ANS Open Forum

In this Open Forum, our guests were requested to address the problem of priorities in nursing research and theory development. These participants are speaking from their own experience in conducting research in nursing, and they have presented here their spontaneous, open opinions related to the questions posed. We welcome your response to their timely ideas.

Frank E. McLaughlin, R.N., Ph.D.,
Chief, Research in Nursing, San Francisco Veterans Administration Hospital, San Francisco, California:

CURRENT PRIORITIES IN NURSING RESEARCH

There are two major movements in nursing that are particularly worthy of major research: (1) the nurse practitioner/expanded role phenomenon and (2) the primary care nursing model(s). Both developments reflect the continuing, evolutionary autonomy of practice desired by

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nurses. The literature base for support of nurse responsibility and accountability in delineated areas of traditional medical practice—i.e., pediatric, family and adult nurse practitioner assumptions of physician caseloads—is quite impressive. Importantly, the components of care regarded as within the traditional domain of nursing are being demonstrated. Nurse performance in areas such as teaching, compliance, prevention, psychosocial counseling and integration of diverse cultural patterns into coherent models of health care is beginning to emerge as a topic of discussion in the literature. However, concerted efforts on the part of both researchers and practitioners are required to further exemplify the unique dimensions of nurse performance in the practitioner movement.

Nursing has provided a valuable service to both the health care consumer and the field of medicine in requiring explicit operational algorithms and clinical protocols to evaluate nurse competence. In essence, medicine was stimulated to provide clinical-process and outcome-evaluative measures. The art and science of traditional medical decision making was explicated in numerous child- and adult-illness patterns. Such concrete means enabled the evaluation of both nurse and physician competence. In short, nursing stimulated medicine to evaluate its own clinical decision-making process, and the health care consumer ultimately benefits.

The nursing field now must proceed to develop behavioral protocols and indices as clear as those developed for pathophysiological assessment and management parameters. Such developments will clearly explicate both the nursing process and the ability to achieve desired outcomes.

The notions concerning primary nursing models of practice are diverse. Conceptually sound statements point out the primary nursing actions, roles and functions that are truly needed. To date, primary nursing remains more of an ideology than a coherent, empirically designed and measurable dimension of nurse role behaviors. It would seem that the structural components within a hospital, institution or health agency would require significant alteration to provide a workable format for primary nurse functions. For instance, a cost-accounting and billing mechanism for nurse services separate and distinct from physician, hospital and pharmacy is required.

A description of primary nurse actions vis-a-vis health and illness problems and the contractual relationship established with patients, clients, families and support systems is mandated. Identification of problems under which primary nurse models are most effective and efficient seems warranted.

Further, articulation of primary nurse actions with other providers, the provision of delimited continuity requirements and the evaluative comparison of primary nurse models in contrast with control/comparative/conventional nursing roles are necessary.

NURSING CONTRIBUTIONS

The boundaries of the field of nursing are clearly in a dynamic state of evolution. There are distinctive patterns of professional nurse activity which merit comment.

Client/family educational programs. The literature strongly supports the leadership undertaken by professional nurses to develop sound educational programs in the areas of prevention, rehabilitation and restoration. Much of what goes on in health education programs draws heavily from

nursing sources (sometimes credited, other times unmentioned). However, considerably more effort is required to gain the appropriate support and recognition for nurse performance in client/family educational programs. Mandated rewards to undergird such professional nurse activity are most necessary. Collaborative professional models of patient education await delineation and evaluation. Research that supports preventive teaching activities, particularly with respect to nurse leadership and participation, demands considerable creativity and effort on the part of the health professional.

The realm of chronic diseases increasingly affects larger segments of an aging population and offers continuous opportunities for constructive nurse practice. The nurse practitioner model in adult chronic illnesses suggests fertile fields of nursing endeavor, particularly in psychosocial adjustments of client and interpersonal support systems. Additionally, realistic alterations in activities of daily functioning build on historic nurse functions. Significant restoration and maintenance activities on the part of RNs do prevent individuals from ending up in nursing homes. The adult nurse practitioner role suggests continued innovation activities in this domain of health need.

The nursing home and extended care environs are nursing domains of care with access controlled by nurses. Nursing has fashioned and will continue to fashion the quality of life experiences for individuals in such facilities. Significant rehabilitation and restorative physical and psychosocial programs undertaken by nurses move some patients out of these protective facilities back into community-based programs, including relocation into homes or quasi-residential placement sites.

NURSING'S MOST PRESSING RESEARCH PROBLEM

There are many constituencies that claim to speak for the nursing profession. It is rather presumptuous for any one individual to lay claim to being a prophet in one's own house. I have taught nursing students, consulted with various projects, reviewed numerous research proposals and manuscripts and executed a number of research studies. These experiences suggest distinct areas in which crucial methodological issues and problems face neophyte and seasoned research investigators.

There are limited theories, constructs, concepts and models that underlie much of what constitutes the practice of nursing. Great strides have been made in developing a scientific base for nursing in the 20 years I have been a nurse. However, much remains to be done to strengthen adequately the scientific basis of health care offered in this country. Nursing continues to play an important part in examining the basis on which clinical, educational and administrative decisions are made, implemented and evaluated in health care.

One problem facing nursing is the development of conceptually sound, reliable, valid and efficient means to measure nursing care. Much work has been done on developing various quality-of-nursing-care indices. Yet all existing tools suffer distinct problems which require continuous work on developing conceptually clear operational means to assess the dimension of care purportedly contained in such instruments. Concern exists regarding the populations and samples of populations to which such quality-of-care measures can be applied.

Further, the operational clarity regarding the kind, type, degree and level of nursing

actions which can be reasonably and clearly tied to such nursing care measures continues to plague researchers. Much work will be required in the next decade to strengthen and undergird desirable psychometric properties within such tools. Numerous colleagues in nursing and other disciplines who serve on funding review groups have raised serious questions about a number of quality-of-nursing-care measures. More thought and effort need to be directed toward the following areas.

- Describe, define and explicate nursing processes leading to specific nursing outcomes.
- Describe, define and explicate setting characteristics that facilitate or inhibit nursing processes directed toward operationalized nursing outcome predictors.
- Describe, define and explicate specific health and illness parameters in which nursing processes are deemed to be effective, efficient and achievable.
- Develop operational tools and measures that can reliably and validly represent quantitative aspects of process, setting and client characteristics and predicted outcomes.
- Set up pilot health models in which nursing controls and monitors client access.
- Replicate models in diverse settings that can be conceptually and pragmatically related to generalized parameters of health care activity.
- Determine the cost effectiveness of various quality-of-care-measurement approaches.
- Publish both successes and nonsuccesses.

Too often nurses have been put into a defensive posture and have short-circuited the laborious frustrating steps needed to fashion desired tools with sound psychometric properties. We need to be honest with ourselves and others in coming to grips with the complex methodological issues represented in the rubric: quality of nursing care.

Mary Cipriano Silva, R.N., Ph.D.,
Associate Professor, George Mason University, Fairfax, Virginia:

CURRENT PRIORITIES IN NURSING RESEARCH

Enhancing Quality and Quantity

The current priority in nursing research is to enhance the quality and quantity of research in nursing. I see us moving forward primarily along two dimensions: one that will broaden our perspectives about nursing research and one that will force us to synthesize existing knowledge about nursing research.

When I speak of the first dimension—broadening our perspectives about nursing research—I mean that nurse researchers need more of an ecumenical viewpoint about research—a viewpoint that takes us outside of self, community and country and imprints us with an international perspective.

How might we accomplish this? We need to foster and increase intercontinental dialogue through more activities such as international theory and research symposiums, international scholars' exchange programs, cross-cultural centers for nursing research, and more journals with an international perspective. In addition, we need to dissolve communication barriers by translating and making accessible important international nursing research studies and proceedings and by supporting

more journals like the *Abstracts of World Nursing Research.*

The second dimension—the synthesizing of existing nursing research—is another high priority. If we do not know where we are, how can we chart where we are going? Certainly the body of knowledge in some areas of nursing is inadequate for synthesis, but in other areas we have considerable information that can be and should be synthesized. Some of these areas include studies related to stress associated with hospitalization and surgery, pain manifestation and reduction, and the effectiveness of certain nursing procedures.

What we need now is a mechanism to bring together these and other studies where substantial nursing knowledge is accruing. To this end, I believe an encyclopedia of nursing research is imperative. In addition, because of the long time gap between the conceptualization of the research problem and its publication, researchers may be unaware of important ongoing research. It seems, therefore, that another approach that would enhance the quantity and quality of nursing research would be directories devoted to studies in progress and in press.

Studying Legal and Ethical Aspects

Another priority of nursing research relates to the profession itself and addresses the necessity for more studies about the legal and ethical aspects of nursing, historical research, methodological research and research related to philosophy of nursing. The latter is especially important in bridging gaps among philosophy, science and theory.

In addition, the profession must address itself to satisfactory mechanisms for applying research findings to practice, education and administration. Perhaps sample prototype models where nursing research has been implemented successfully could be developed and shared with interested others.

In regard to nursing education, pressing priorities include studies related to continuing education and adult education. With mandatory continuing education for licensure renewal becoming a reality, we must clarify the nature and effectiveness of these programs in meeting continuing education objectives of "currentness" and "competency." And with the increasing number of persons over age 30 entering schools of nursing at the baccalaureate level, we need studies to identify the special characteristics and needs of these adult learners.

Identifying Nursing Contributions

A third priority of nursing research—research in clinical practice—can best be addressed by identifying those contributions that fall within the discipline of nursing and that other disciplines are unlikely to pursue. Such an approach implies that you and I are able to describe nursing practice and differentiate it from other types of practices. Perhaps a definition of nursing practice will clarify this point.

For example, I see nursing practice as a dynamic entity, based primarily on scientific and humanistic nursing knowledge, which occurs in any environment in which nurses use the nursing process to assist humans to cope holistically with states of dying, illness, chronicity, disability and recovery or to understand and assume responsibility for states of wellness. Out of this definition of nursing practice, several priorities for clinical nursing emerge. These priorities include the study of phenomena such as health and illness and the environments

where they occur, chronicity, prevention, rehabilitation, self-care, coping, comfort, caring, wholeness, health education, client presence, nurse presence and nursing process.

Certainly other disciplines, you may be thinking, study some of these phenomena too. Yes, they do, but the links which bind these phenomena to nursing, assuming "client presence," are the concepts of "nurse presence" and "nursing process." In other words, these two concepts identify the logically necessary conditions which must be present for *nursing* practice to occur. The other concepts vary through time as societal needs and values and scientific knowledge change.

CURRENT PRIORITIES IN THEORY DEVELOPMENT IN NURSING

There are three priorities for theory development in nursing: the testing of existing nursing theories, the generation of new nursing theories, and the compilation of existing and emerging nursing theories and related discipline theories.

Within the past two decades, many nursing theories, models and conceptual frameworks have been developed by nurse scholars. All are important in the sense that they help us think through the nature of nursing from a variety of perspectives. More importantly, however, all are important because they help us to identify common themes which comprise the core of nursing.

But the identification of common themes is not enough. These themes must be tested. In other words, theory and *scientific* theory are not the same. Theory can be defined as a set of related statements, usually postulates and definitions, which have been derived from scientific data and philosophical beliefs. Scientific theory goes farther. It implies the formulation and testing of hypotheses. Therefore, scientific theory involves the formulation, testing and verification of hypotheses which have been deduced from a set of statements derived from scientific knowledge and philosophical beliefs. My reason in distinguishing the two is to underscore the fact that currently in nursing, we have many theories, models and conceptual frameworks, but few, if any, scientific theories, although important strides in theory testing are currently going on.

In addition to theory testing, another priority in theory development is the generation of new or reformulation of old theories. I believe that the scope of these theories should reflect "middle-range" or "micro" theories. I say this because current theories of nursing tend to be of a "macro" nature and consequently are more difficult to test than those theories of lesser scope. However, these "macro" theories are extremely valuable as starting points for the generation of subtheories and testable hypotheses. In this way there would be linkage of subtheories to parent theories, and generalizability would be enhanced without sacrificing diversity. The generation of theories that help us to understand the relationships among existing theories will serve the progress of nursing science better than new theories developed for their sake alone.

A third priority in theory development is a need for the compilation of existing and emerging nursing theories and related discipline theories. Some valuable beginning efforts have already occurred in this area, but more needs to be done. What I have in mind would be a Handbook of Nursing and Related Discipline Theories which would not only summarize the basic propositions of each theory but would also critique the theory based on general stan-

dards of adequacy. In addition, all research which has tested the theory would be identified and summarized. Then and only then would the status of a particular theory be assessed along a valid-nonvalid criterion for a given point in time.

It is important that we also include related discipline theories because many of the variables studied in nursing are within the primary domain of another discipline, for example, role and role theory. We will and should continue to use these theories if they best explain the variables under study, but they need to be interpreted within the framework of nursing. However, we must keep in mind that whenever we use and test theories from another discipline the knowledge that accrues belongs more to the other discipline than to our own. This is both rightly and logically so.

NURSING'S MOST PRESSING METHODOLOGICAL PROBLEM

The most pressing methodological problem facing nursing today, and one that will become more severe in the future, concerns itself not with the inadequacies of research methodology (of which there are many) but with real and potential inadequacies of personal commitment, scholarship and even ethics. This problem has been eloquently addressed by Cournand.[1] He talks about stresses which threaten one's scientific code of ethics such as intolerance to other scholars' ideas, using the work of others to advance one's own reputation and the selling of research expertise for monetary gain. As more and more nurses obtain doctoral degrees and vie for limited and powerful positions within or outside of the university, these problems will become more commonplace and, if not attended to, will severely undermine the advancement of nursing knowledge.

Closely related to the above problem is the steady pressure exerted on master's-prepared nursing faculty to obtain a doctorate. The primary concern is one of viability—if I do not get a doctorate, I cannot obtain promotion, tenure or an adequate salary. These concerns cannot be underestimated—they are real, valid and important. But we must not lose focus of the primary goal of the doctorate—to advance nursing practice and nursing knowledge within the ethical norms adhered to by conscientious scientists. These norms, according to Cournand, include intellectual integrity and objectivity, doubt of certitude, recognition of error, unselfish engagement and communal spirit.

[1]Cournand, A. "The Code of the Scientist and Its Relationship to Ethics." *Science* 198:4318 (November 18, 1977) p. 699–705.

Joanne S. Stevenson, R.N., Ph.D.,
Associate Professor, Assistant Director for Research and Director of Center for Nursing Research, The School of Nursing, The Ohio State University, Columbus, Ohio:

CURRENT PRIORITIES IN NURSING RESEARCH

The most critical priority in nursing research is the need for studies that contribute to the science of health in general, not just to current pragmatic questions of interest to nursing practice. I appreciate the argument that quality-of-care studies, studies about the effects of nursing procedures and other pragmatic kinds of research are important in the professional-political arena of today. However, the majority of research conducted by nurses should always be directed toward improving the knowledge base about human

health through questions that have not been (and are not likely to be) investigated by researchers from other disciplines.

Nurse researchers can pose research questions about aging or about health and illness in the aged which differ from the questions posed by pure (biological) laboratory scientists or by nonbiologically trained social scientists. Nurse researchers are clinicians first of all and have had face-to-face experience with sick and well, alert and disoriented elderly. They use these experiences in developing research questions; thus their questions more often than not have a grassroots experiential/observational hypothesis behind them even before the first bit of study data is collected.

At the opposite end of the age continuum, nurse researchers have posed questions about the learning ability of premature infants and about premature infants' responses to music, to the mother's voice, to rocking and to swinging in the incubator.

Such questions would not be posed by physicians, whose attentions are focused on the life-threatening problems of prematurity. Such research would not be attempted by disciplines concerned with human learning. Nor would it be attempted by those disciplines concerned with the effects of rhythmic movements or sound on humans. Such scientists do not have experience with or easy access to premature infants. Furthermore, scientists interested in the effects of sound or rhythmic movement are not likely to be concerned with infant development as the outcome parameter. Only nurses put all these things together into a focus for research.

The aged population and premature infants are but two of the areas where nursing can make unique research contributions in the mainstream of the scientific community.

NURSING'S MOST PRESSING RESEARCH PROBLEM

Nursing has two pressing research problems. One is that we are often not allowed to contact potential research subjects without first obtaining permission from a physician. Another dimension of this problem is the pejorative practice of nursing studies being monitored by physicians for scientific rigor and/or patient safety. There is no more justification for physicians to monitor nursing studies than for nurses to monitor medical studies.

The other problem is the critical need for a valid instrument armamentarium. Too much reliance on paper and pencil instruments—scales, questionnaires, knowledge tests, personality inventories and interview schedules—during the past four decades now retards our efforts to develop more direct research measures.

We have concentrated on the psychologically or sociologically oriented research questions to the exclusion of concomitant biological parameters of the same phenomena. For example, our studies of stress are in large majority paper and pencil or interview studies, with much less work on the physiological and biochemical concomitants of that same stress in the subjects. We have not traditionally performed animal studies as other fields have done. The use of animal models allows more freedom to create and test biological phenomena. We have only begun to work with bioengineers in the development of new instrumentation suitable for research questions asked by nurses. Much more substantive work is needed so we are less tied to the single option of paper and pencil instruments.

CURRENT PRIORITIES IN THEORY DEVELOPMENT IN NURSING

I have read far too many manuscripts dedicated to discussions about the criteria

for evaluating theories or about the criteria for defining concepts in operational terms. It is time to stop concerning ourselves with metatheorism and get on with developing and testing theory(ies).

Furthermore, nurses needlessly limit their theorizing to what they consider "nursing." Dewey's principle of Autonomy of Inquiry stated that the "pursuit of truth is accountable to nothing and to no one not a part of that pursuit itself."[1 (p 3)] As nurses and theorists, we need not be sensitive to false territorial boundaries which are not scientific but political. We should not be concerned with the development of theories of nursing—who ever heard of a theory of dentistry or medicine? Nor should we be absorbed with the development of theories *for* nursing.

Our goals should be directed toward the development and scientific testing of theories about human beings as they are conceived, born, grow, mature, age and die. If we limit ourselves to theorizing only about nursing practice, we make ourselves into second-class theorists/scientists who only play the game within the safe territory that has been set aside for us.

[1]Kaplan, A. *The Conduct of Inquiry* (Scranton, Pa.: Chandler Publishing Co. 1964) p. 3.

Eleanor G. Feldbaum, R.N., Ph.D.,
Director, Program of Health Services Delivery, Department of Behavioral and Social Sciences, University of Maryland, College Park, Maryland:

NURSING CONTRIBUTIONS

Nursing can make important contributions to health sciences by utilizing its unique position and retaining a generalist or holistic perspective. The U.S. health delivery system has become overprofessionalized and consequently overspecialized. Currently, hundreds of professional groups are jealously guarding their autonomy and realm of expertise from encroachment by others. As a result, health consumers are receiving truncated and segmented care for what they perceive as holistic needs.

Nurses can and should rise above and be mediators in battles of the professions, and they should rise above specialistic orientations. Nurses are in the unique position of being at the center of the "multifurcated" health system. Being closest to patients, they are charged with coordinating the efforts of myriads of specialized health actors. From this vantage point, nurses can see what is wrong and, often, what is right about the health system. Moreover, their position enables them to evaluate health care not only from their own but also from the consumer's perspective.

Another aspect of the nurses' unique position is the size of the nursing corps. Nurses by far comprise the largest sector of health workers. Because of their numbers, nurses could demand attention if they would articulate their views and concerns to those engaged in formulating health policies.

My studies of RNs repeatedly indicate that nurses do not view the political arena as a forum to redress their grievances about the delivery of health care. As a political scientist, it seems inconceivable to me that such issues as national health insurance, health planning and professional standards review do not elicit letters and testimony, as well as requests for participation from working nurses. It is ironic that lawyers are initiating legislation and writing books concerning the rights of patients. Nurses are in the position to be patient advocates, in addition to knowing what rights are in need of protection. Yet individual nurses are strangely quiet about

these matters. Why are they not fulfilling advocacy and bridging roles?

CURRENT PRIORITIES IN THEORY DEVELOPMENT IN NURSING

Theory development generally evokes two types of responses. The first is that theory is the domain of the most highly educated, those persons holding doctorate degrees. The second is that theory development is an esoteric activity which has no relevant or practical value. Both of these responses are erroneous, defeatist and harmful.

While it is true that graduate education exposes students to various theories, it is not true that students learn to modify, adapt or amalgamate theories to explain real life situations. Theories are developed by asking "why" and then by asking "why" again and again. Each answer should be more encompassing than the first, and each should explain a wider range of behavior.

In order to answer the "why" questions, perhaps even more than exposure to theories, persons need to be exposed to a wide range of human behavior and responses. One does not need to be a psychology major to know an infant's cry does not always mean hunger. Most mothers could give more answers to why the infant cries than could a childless doctoral candidate. Similarly, one does not have to understand theories of personality to explain why people are upset by segmented, impersonal or abrasive health care. Nurses working closely with patients can certainly give answers; they just need training and encouragement not to accept the first "why" answer but to continue asking "why."

Theory is not an esoteric exercise. If individuals understand why things happen, they can begin to make suggestions for improvement. Without such understanding, changes are bound to be disruptive and often are doomed to fail.

A perfect example is provided by the American Nurses' Association's position that professional nurses must hold a baccalaureate degree. Certainly in the 1970s, when a college education is mandatory for entrance into almost all white-collar positions, this statement should not evoke such intense negative response. Why has it? Because more than three fourths of all RNs hold diploma degrees, nurses feel their professional status is being questioned. Even though the ANA position has always included a "grandfather clause" which insures that individuals who graduate before a certain date will not be affected, the negative response still exists. Why? If nursing leaders asked "why" often enough and went beyond the first-level response, they would realize that this position undermines the worth of the majority of working nurses' education and experience. Everyone needs to believe that what they have achieved and what they have done have some value and meaning. Can you tell a nurse who was educated when diploma programs were the norm and who has worked for 20 years that the new baccalaureate-degree graduate is the professional! If ANA leaders had recognized that feelings of self-worth, motivations for self-actualization and a host of other strongly held and needed values were being undermined, they could have developed ways to implement their goal without threatening the very persons the association is said to represent.

Thus theory development must be approached at all levels of nursing education. Students should be introduced to existing theory and trained to ask the "why" question about all aspects of education and health care delivery. Every

nurse should be prepared to answer such questions as: "why" is the patient reacting that way, "why" am I performing this task, "why" are health care instructions not being followed and "why" are consumers receiving inadequate care? Once these questions begin to be answered, successful suggestions for change can be offered by working nurses.

NURSING'S MOST PRESSING RESEARCH PROBLEM

Nursing, in striving for professional recognition and status, appears to be developing the negative aspects of other professional groupings. In attempting to define a distinct and separate area of expertise, nursing is losing its generalist focus. This is most clearly seen in the clinical specialty areas where the medical model is emulated. Instead of recognizing that specialization has been a primary cause of fragmentation in the health delivery system, nursing is joining the melee and losing sight of its holistic function.

Schools of nursing, especially those offering collegiate and graduate programs, are parochial in outlook and are not using the vast resources found within university structures. For example, graduate students pursuing a field in nursing administration could meet course requirements in business or public administration.

Similarly, research methods and statistics need not be taught exclusively within departments of nursing. Certainly sociological, educational and psychological theories, methods and statistics are relevant to nursing. Moreover, this parochialism seems to be increasing as the numbers of nurses with graduate degrees is increasing.

Last, nursing must increase the number of nurses prepared at the doctorate level. It is foolhardy to believe that master's-degree students should be taught by those holding nonresearch-oriented master's degrees. This is especially problematic for the many schools of nursing instituting doctoral programs. Students preparing for their doctorate cannot be taught by persons of lesser educational attainment. Moreover, they need to be taught by persons trained in conducting research. Again, nursing can meet these demands by utilizing the many resources offered by various departments within the university.

CURRENT PRIORITIES IN NURSING RESEARCH

There are two major priorities that nursing should establish for research attention. Both have been discussed above. First, proposals for change must emanate from sound theoretical bases as well as from a clear understanding of "what is." Too often change is suggested and even initiated without such understanding. The ANA's position on professional education provides an example of proposing change without first identifying the current situation's ability for change. While it is fine to want a baccalaureate degree for professional practice, it is quite another matter to assess whether a baccalaureate-degree education can be made available to all aspiring nurses, as well as to upwardly mobile RNs. The sad fact is that there are not enough collegiate programs to educate all those desiring a bachelor's degree. Presently, four-year programs are denying entrance to almost half of their applicants because of shortages in space, faculties and training facilities. The percentage of RN rejections is even higher, for not all colleges have programs geared toward the working nurse. Thus this proposal will certainly create more dissension among nurses and may very well be the first formal step toward creating a two-class opportunity structure within nursing.

Second, nurse researchers should use their unique position within the health system to address questions related to problems of delivering equitable and humane care to health consumers. Nurses should study and test assumptions of health policies and articulate findings to policy makers. Within the next decade, major health issues will be addressed, legislated and instituted; and nurses should be in the forefront of assessing and evaluating policy strengths and weaknesses and be the initiators for proposals for change.