparers, insurance agent, financial planner, stockbroker, realtor, etc. Make a similar list of all of the medical practitioners that you and all members of your household use. Prepare a list of all your insurance policies, bank, mutual fund, and brokerage accounts, credit cards and loans. If you have participated in any pension plans, keep a list of pension benefits for which you are eligible from current and previous employers. When compiling all this information, don't forget to include account numbers and telephone numbers.

Rent a safe deposit box and add access for the person who would handle your affairs in case you could not. To get this done, your designee will have to go to the bank with you and sign. Write down the box number and location of the key and keep it with your financial records at home. Also, set up your file at home dividing it between active (past 12 months) and inactive (older than 12 months) preferably in a metal file cabinet.

What to keep in the **safe deposit box:** estate planning documents such as wills and trusts with a copy of each kept in your home file; ownership documents such as deeds, titles, stock certificates, bonds, and notes from those who owe you money; documents relating to marriage, divorce, births, deaths, adoptions, citizenship and social security; valuables such as jewelry; proof of loans paid. Next, make a list of the contents of the box and keep it in your active file at home.

What to keep in your **active home file** in a fireproof home safe: your durable power of attorney and health care directive; insurance policies; and the lists that you have just compiled. Items that should be kept in a metal file cabinet: copy of most current tax returns; bank, mutual fund, and brokerage statements and confirmations as well as loan statements for the past twelve months; current employee benefit materials and medical records for the past twelve months; pay stubs for the year to date; receipts for all items under warranty (as well as all manuals and warranties); receipts for major purchases and tax deductible items for the year to date. When in doubt, remember that this file should be accessible and easy to use since it is the one that you will be using most frequently.

What to keep in your **inactive home file,** in a metal file cabinet: copies of all prior years' tax returns and corresponding records to support deductions taken; six years of bank statements but keep canceled checks only if they support your deductions; brokerage and mutual fund statements older than twelve months; prospectuses and annual statements from any mutual funds purchased; employee benefit statements older than twelve months; terms of all credit cards; receipts for major purchases; and health records older than twelve months.

Although the job of setting up this system may seem tedious, it does save time and simplify your life going forward. You will be pleased to find your records more quickly when you need them and, in the event that you are incapacitated, your family will as well! ◆

__Nora Gillespie__ is a Certified Financial Planner, licensee®, a Certified Fund Specialist and a Life and Health Insurance Consultant. She is the founder of The Wrightbridge Company, Inc. a fee-only financial consulting firm with facilities in Charlottesville and Richmond, Virginia and which specializes in planning for individuals, families and small businesses.

LEGISLATIVE DAY

A Day and Program Designed to Enhance Nurses' Political Involvement

Introduction

Nurses are the largest group of health care providers and as such they have the tremendous potential power to influence legislation. The need for nursing to have political power has been receiving increasing attention. The tremendous success of such programs as ANA's N-STAT (please see page 13) have involved more nurses than ever before in the legislative process.

Nurses traditionally have tended to dismiss their importance in the political process and exercise of power. Only when nurses fully understand that power is essential to effecting change will we succeed in convincing policy makers of nursing's role in reforming the health care system.

So much of nurses professional lives are, and will continue to be affected by legislation.

- The Nurse Practice Act of each state controls nursing education and practice and can be amended or rewritten in the legislative process.
- Bills have been introduced which have altered or created funding for nursing education, national health insurance, public health services, licensing of paramedical workers, funding for certain drugs, ability to declare death and numerous others.

Increasingly, health policy is established and made by elected and appointed officials who are not particularly knowledgeable about health care or nursing. It is up to nurses to educate and influence policy makers. Our goal at Legislative Day is to increase nurse's awareness of the need to become more involved in the legislative process.

A Legislative Day Primer

Nurses, students and faculty members are invited to use this information to prepare for "Leg. Day." The materials may be copied and documents found on the listed web sites will be useful supplements. Please note that at press time, some documents now on the web were not available for inclusion here.

Every participant on February 4 will receive a copy of VNA Health Policies, as well as a legislative handbook. In addition, in-site materials will include a copy of a current piece of legislation. The plenary session at 9:15 on February 4 is designed to impart information on how to talk with your legislator. Discussing general nursing and health information is always appropriate and useful for meetings with legislators. It is crucial to be prepared and focused in order to make the best use of your time and that of your legislator.

Useful Tips to Make the Most of "Leg. Day:"

- See the **VNA 1998 Legislative Platform,** the basis for how VNA determines what legislative bills and issues to support during the session.
- Contact the Joint Commission on Health Care/JCHC (at: 804-786-5445 or http://legis.state.va.us.jchchome.htm) to access any proposed legislation for the 1998 session. (Information on JCHC is included below and in on-site materials.)
- Identify current state legislators, especially the delegate and senator from your district. Call the General Assembly at 804-698-1470 to request a list of delegates and senators (to be included in the on-site materials). These lists can be downloaded from the internet at http://legis.state.va.us/. Another handy resource for purchase is the VIRGINIA CAPITOL CONNECTIONS HANDBOOK, 1998 edition from David Bailey Associates at 804-643-5554 ($2.00 + tax).
- Contact the VNA district (see directory on page 2) in your area. Many districts hold legislative briefings or may be able to identify an individual to provide additional information to your group.
- Continue reading the content in this issue as a foundation for a successful day at the General Assembly and for all future contacts with legislators. These materials include: HOW THE GENERAL ASSEMBLY WORKS; HOW A BILL BECOMES LAW; HOW TO OBTAIN A COPY OF A BILL; PASSAGE THROUGH THE LEGISLATIVE PROCESS; CONTACTING A LEGISLATOR. (Also see the internet at http://legis.state.va.us/.)
- Consider writing or contacting your legislator concerning a specific issue of professional or personal interest. How-to suggestions follow.

1997-1998 VNA Legislative Agenda

Priorities for Action:

The Virginia Nurses Association supports legislation which will assure access and affordable quality health care for all Virginians.

ADEQUATE FUNDING:

- To support provision of health services in Virginia's schools.
- For appropriate use of telecommunications technology for diagnosis and treatment of individuals where access is an issue.
- For health care delivery systems which provide pre-hospital care, diagnosis, and treatment of trauma patients.
- For effective poison control centers.

ACCESS:

- To affordable and appropriate health care services for all age groups and populations, especially those in rural and underserved areas.
- To assure patient choice in health care.
- To promote the formation of multidisciplinary health care delivery systems, including physicians, certified nurse midwives, nurse practitioners, and other mid-level providers.
- Support funding for data collection and analysis of the health care workforce.

QUALITY:

- Open and honest communications between provider and patient such that all treatment options are explained for informed decision making.
- Monitor and disseminate information regarding quality patient outcomes in health care delivery systems.
- Ensure confidentiality of patient records and information.

PROMOTION OF THE PUBLIC'S HEALTH AND SAFETY:

- Maintain a strong public health infrastructure that protects the public from infectious and communicable diseases and other threats to the public health.
- Support programs to prevent intentional and non-intentional injuries.
- Support public/private partnerships for health promotion and disease prevention.

Priorities for Action:

The Virginia Nurses Association supports professional workforce legislation which assures adequate numbers of appropriately prepared providers functioning within their scope of practice.

- Continued work to evaluate health professions regulation for its effectiveness, accountability to the public, and flexibility in a changing health care environment.
- Third-party direct reimbursement to all advanced practice nurses (e.g., certified nurse midwives, nurse practitioners, and psychiatric clinical nurse specialists.)
- Alternative programs for impaired health professionals.
- The use of distance learning for formal and continuing education of the health professions.
- The removal of barriers to professional practice by all qualified and competent health care providers.
- Increased scholarship funding for nurses in advanced practice education programs.

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Legislative Day

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THE VIRGINIA GENERAL ASSEMBLY

The 1998 General Assembly will convene on **Wednesday, January 14** for a sixty-day ("long") session. Odd-numbered years are mandated by the Constitution of Virginia to be thirty-day ("short") sessions, and even-numbered years to be sixty-day ("long") sessions. The term of office of the House of Delegates (two years) forms the basis for an understanding of legislative odd and even numbered years.

The Virginia General Assembly is comprised of a total of 140 members: 40 serve in the Senate, and 100 in the House of Delegates. Each resident of Virginia is represented by two elected legislators in the General Assembly—one Senator and one Delegate. Senators are elected for a four-year term in odd years; Delegates are elected every two years in odd years.

The House of Delegates

Long Session (even numbered year) (sixty days)	• Assumes office in January • Enacts a biennial budget • Introduces new legislative proposals • Is permitted to "Carry Over" (postpone) Certain legislative proposals to the following year
Short Session (odd numbered year) (thirty days)	• Second year of term • Enacts supplemental budget appropriations • Introduces new legislative proposals • Is permitted to act on proposed legislation carried over from preceding year

This two year pattern completes a legislative cycle.

The Senate possesses all the legislative privileges and prerogatives of the House of Delegates, with the exception that the Senate acts upon the budget legislation as introduced and proposed by the House of Delegates. The Senate serves a four-year term which matches two of the House of Delegates legislative cycles.

State wide offices are filled for four year terms in odd years. A new governor, lieutenant governor and attorney general will take office in January, 1998.

JOINT COMMISSION ON HEALTH CARE

The Joint Commission on Health Care (JCHC) was created by the 1992 Session of the Virginia General Assembly, pursuant to Senate Bill 501 and House Bill 1032. This sixteen-member legislative commission, with a separately staffed agency, continues the work of the Commission on Health Care for All Virginians begun in 1990.

The JCHC presents its recommendations for legislative action prior to each session of the General Assembly. These recommendations are based on studies undertaken as a result of legislative action in the previous session. The JCHC reviews/studies issues related to health care, the health workforce, the academic medical centers, indigent health care financing, and a variety of insurance issues among others. (1998 recommendations may be found on http://legis.state.va.us.jchchome.htm.)

HOW A BILL BECOMES LAW

Bill

A proposal to enact new legislation or amend (change) an existing Statute. A bill will almost always affect the Code of Virginia by creating or amending statutory law. (Exception: "private bills," or the enactments affecting a single individual).

Resolution

A legislative proposal for an action not affecting statutory law (Code of Virginia). For example, resolutions may:

- Request a legislative study of a specific subject area.
- Inform the U.S. Congress of the sense of the General Assembly on an issue.
- Propose an amendment to the Constitution of Virginia.
- Commend or honor an individual or organization.
- Create a legislative commission.

A **proposed bill or resolution** as printed contains all information necessary for that specific piece of legislation. The items in a proposed bill are these:

Number

House of origin (House or Senate) and number in order of introduction. Bill numbering is consecutive through two annual sessions. The numbering begins on the even-numbered year (HB1, SB1) and continues through the following odd-numbered year (HB2---, SB9---).

Offered

Date of introduction of the legislation.

Descriptive Statement

A bill to amend the Code of Virginia (Code Section), relating to a (Subject of Bill). Or, a summary statement of the subject of the resolution.

Patron(s)

The person(s) responsible for introducing the legislation. NOTE: Should the entry state "BY REQUEST" followed by the name of the legislator, it means that a member has introduced the legislation upon "request." The member agrees to introduce the legislation, but is not committed to encourage its passage.

Referred to

The committee assignment.

Bill

All new or amended wording is printed in *italics*. If the bill amends selected portions of an existing statue, the current wording is printed in Roman type and crossed through with dashes (e.g. ~~incorrect~~).

Resolution

Text is in Roman, and is printed in italics if the proposed resolution refers to new or amended sections of the Constitution of Virginia.

Effective Date

If no specific date appears on the last line of the bill, it will become effective on the standard date of July 1, of that year. Any other information will be stated on the last line, such as:

- "An emergency exists and this act is in force from its passage" (becomes effective upon the signature of the Governor).
- Shall become effective January 1, 199- or whatever date has been selected (is used when an extended time period is required before the statute becomes operative).

HOW TO GET A COPY OF A BILL

There are several ways to obtain a copy of a bill. It is MOST IMPORTANT TO DESIGNATE THE SPECIFIC VERSION, i.e., original version, amendment in the nature of a substitute, or engrossed version. Having the bill number is almost mandatory to obtaining a copy.

- Call your delegate or senator and request a copy through his or her office.
- Copies of enrolled bills (those that have passed both houses) are available through Joseph H. Holleman, Jr., Clerk of the House of Delegates, or from the Legislation Information Office, House of Delegates at PO Box 406; Richmond, VA 23203. There is no charge for this service. Ordering may be done by telephone. The information office's number is (804) 698-1470.
- The General Assembly Building is at Ninth & Capitol Streets, Richmond. The **"Bill Room"** is downstairs. Request the bill by number.

Where To Call For Information on Bill Status

Legislative Information Office	(804) 698-1470
General Assembly	(804) 786-7281

(The General Assembly can provide a status report on a bill, can look up a subject to get a bill number, can look up a delegate and see what they have sponsored, etc. Providing as much detail and the bill number speeds up the process during a busy session.)

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Legislative Day

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PASSAGE THROUGH THE LEGISLATIVE PROCESS

(Complete details of Passage . . . will be in the handbook provided on February 4.)

1. A bill is drafted by the Division of Legislative Services and is printed containing the bill number, title, date of introduction, specific section of Code of Virginia to be affected, patron, committee assignment, and text.
2. Bill is introduced and sent to the appropriate committee for action. The committee may:
   - Study the measure as presented and vote to report the bill to the floor for action.
   - Amend the text and vote to report the bill to the floor for action.
   - Substantially amend and rewrite the text, and vote to report the bill to the floor for action.
   - Vote to kill the bill.
   - Declare the bill to be PASSED BY INDEFINITELY (PBI). Should this occur, the committee has chosen "not to consider the bill for any legislative action."
   - Re-refer the bill to another committee for action, or recommit to the same committee for further study.
   - Take no action whatsoever. In this situation the bill is killed automatically at the close of business of the final day permitted for committee action.
   - Carry over to following legislative session/postpone action for one year (permitted in even-numbered years only).
3. If the bill is voted upon in committee and reported to the floor for house action:
   - the bill will have its FIRST READING.
   - after a calendar day, the bill is again read and printed on the calendar for its SECOND READING. Amendments are considered and the bill debated. Members vote the question, "whether it shall be engrossed, read, and printed on the calendar a third time." A surviving bill is referred to as an ENGROSSED BILL.
   - If the House agrees to ENGROSSMENT the bill is reprinted with amendments and appears on the calendar as its THIRD READING. In its house of origin, an engrossed bill is not debatable or amendable, although members may speak to the issue for or against the bill. When not in its house of origin, an engrossed bill on its third reading is debatable and amendable.
4. If the bill passes on the floor of the house of origin, it is sent to the second house for action. The same steps are followed in the second house.
5. If approved by both houses, the bill is sent to the Governor. The Governor may
   - sign the bill into law
   - veto the legislation (to be returned to the General Assembly within seven days for a possible override of the veto). This provision is mandated by the Virginia Constitution but rarely occurs in legislative practice. See also: 1980 Amendment - Gubernatorial Veto Override.

A **resolution** is drafted, printed, introduced, and assigned to committee in the same manner as a bill. The majority of resolutions are either SENATE JOINT or HOUSE JOINT RESOLUTIONS (SJR, HJR), and require concurrence and agreement by both houses.

A resolution will follow the same general legislative process as a bill and requires similar committee and floor actions.

TIPS ON CONTACTING A LEGISLATOR

Try to find out as much as you can about your elected officials before your visit. For example: What committees do they sit on?; What leadership positions do they hold?; Do you know anyone who knows them? Committee lists are included in the on-site handbook and can be requested or picked-up at the information desk of the General Assembly building. See also http://legis.state.va.usl.

If the person you are lobbying does not sit on a committee addressing issues important to you, do not expect them to know much or even anything about the issue. Explain the issue and ask for a vote when the issue comes to the floor.

DON'T BE SURPRISED IF YOU END UP TALKING WITH THE STAFF. If you are not successful in seeing your elected official, speak with his/her aide. Leave your business card or a message with the secretary so that your elected official will know you were there. The staff concerned with health care/manpower issues is an important person. Expect less than one hour of the person's time. This is the busiest time of the year. Thank them for their time.

ASK AND OFFER. That is, ASK the elected official to support your issue. OFFER to testify, provide background information, set up a meeting with health care people in your district, VOLUNTEER to work on the election campaign or provide a forum for campaigning. Those elected officials up for re-election are already thinking of their campaigns.

THANK THEM for positive past votes and past positive actions of support. Be friendly. If they disagree with your position, try to find an area of the subject on which you can agree. Find out if the position is a final one or if you can provide further information at a later date to persuade a change of heart.

FOLLOW-UP. Each legislator has a local office and can see constituents when they are home after the session. Continue to contact your legislators by phone or in person, or write to them regularly.

When writing, use:

The Honorable _____
The Virginia House of Delegates
General Assembly Building
910 Capitol Street
Richmond, VA 23219
(Or local address)
Dear Delegate _____:

The Honorable _____
The Virginia Senate
General Assembly Building
910 Capitol Street
Richmond, VA 23219
(Or local address)
Dear Senator _____:

LETTERS should be polite, brief and to the point—stating your stand, identifying the bill (or issue) under discussion by number, urging action or amendments and your reasons, and giving your address and phone number. ◆

NEWS BRIEFS

DISTRICT 3 ANNOUNCES MEETING SCHEDULE FOR 1998

January 27

Board meeting at 5:30 p.m. with Program at 7 p.m. Program is Update on Managed Care presented by Cindy Zerfoss, CNS. This will be held in the South Terrace Conference Room at Lynchburg General Hospital in Lynchburg.

March 24

Board meeting at 5:30 p.m. with Program at 7 p.m. Program is "What's happening in Oncology?" presented by Dr. Halpin. This will be held in the South Terrace Conference Room at Lynchburg General Hospital in Lynchburg, Va.

April 28

Board meeting at 5:00 p.m. Annual District 3 Awards Dinner will be held that night starting at 6 p.m. with a program entitled Alternative Therapies in Healthcare presented by various local professionals. Exact location will be announced later.

Please contact Joanne Burks, RN, for further details at (804) 929-8172.

DISTRICT 5 NEWS

At the VNA Convention, members of District 5 were saddened to learn of Evelyn Bacon's death. As former president of District 5 and active in other endeavors in Virginia, she had a special knowledge of nursing. We will greatly miss her humor and her stories of nursing events in the commonwealth.

The next professional meeting of District 5 will be January 15 at 6:00 p.m. and will be held at the Hunter Holmes McGuire VA Medical Center. All nurses and nursing students are encouraged to attend the presentation on "The VNA's Project: Quality Report Card" by Georgine Redmond, PhD, RN and Jeanne Sorrell, PhD, RN. As one of six pilot studies across the country, their study may have a great impact on the future delivery of nursing care in Virginia. District 5 members be sure to bring a friend and share a ***District 5 - News & Views*** on this special event. If you need more information, please call Elisabeth Hutton at (804) 530-3822.

All of us from District 5 send greetings and best wishes to you for a good and prosperous new year. We look forward to seeing you at one of the district's professional meetings.

DISTRICT 9

8th Annual Legislative Dinner was held in Staunton on September 15, 1997. Over one hundred nurses registered for the event. Arlene Wiens, PhD, RN, VNA Vice President and outstanding district nurse of the year award winner represented Democratic gubernatorial candidate, Don Beyer in a brief address to the nurses. Vance Wilkins, Republican representative from House District 24, offered information regarding Jim Gilmore's qualifications to represent Virginia as governor. During dinner, House of Representative's candidates and nurses shared views and opinions on issues, regulations and laws.

The panel discussion, moderated by Teresa Boshart-Yoder, MSN, RN, included:

Democrat Representative Creigh Deeds, House District 18

Republican Representative Steve Landes, House District 25

Republican Representative Vance Wilkins, House District 24

Republican Representative Glenn Weatherholtz, House District 26

Green Party Candidate Dale Anne Diaz, House District 26

Green Party Candidate Eli Fishpaw, House District 18

Democrat Candidate Ben F. Fordney, House District 26

Green Party Candidate Daniel Metraux, House District 24

Green Party Candidate Sherry Stanley, House District 25.

Issues addressed included health care reform, managed care, advanced nursing practice, complementary/alternative health care practices, seat belt/child seat restraint laws, school nursing, and taxes.

District 9 of The Virginia Nurses Association co-sponsored this event with the Jefferson Chapter, Virginia Association of Women's Health, Obstetrics, and Neonatal Nurse (AWHONN), Emergency Nurses Association, Shenandoah Valley Chapter (ENA) and the Central Virginia Association of Occupational Health Nurses (CVAOHN).

This event is a wonderful example of several special interest nursing organizations pooling resources and efforts to present a common voice to legislators. An informed and interested constituency can be a powerful influence as important health-related and social issues are addressed by lawmakers.

Ivo Abraham, PhD, RN, FAAN—Professor of Nursing and Associate Professor of Psychiatric Medicine at the University of Virginia—was recently re-appointed to a second four-year term as Consulting Editor of the Annals of Behavioral Medicine, the interdisciplinary journal published by the Society for Behavioral Medicine. Abraham continues to serve as Editor, Technical Notes for the Western Journal of Nursing Research.

Catherine Kane, PhD, RN, FAAN—Associate Professor of Nursing and Associate Professor of Psychiatric Medicine at the University of Virginia—was recently and unanimously elected Chair of the Behavioral Health Care Professional and Technical Advisory Committee (PTAC) of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The Behavioral Health Care PTAC reviews accreditation standards related to behavioral health care and advises JCAHO on the relevance, implications, and performance criteria for these standards and makes suggestions for revision and or addition of new standards. Kane has served as the representative of the American Nurses Association for four years. She will serve as chair for one year.

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Newsbriefs

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Barbara J. Parker, PhD, RN—Professor of Nursing and Director of the Center for Nursing Research at the University of Virginia—recently participated in a **National Nursing Summit on Violence Against Women.** The summit, sponsored by the U.S. Public Health Service's Office on Women's Health within the Department of Health and Human Services, was held on October 20, 1997 in Washington, DC and convened experts to discuss how to improve the quality of education, prevention and intervention strategies, universal screening, and workplace initiatives regarding violence against women.

In addition, Parker's book, *Conceptual Foundations of Professional Nursing Practice*, (second edition) was recently selected by Doody's Rating Service for its "Buyer Guide to the 250 Best Health Sciences Books, 1997."

Ann Gill Taylor, EdD, RN, FAAN—Professor of Nursing and Director of the Center for the Study of Alternative and Complementary Therapies at the University of Virginia—is the recipient of a $500,000 grant from a private Canadian foundation.

The monies received will be used by Taylor to investigate the efficacy, safety, and cost effectiveness of biomagnetic devices in relation to promotion of health, or to the treatment of various pain conditions. The research is titled "Electromagnetic and Magnetic Field Interactions with Body Systems" and will involve collaborative studies with physicians in physical medicine and rehabilitation, neurology, rheumatology, endocrinology and plastic surgery, as well as a biophysicist, and statisticians from the Center for Health Evaluation and Research at the University of Virginia.

The objectives of this two-year project are to 1) test the effects of pulsed electromagnetic fields in reducing pain; and 2) test the effects of static magnetic fields to determine if these fields interact with biological systems to reduce pain in populations suffering from a variety of conditions.

Biomagnetic therapies have received widespread media attention in recent months, due to the growing use of magnets among sport celebrities. According to Taylor, "In clinical practice, magnetic and bioelectromagnetic applications offer the possibility of economic and effective diagnostic and non-invasive therapies for disease and pain-related problems, especially those considered nonresponsive to conventional treatment."

The Center for the Study of Complementary and Alternative Therapies was established in 1996 through a three-year, $1.3 million grant from the National Institute of Health's Office of Alternative Medicine and funding from the National Institute of Dental Research. It is one of ten such federally funded centers in the nation, and the only one administered by a nursing school.

For more information, please contact: Ann Gill Taylor, Director, Center for the Study of Complementary and Alternative Therapies, Professor of Nursing, (804) 924-0087 or Karen Ratzlaff, Public Relations, (804) 924-0084.

Ellen G. Seal, MEd, RN, CNA, was given the District 5 Nurse of the Year award.

Employed at McGuire Veterans Administration Medical Center for 33 years, Ellen has served in many capacities and is now Associate Chief, Nursing Service for Education. She is Co-Chairperson for the Nursing Professional Standards Boards and serves on the Week of the Nurse and Recruitment and Retention Committees.

Ellen has served on the Board of Directors and in several roles within VNA. She is a gracious lady who gives unselfishly of her time and talent, always willing to lend a hand and very deserving of this honor.

AMERICAN CANCER SOCIETY

We are pleased to announce the following individuals have been awarded the American Cancer Society, Virginia Council Nursing Hope Fellowship: **Fannie Utz** of Madison and **Pam Kennedy** of Hampton. Both applicants will be pursuing their B.S.N. with the grant monies.

For many years the American Cancer Society, Virginia Council, has supported the continuing education of nurses who demonstrate interest in cancer care. Annually, applications are reviewed by a team of nurses and two are selected to receive the fellowship. This year 1997/98 the fellowship has been increased to $2,000 per recipient.

In the past, we have not received the number of applications we believe reflects the need and interest of nurses in our state. We have redesigned the application process and are currently seeking avenues to reach nurses most interested in cancer care.

The request for applications begins in January, deadline for receipt is the end of March. Selection is completed by July 31st. For more information, please call Karen Babb, BSRN, Sr. Community Specialist, American Cancer Society at (757) 853-6638. Thank you!

VCU SCHOOL OF NURSING RECEIVES $171,000 GIFT

Virginia Commonwealth University's School of Nursing recently received a $171,000 gift, the largest ever made to the school by an individual.

Margaret Stokes, a VCU alumna from the class of 1944, who died in August, 1996, made provisions for the gift in her will.

Stokes, an active member of VCU's Medical College of Virginia Alumni Association, specified that the gift be used to fund nursing fellowships, which will be granted to doctoral students to support their research. These fellowships will be the first ever offered in the School of Nursing.

"Our alumni exhibit a deep abiding love for this school, both for what it was then and what it is becoming," said Nancy Langston, PhD, RN, dean of the School of Nursing. ◆

Legislative Coalition of Virginia Nurses— Elects Officers and Develops 1997-98 Legislative Agenda

Editor's Note: Periodic updates on the Coalition are included to involve nurses in the legislative process.

In the October meeting of the Coalition, members elected Chairman, Becky Rice of VNA; Vice Chairman, Jessica Jordan of the Virginia College of Nurse Midwives; and Secretary-Treasurer, JoAnne Henry, individual member. The Coalition has been meeting for two years to bring together nursing organizations and nurses interested in improving health care and nursing practice. Individuals or members who are interested in joining should contact Becky Rice at 202-496-1093 or JoAnne Henry at 804-828-2011 for membership information.

The Legislative Coalition has developed the 1997-98 Legislative agenda and the next meeting is on January 16, 1998 at 2 PM. The meeting agenda includes presentations by nursing organization members of their legislative agendas and a review of the bills introduced to the General Assembly for its 1998 session. All nurses are invited, please notify JoAnne Henry at 804-828-2011 if you plan to attend.

The Legislative Coalition was created to develop and implement a legislative agenda for Virginia nurses, educate nurses on legislative issues, and promote inclusion of nurses in policy-making bodies such as boards and commissions. The benefits of membership include coalition building on policy issues related to health care and nursing, building a network of nurses who are knowledgeable and involved, increasing the influence of nurses in the legislation and the policy-making process, and collaborating to build a nursing health care agenda for Virginia. Frequent communication is essential to assure that nurses can be actively involved in policy development and the legislative process. The Coalition meets monthly during the Fall and Winter months.

Organizations and individuals may join. The categories of membership and first year dues are:

- Statewide Nursing Organizations are entitled to 2 voting members. Each will receive written communication for action alerts and meetings. Dues: $50.00.
- Regional Specialty Organizations or Chapters are entitled to one voting member. The member will receive written communication about meetings and action alerts. Dues: $25.00.
- Organizations interested in nursing but who do not represent nursing organizations may have one voting member. The member will receive written communication about meeting and action alerts. Dues: $25.00.
- Individuals may receive mailings and action alters. No vote is accorded in this category of membership. Fee: $15.00.

Membership applications are available from JoAnne Henry, 14209 Regatta Pointe Road, Midlothian, Virginia 23112.

Membership Application

Organizational Membership:

Organization name:

Coalition members:
1st member:
Address

Phone numbers: (W)
(H)
(FAX)
email:

2nd member:
Address

Phone numbers: (W)
(H)
(FAX)
email:

Individual:

Name:
Address

Phone numbers: (W)
(H)
(FAX)
email:

I have enclosed a check for $_____
Date:

VIRGINIA NURSES

A new column for and about nurses in Virginia and the diversity of nursing roles.

Veronica Phillips-Arikian

As a nursing student in the 1970's, I never imagined the scope and diversity of fascinating work I would be offered the opportunity to do with my RN. Although I have been a nurse for more than 20 years, I am still in the process of "becoming," and, to that end, I am optimistically preparing myself for the "next act." The possibilities for growth in nursing are truly amazing, and I am constantly in awe of the accomplishments of my nursing colleagues. I can honestly say that, in nursing, I have worked alongside some of the most inspiring individuals I have ever encountered. I have also witnessed some of the "dark side" of nursing exposing its worst in "cultural" responses, such as oppressed group behaviors and abusive work and educational practices that have been documented in the literature. Fortunately, the essential goodness of nursing and nurses far outweighs the "dis-ease" in the profession.

Despite the changes in the health care setting, I see nursing perched on the edge of tremendous opportunity—it wil be up to us to "seize the day." I have never felt that more strongly than I do now—nursing will either take the plunge into the next century, or we will slowly languish and weaken trying to resist change rather than being part of it. I am convinced that what could harm the nursing profession is not the instability of the health care system, but the internal divisiveness and rigidity that still haunts and undermines our decisions on definitions of nursing roles, position on education for entry into practice, and expansion of advanced practice. Energies expended in our "sibling rivalries" would be more wisely spent on resolving our internal political issues as quickly as possible.

What brought me to this point is a career that looks like a crazy patchwork quilt of clinical practice, academia, administration and research. In my current position, I am a test consultant and Director of Assessment and Evaluation for the National League for Nursing in New York City. I now divide my time between Virginia and New York, constantly readjusting my cultural antennae. The NLN began in 1893 at the Chicago World's Fair when a group of nurses established the American Society of Superintendents of Training Schools for Nurses. It was the first association of nurses in the U.S. and advocated for quality in nursing education. Now, over 100 years later, the NLN's stated mission is to advance quality nursing education that prepares the nursing workforce to meet the needs of a diverse population in an ever changing health care environment. There are over 2,000 member nursing schools and health care agencies, and thousands of individual members, 42 state and regional constituent leagues. The NLN has several centers, functions, and subsidiaries. For example, the Accrediting Commission accredits all types of nursing education programs, the NLN Press publishes hundreds of scholarly and consumer-oriented books, and the NLN produces the journal *Nursing and Health Care Perspectives.*

At the NLN, my work in the Assessment and Evaluation department involves daily contact with clinicians and faculty in the U.S., including Puerto Rico and Guam to guide the process of exam development from the beginning of the blueprint to the debut of the final product for marketing. The NLN produces all types of tests, from preadmission to achievement, practice assessment and certification exams for use in a variety of settings. For example, New York State accepts the NLN's Child Abuse practice test to satisfy the condition for nursing re-registration. I have recently worked on exams in anatomy and physiology, microbiology, psychiatric nursing, nutrition, childbearing, pediatrics, pharmacology, and holistic nursing. One advantage to this position is that it requires the most up to date knowledge base possible. Therefore, I am gathering nursing and health information from the latest texts, from the media, and the internet. A topic that was stored away in memory is now thoroughly researched and made current.

My volunteer position is as the editor for the *VNT* since its inception as a small newsletter in 1989. In trying to find a way to contribute to the VNA within serious time constraints, I found I could offer literary skills to help put together a communication tool for the VNA. And from a little newsletter . . . well, the rest is history. I believe that for all the hours I donated to help produce the VNT, I, in turn, received a valuable education in the political and humanitarian power that lies within the nursing profession. Nursing, the willingness and desire to care for, nurture, and help heal others connects all of us to a common goal.

A classic overachiever, I am an "available" phone mom to my two older college age children, a "day-to-day" mom to my school-age children, I joyfully take a daily role in the lives of my parents, am still steadfastly plodding tortoise-like toward a PhD in nursing, and will examine the possibility of becoming a certified nurse practitioner down the road. Why do I do this? Because I know I have more to give, it nourishes the soul, and I love it. ◆

VIRGINIA NURSES ASSOCIATION
STATEMENT OF FINANCIAL POSITION
June 30, 1997 and 1996

ASSETS

	1997	1996
Current assets		
Cash	$ 178,798	$ 168,919
Investments	40,000	19,350
Accounts receivable	14,020	17,047
Prepaid expenses	3,315	3,993
Total current assets	236,133	209,309
Property and equipment		
Furniture and equipment	23,082	22,582
Less accumulated depreciation	20,576	18,611
Property and equipment, net	2,506	3,971
Total assets	$ 238,639	$ 213,280

LIABILITIES AND FUND BALANCES

	1997	1996
Current Liabilities		
Accounts payable	$ 3,313	$ 22,166
Payroll taxes payable	2,431	0
Accrued retirement payable	736	986
Deferred revenues	43,626	43,858
Total current liabilities	50,096	67,010
Fund Balances:		
Temporarily restricted		
Peer Assistance for Chemically Dependent Nurses	4,971	5,276
Council for Nurse Practitioners	80,901	74,591
Council of Clinical Nurse Specialists	2,230	1,952
Total restricted	88,102	81,819
Unrestricted	100,441	64,451
Total fund balances	188,543	146,270
Total liabilities and fund balances	238,639	213,280

VIRGINIA NURSES ASSOCIATION
STATEMENT OF ACTIVITIES
For the Years Ended June 30, 1997 and 1996

	1997	1996
Revenues		
Membership dues	$ 179,381	$ 174,085
Convention and meetings	9,158	45,389
Program and other	17,815	19,659
Legislative Day	21,041	17,368
Promotional sales	10,192	17,662
Publications	1,465	2,625
Interest	3,518	3,558
Miscellaneous	59,809	34,908
Peer Assistance for Chemically Dependent Nurses	35	359
Council of Nurse Practitioners	50,327	32,208
Council of Clinical Nurse Specialists	666	534
Total revenues	353,407	348,355
Expenses		
Salaries and employee benefits	87,844	86,218
Convention	14,348	44,241
Program and other	2,185	11,652
Legislative Day	28,545	12,886
Professional fees	7,200	28,899
Publications	3,555	25,846
Promotional cost of sales	9,295	11,625
General administration	53,160	32,879
Office supplies and expense	10,345	12,713
Rent	16,483	15,776
Payroll taxes	6,760	6,566
Insurance	8,225	6,741
Travel	4,005	6,578
Depreciation	1,965	2,334
Membership campaign	10,650	6,782
Scholarships and contributions	1,824	2,450
Peer Assistance for Chemically Dependent Nurses	340	5,542
Council of Nurse Practitioners	44,017	30,669
Council of Clinical Nurse Specialists	388	347
Total expenses	311,134	350,744
Excess of revenues over expenses	42,273	(2,389)
Fund balances - beginning of year	146,270	148,659
Fund balances - end of year	188,543	146,270

VIRGINIA NURSES ASSOCIATION
STATEMENT OF CASH FLOW
For the Years Ended June 30, 1997 and 1996

	1997	1996
Cash flows from operating activities		
Change in net assets	$ 42,273	$ (2,389)
Adjustments to reconcile changes in net assets to cash provided by operating activities		
Depreciation	1,965	2,334
(Increase) Decrease in operating assets:		
Accounts receivable	3,027	2,461
Prepaid expenses	678	(291)
Increase (Decrease) in operating liabilities:		
Accounts payable	(18,853)	5,923
Payroll taxes payable	2,431	(2,193)
Accrued retirement payable	(250)	986
Deferred revenues	(242)	(3,950)
Total adjustments to net income	(11,244)	5,270
Net cash provided (used) by operating activities	31,029	2,881
Cash flows from investing activities		
Purchases of investments	(20,650)	(19,350)
Purchases of equipment	(500)	(604)
Net cash provided (used) by investing activities	(21,150)	(19,954)
Cash flows from financing activities		
Principal payments on notes payable	0	(5,555)
Net increase (decrease) in cash and cash equivalents	9,879	(22,628)
Cash and cash equivalents at beginning of year	168,919	191,547
Cash and cash equivalents at end of year	$ 178,798	$ 168,919
Supplemental cash flow information:		
Cash paid during year for interest	$ 0	$ 94
Cash paid during year for income taxes	4,095	0

CONTINUING EDUCATION PROVIDERS FOR 1997

There are 41 agencies currently approved by the Virginia Nurses Association to provide contact hours for nurses:

Alexandria Hospital
American College of Health Care Administrators
American Diabetic Association
AmSECT
The Arlington Hospital
ASPO/LAMAZE
Association for Ambulatory Behavioral Health Care
Association of Occupational Health Professionals
Augusta Medical Center
Career Development System
Carilion Health Care System
Centra Health Department of Education
Children's Hospital of The King's Daughters
Columbia Reston Hospital Center
Columbia Hospitals/Richmond Market
Community Hospital of Roanoke Valley College of Health Sciences
Danville Regional Medical Center
DePaul Medical Center
Eastern State Hospital
Fairfax Hospital
Fauquier Hospital
Greater Southeast Community Hospital
Hampton University School of Nursing
Health Management Strategies International, Inc.
Columbia Henrico Doctors' Hospital
Hunter Holmes McGuire Veteran Medical Center
Lewis Gale Medical Center
Mary Washington Hospital MediCorp
Mid-Atlantic Renal Coalition
Mount Vernon Hospital
Potomac Hospital
Reston Hospital Center
Richmond Memorial Hospital
Sentara Health System
Shenandoah University
University of Virginia Health System/
Center for Organizational Development
University of Virginia Health Science Center/
Continuing Health Care Education
Virginia Geriatric Education Center
VenCor Hospital Arlington
Veteran Affairs Medical Center - Nursing Services
Western State Hospital ◆

PROFESSIONAL ACTIVITIES

THE VIRGINIA INTERVENTION PROGRAM: A NEW APPROACH FOR IMPAIRED HEALTHCARE PROVIDERS

April 30-May 2, 1998
The Fort Magruder Inn and Conference Center • Williamsburg, Virginia

The Health Practitioners Intervention Program is designed to protect public safety by encouraging providers who may be impaired to seek treatment and be monitored, if necessary, without being subjected to formal disciplinary action.

This conference, for the 240,000 licensed or certified health care practitioners in Virginia will introduce the new intervention program and will provide participants with information that will enable them to understand addictive illness, recognize signs and symptoms of impairment and access the new program. Participants will also learn about different levels of treatment, how to assist with intervention and monitoring and ethical and legal implications of this problem.

For more information contact Lynda Myers, University of Virginia 804-924-5318 or Ernie LeClerc, The William J. Farley Center 800-582-6066 or 757-565-0106.

NATIONAL KIDNEY FOUNDATION

SEVENTH ANNUAL SPRING CLINICAL NEPHROLOGY MEETINGS
NURSES AND TECHNICIANS PROGRAM
MARCH 26-29, 1998
OPRYLAND HOTEL
NASHVILLE, TENNESSEE
FOR REGISTRATION INFORMATION
CALL 1-800-622-9010

THE VULNERABLE POPULATIONS COMMITTEE will meet on January 24 at 10:00 a.m. at VNA headquarters. For directions or more information please call Suellen DeWitt at 804-741-7827.

THE RESEARCH COMMITTEE will meet on January 16th at 9 a.m. They will meet in McCloud Hall, Room 2007, University of Virginia, Charlottesville. Please call Suellen DeWitt for further information, 804-741-7827.

NEW NURSING THEORIES ORGANIZATION

Oakland University's School of Nursing is serving as the headquarters for a new group focusing on a major nursing theorist, Imogene M. King. "The mission of the newly formed King International Nursing Group is to improve nursing care and contribute to the science of nursing through the advancement of King's interacting systems framework and related theories," said Dr. Christina Sieloff, assistant professor, School of Nursing, and the Group's President.

King is one of more than twenty theorists within the nursing profession. Using a certain nurse theorist to provide nursing care is comparable to using a particular political party to guide one's voting preferences—"It gives you a framework to guide your thinking;" (Sieloff).

The King framework identifies three groups of people: an individual, individuals in pairs or small groups, and larger groups such as communities.

Dr. Sieloff said she chose to establish the King Group for many reasons. "King's way of thinking about nursing care made the most sense to me and her work has not been recognized by a formally organized group. There is also a need to coordinate communication on Dr. King's work. Anyone from around the world can contact us for information. We will try to link them with other people in their area who can help them. The Group will be helpful for students, nurses, faculty and administrators—anyone who wants to know about Dr. King and her work."

Christina Leibold Sieloff, R.N., Ph.D., C.N.A.
President
King International Nursing Group
248-370-4492
Fax: 248-370-4279
email sieloff@oakland.edu ◆

Virginia Nurses Association Membership Application

7113 Three Chopt Rd • Suite 204 • Richmond, VA 23226 • (804) 282-1808 • Fax: (804) 282-4916

Date _____

Last Name/First Name/Middle Initial

Social Security Number

Basic School of Nursing

Credentials

Home Phone

Graduation (Month/Year)

Home Address

Work Phone

RN License Number

Home Address

Home Fax Number

License State

City/State

Work Fax Number

County

Zip Code

Employer Name

Employer Address

Employer City/State/Zip Code

MEMBERSHIP DUES VARY BY STATE

Membership Category (check one box)

M Full Membership Dues—$190.00
- ☐ Employed—Full Time
- ☐ Employed—Part Time

R Reduced Membership Dues—$95.00
- ☐ Not Employed
- ☐ Full Time Student
- ☐ New graduate from basic nursing education program, within six months after graduation (first membership year only)
- ☐ 62 years of age or over and not earning more than Social Security allows.

S Special Membership Dues—$55.00
- ☐ 62 years of age or over and not employed
- ☐ Totally Disabled

Note: $7.50 of the SNA member dues is for subscription to *The American Nurse*. $14 is for subscription to the *American Journal of Nursing*. Various amounts are for subscriptions to SNA/DNA newsletters; check with your SNA office for exact amount.

State nurses association dues are not deductible as charitable contributions for tax purposes, but may be deductible as a business expense. However, that percentage of dues used for lobbying by the SNA is not deductible as a business expense. Please check with your SNA for the correct amount.

Payment Plan (check one box)

☐ **Full Amount Payment**
- ☐ Check
- ☐ MasterCard or VISA Bank Card (Available for annual payment only

Bank Card Number and Expiration Date

Signature for Bank Card

☐ **Installment Payment** (checks only). Three payments annually with additional service fee applied—$64.66

☐ **Payroll Deduction**—This payment plan is available only where there is an agreement between your employer and the association to make such deduction.

Signature for Payroll Deduction

Payment Plan (continued)

☐ **Electronic Dues Payment Plan (EDPP)—$16.16**
Read, sign the authorization and enclose a check for first month's EDPP payment (contact the SNA/DNA for appropriate rate). 1/12 of your annual dues will be withdrawn from your checking account each month in addition to a monthly service fee.

AUTHORIZATION to provide monthly electronic payments to American Nurses Association (ANA):

This is to authorize ANA to withdraw 1/12 of my annual dues and any additional service fees from my checking account designated by the enclosed check for the first month's payment. ANA is authorized to change the amount by giving the undersigned thirty (30) days written notice. The undersigned may cancel this authorization upon receipt by ANA of written notification of termination twenty (20) days prior to the deduction date as designated above. ANA will charge a $5.00 fee for any return drafts.

Mail with payment to VNA at the above address

Signature for EDPP Authorization

DO NOT SUBMIT THIS APPLICATION WITH YOUR ANCC APPLICATION

TO BE COMPLETED BY SNA

Employer Code _____

STATE DISTRICT

Approved By Date

Expiration Date ____/____ Month Year

$_____ AMOUNT ENCLOSED CHECK #

If applicable, Sponsor _____

SNA membership # _____

MEMBERSHIP APPLICATION