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# Nursing Participation in Health Care Reform Efforts of 1993 to 1994: Advocating for the National Community

Rubotzky, Alicebelle Maxson RN, CS, PhD

## ▼ Author Information

Associate Professor; Department of Nursing; Rhode Island College; Providence, Rhode Island

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## ▼ Abstract











This report of a postmodern feminist oral history tells a contemporary story of the success of nursing in overcoming the impediments of tradition, organizing and acting as an identifiable group, and speaking out with clarity as advocates for the health of American society. This was an important historical, transitional, and celebratory time for nursing. Continuing advocacy for health care for all Americans requires developing expertise in both traditional and feminist leadership, understanding how political theories and history affect policy development, and active participation in American democracy. Future actions require incorporation of lessons from the recent past.

Nursing in the United States started 1992 as an assertive, organized professional discipline with the intention of influencing national public policy. The organized resolve to influence an entire nation was a clear break from the traditional, historical role of this traditionally women's profession. The subsequent events of 1992 to 1994 illustrate a pivotal story of a discipline becoming an advocate of political significance, overcoming the barriers of traditional views, organizing as an identifiable political interest group, and speaking out with clarity as an advocate for the health of all Americans. The discipline experienced initial success followed by severe setback, and then launched itself again into the continuing redefinition of its role in American society.

In 1993, the newly elected President of the United States, William Clinton, directed the formation of a national Task Force for Health Care Reform. Professional nurses were included in the membership of this task force. This article examines the experiences of the nursing leaders and staff who accomplished health care policy development in the national effort for health care reform of 1993 to 1994. <sup>1</sup> Postmodernism and feminism both informed the study and served as interpretive lenses.

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## LITERATURE REVIEW

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### Historical review of political activism in nursing

The work of nursing is historically linked with the cultural expectation of the work and family obligations of women. <sup>2</sup> Nursing in the United States began its quest for recognition as a professional discipline in the late 19th century, when a few schools of nursing were instituted, following the model of Florence Nightingale and the Nightingale School at St. Thomas Hospital in London. The change from nursing as exclusively a family responsibility of women to a professional discipline brought with it a need to reexamine the long tradition of women's lack of direct involvement in American society's formal institutions. But without the privilege of voting, American women had no official means of participating in the policy making of government. English common law, which was used by the American colonies until the mid-18th century, severely restricted opportunities available to married women. <sup>3</sup> Through marriage, the husband and wife were one under the law, and consequently, married women were legally nonexistent. An unmarried woman remained under the protection and direction of her father. The first organized call for the rights of all American women was at the Seneca Falls convention in 1848. <sup>3</sup> A suggestion at that convention for giving women voting rights was considered scandalous by many, including many women in attendance. Women's right to vote was not obtained until 1920. Early 20th-century nursing noninvolvement in public policy included long-term silence and ambivalence regarding the national effort for women's suffrage, until suffrage was finally publicly endorsed in the *American Journal of Nursing* in 1913. <sup>4</sup> Individual nurse leaders such as Lavinia Dock, Lillian Wald, and Isabel Stewart broke traditions of silence on a personal level and rallied nurses' support by speaking out clearly on suffrage, women's rights, professional issues such as licensing, and local injustices regarding health care. <sup>5-7</sup> Nurses as an identifiable national group did not act collectively or speak from a unified position regarding national social issues of the late 1800s and early 1900s.

In 1957 and again in 1959, Representative Forand from Rhode Island introduced a bill proposing health care for older adults. The American Nurses Association (ANA) not only endorsed the Forand Bill, but it advised that nursing, home care, and long-term care be added to the benefits. <sup>8</sup> Both bills were defeated. Seven years later, when Medicare was introduced in President Johnson's administration, nursing again publicly declared its position of support. Later in the 20th century, nursing as an identifiable professional discipline was even more clear and outspoken. Nursing, now organized and with the clarity of purpose previously seen primarily in a few individual nursing leaders, demanded health care reform. In 1991, before the presidential campaign began, *Nursing's Agenda for Health Care Reform* <sup>9</sup> was published. It outlined goals for universal access to health care and a national plan for prevention of illness and maintenance of health through primary care. Political party representatives received letters, calls, and visits from activist nurses. The nurses' call for reform joined those from other vocal groups, and reform quickly became a campaign issue for all political candidates in the 1992 election. This assertive, organized, publicly declared agenda for change from nursing about a national social issue was a clear break from the precedents of limited social action previously displayed by the nursing discipline.

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### American social and health care policy

Major social legislation has not been a priority for the United States. In 1935, the National Social Security Act was passed following the Depression, in spite of tremendous opposition. <sup>10,11</sup> Social Security was the most encompassing national social legislation since the country began. Social Security was intended to include provisions for health care for older adults and for families with young children, but that plan was delayed because of strong opposition from the American Medical Association (AMA). <sup>10-12</sup> The AMA erroneously charged that physicians were not included in the planning. <sup>10</sup> The delay unexpectedly lasted until 29 years later,

- **INTERPRETATION AND DISCUSSION**
  - Celebrate nursing's accomplishments
  - Learn about power and conflict from the participants' experiences
  - Dispel misinformation about the reform efforts
  - Continuing advocacy for health care for all Americans
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when Medicare was finally passed.

The United States lags behind all other industrialized countries in the provision of health care to its citizens. Germany had pensions for older adults and basic health care for all its citizens in the 1880s, established by Bismarck. <sup>13,14</sup> Winston Churchill began large-scale public unemployment insurance in the United Kingdom in 1911. <sup>14</sup> Canada introduced its current health care system for all citizens and residents in 1971. South Africa, formerly the only other industrialized country without health care for its citizens, established its program in 1998. Although limited accessibility to health care in the United States was repeatedly identified as a problem in the 20th century, the number of uninsured is currently increasing. In 1912, Theodore Roosevelt and Woodrow Wilson both pledged to improve the nation's health. Presidents Franklin Roosevelt, Harry Truman, John Kennedy, Jimmy Carter, and Richard Nixon all had varying degrees of unsuccessful attempts to pass some kind of broad-based health care insurance. <sup>13</sup> In 1988 under Ronald Reagan's presidency, Medicare was expanded with bipartisan support to assist with catastrophic medical costs, but this was repealed because of widespread opposition. <sup>13</sup> The opposition was strongest from affluent older adults, who were required to pay increased Medicare premiums in order to keep the legislation self-supporting.

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#### Health care reform process of 1993 to 1994

On September 22, 1993, President Clinton delivered to Congress, cabinet members, and an estimated 100 million Americans through television, his speech proposing the most dramatic social legislation since Social Security was introduced almost 60 years before. The proposal was for a broad health care system that would begin to match, in its coverage of all citizens, those of other industrialized countries. The proposal built on the unique American system of job-related private insurance, combined with the federal systems of Medicare and Medicaid. The speech was delivered well and received well, in spite of the strong opposition that was developing from politicians and lobbyists for insurance companies and the health care industry. <sup>12,13,15</sup>

The President's speech marked the culmination of a long effort to prepare a health care legislative package for introduction to Congress. The effort began a few days after his inauguration. On January 25, 1993, he formally announced that his wife, Hillary Rodham Clinton, would head the Task Force for Health Care Reform. Ira Magaziner was assigned as day-to-day operating head of the task force and as chief collaborator to Hillary Rodham Clinton. Ira Magaziner was a presidential advisor, former business consultant, former fellow Rhodes scholar at Oxford with the President, and long-time friend of the Clintons. <sup>13</sup> Johnson and Broder <sup>13</sup> explained that the original plan was to have a task force of about 98 people, including some congressional committee staff as members. But House and Senate members wanted their own staff on the task force too, so they were included also. "The task force grew. Eventually more than 630 people, broken down into 8 'cluster teams' and 34 'working groups' were slaving away. Depending on their own areas of expertise and responsibility, they began drafting policy options and proposals. About a thousand other people later vetted their decisions."

<sup>13</sup>(p113)

Completion of the task force responsibilities was planned to be in 100 days, even if 18-hour days and 7-day weeks were necessary. A series of "toll gates" were scheduled. Each of the "working group" leaders was to present findings that would help the task force make decisions about the plan. The sixth and seventh toll gates would have people from outside the task force-lawyers, health professionals, and consumer representatives-critique the proposed plan. <sup>13</sup> The task force, in spite of long hours and full weeks, took 9 months instead of 100 days to complete its task.

The *President's Health Security Plan* <sup>16</sup> was published in 1993 and was readily

available to the public through bookstores. *Nursing's Agenda for Health Care Reform* 9 remained the guide for nursing's activists. By 1994 there were six additional position papers published by the ANA and its affiliates regarding the organization and delivery of health care. Information about *Nursing's Agenda for Health Care Reform* and the national effort to create a new system of health care was broadly publicized in nursing journals. *American Nurse* reported on reform progress in every issue of 1993 and 1994. Virginia Trotter Betts, president of ANA at that time, also wrote an informative column about reform in every issue.

In the spring of 1996, an article by Virginia Trotter Betts summarized the actions of nursing from the beginning of the development of *Nursing's Agenda for Health Care Reform* to the aftermath of the defeat of the Health Security Act. 17 It is an informative analysis that describes nursing's essential health care policy requirements and illustrates a new era of political sophistication for the discipline. The continuing support of some legislators for parts of nursing's agenda was encouraging for Betts. She also expressed pride in the unification of nursing and nursing's involvement in public policy and political activism. "Professionally and politically, nursing enters the post-health-reform era more unified than ever before in our history." 17(p7)

Although the 103rd Congress passed absolutely no health care legislation, President Clinton was uniquely successful among US Presidents in bringing the topic of a basic US health care plan for all citizens to congressional and national debate. The processes of development of the health care reform plan and its presentation to the country, the political processes it generated, and its ultimate failure have been the subject of several books. 12,13,15,18 Although organized nursing was strongly in favor of passing the President's National Health Security Act and actively participated in the formulation of the proposed policy to ensure that points from *Nursing's Agenda for Health Care Reform* were included, there is little or no mention of nursing's role in any of the popular books on the subject. Nursing journals, newsletters, and other publications covered health care reform efforts and nursing implications comprehensively. The personal experiences of nursing leaders within the reform efforts as they diligently pursued patient advocacy on a national level are not available in nursing or popular literature.

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## METHOD AND DESIGN

This article reports a postmodern, feminist oral history. Over 25 years of feminist research has honed the oral history process and has changed it from a tool primarily used by historians. Oral history once was and still is used as an accepted positivist historical method, with careful rules for maintaining objectivity. But it also has become a valued method of postmodern research and, additionally and specifically, a feminist methodology. 19 Feminist oral history is observed to be empowering to women and a precursor to community and individual advocacy. Feminists seek a nonhierarchical egalitarian relationship between researcher and participant. This relationship is part of the data generation process in both language and behavior. It extends through all parts of the research process, including the reporting of findings with the avoidance of pedantic language.

Research based in postmodernism seeks understanding rather than a single truth. 20,21 Oral history based in postmodernism has a broad view of the subject matter; it values personal, contextual, and multiple interpretations of history; and it has less concern about seeking out the single truth as corroborated by multiple sources that is seen in modern oral history. Feminism is a product of the postmodern era and reflects concepts of poststructuralism and critical theory. Feminist theory is similar to critical theory in that they are both emancipatory and idealistic. 22 Feminist theory focuses on women and their experiences, whereas critical theory is not gender focused. 19,23 Feminist theory is nondichotomous, nonhierarchical, and relational. Other important aspects of feminist theory are the tenets that the personal is political and the affective is as important as the cognitive. 22,23

Diversity, intellectual conflict, analyses of power relationships, and globalization of economic and social thinking characterize the postmodern epoch. <sup>24</sup> The topic of US national health care policy reform encompasses political and social action with the accompanying intellectual conflict, power struggles, social implications, and international comparisons. The broad concept of postmodernism with all its developments and contradictions provides a logical basis for this research. Although professional nursing theory incorporates scientific values from both modernity and postmodernity, nursing's leaders accept feminist theory better than the majority of practicing nurses. <sup>25</sup> Contemporary nursing is enriched by increasing numbers of men. Nevertheless, the discipline of nursing is historically based on women's work, and after more than a century as an organized professional discipline, nursing's membership remains mostly women. A study of nursing is a study of a women's profession. Feminism and postmodernism are relevant both as theoretical foundations and as interpretive lenses.

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#### Selection of participants

A purposeful sample of nurses was selected whose function on or support of the Task Force for Health Care Reform was of a long-term nature, extending through most of its existence. There were 13 participants: 10 registered nurses and three staff members of a nursing organization. Participants included nurses in leadership positions of the ANA, National League for Nursing (NLN), and American Association of Colleges of Nursing (AACN); nurses who were cochairpersons or members of task force cluster groups; those on the staff of Senators; and nurse representatives from various academic settings. Several nurse participants fulfilled more than one of the criteria. All of the participants are women of achievement, having risen to respected leadership positions in their chosen profession. Men were not deliberately excluded from the study nor deliberately sought. In the search for participants, there were no men nurses or staff suggested by other participants or identified in the literature.

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#### Data generation

All participants took part in 90- to 120-minute audiotaped interviews directly or by telephone that were guided by open-ended questions based on nine research questions. Interviews elicited participants' perceptions regarding their experiences in the health care reform efforts of 1993 to 1994, power relationships in those experiences, their motivation to become involved and what sustained their interests, resultant attitude changes, perceptions about nursing's participation, the future of health care in the United States, and recommendations for nursing education and practice with respect to future political advocacy. Data were primarily obtained through interviews but include information from field notes and the use of incidental observations both by participants and the researcher.

This report is limited to the topics of overall participation and related power relationships throughout the completed work of the President's task force. Description of the participants' experiences, with ongoing analyses and final interpretations regarding nursing's future actions and participation in American democracy, are discussed.

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#### Style of presentation

This report relates the personal perceptions of participants, emphasizing their personal and interactive experiences rather than the role of an organizational official or an individual celebrity. This approach enhances the possibility of transferability of findings to the nurse who is interested in learning about political advocacy, but who is not necessarily interested in the experience or analysis of upward career mobility. The study is not biographical. It reports what was said

and not the name of who said it. The participants are contemporary nursing heroines and national figures in nursing. Their biographies will be an important contribution to nursing history. Their personal successes in their chosen profession are one important reason they were selected for leadership roles in the reform efforts. Nevertheless, heroes and heroines remain part of the traditional systems of modernity, competition, and dichotomous, hierarchical relationships. The use of celebrity names stimulates distraction to the content of the findings. Such distractions do not support the feminist values of mutual respect and noncompetitive, nondichotomous, egalitarian relationships. The identity of the participant is not intended as the point of interest of the narration.

Participants' own words are frequently used to gain full benefit of the oral history method, which provides the potential for realistic and vicarious experience as suggested by Sandelowski. 26 Speech patterns, the values expressed, and individual commentary all contribute to a picture of the unique personality of each participant. Feminist scholars speak of the empowerment of using women's own words and encourage their use. 27 It is possible that giving voice to the stories of the participants will have an empowering result for other nurses and the professional discipline.

Wolcott 28 explains three aspects of qualitative research: description, analysis, and interpretation. Description is presented here through chronological order and through progressive focusing, 2 of the 10 separate suggestions from Wolcott. Analysis is ongoing in qualitative research 20 and is interwoven with description throughout this report. According to Wolcott, interpretation is separate from analysis, is more freewheeling, can use theory to provide structure, and gives the researcher an opportunity to personalize and explain, "This is what I make of it all." 28(p44)

Participants' descriptions are organized along a chronology beginning with the origins of *Nursing's Agenda for Health Care Reform*. The chronology 1 (p56) lists the events and time around which the findings are organized (Table 1).



Table 1

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DESCRIPTION OF FINDINGS WITH ONGOING ANALYSIS

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*Development of Nursing's Agenda for Health Care Reform*

For nursing, the specific efforts for reform began in 1989, long before the 1992 political campaign began. Most nurses believed strongly that because they were openly criticizing the health care system, they needed to have a plan of correction. Nurses in all nursing organizations had convictions about the ways that health care delivery needed improvement. Many of those nurses were considering or actually developing a written statement of objectives for health care reform by 1990 to 1992. They conferred with colleagues from nursing and other disciplines and determined their view from a nursing and consumer perspective. According to one participant, most of the nursing organizations had a working document of an agenda for health care.

At the ANA board meetings in 1989, the board members felt a great deal of pressure to be definitive about the overall health care system. At each meeting there was a need for discussion about some aspect of health care. Proposals were offered about what to do, but it was in a piecemeal manner.

We spent a great deal of time on policy questions at the [ANA] board at that time. It seemed to me that the care-giving system wasn't working for our patients. And while it wasn't working necessarily in the best interest of nursing either, it especially was not working for our patients. It seemed increasingly clear that the health care system was falling apart right in front of us. So there were

different actors on the hill trying to put their thumb in the dike, and our staff would say, do we want to support them with this thumb in the dike? So in the September board meeting, I believe it was 1989, I made the motion that we at ANA form and fund a task force [the motion passed].... So we had a Task Force on Cost, Quality, and Access. That was the driving force that turned out to be *Nursing's Agenda for Health Care Reform* .... It is an historic document. <sup>1</sup> (p56)

Forming the Task Force on Cost, Quality, and Access (TFCQA) was a major time and financial commitment for the ANA. Members were appointed based on their strong beliefs and their representation of diversity of opinions. Consultants were hired to inform TFCQA members about health care systems in other countries such as Canada, Japan, Great Britain, and Germany. Members became very knowledgeable about worldwide health care systems. Those diverse systems provided options to be considered in writing the agenda.

*Nursing's Agenda for Health Care Reform* identified a firm and clear position that a comprehensive basic health care plan was needed for all people, regardless of their ability to pay, and the plan would be a public and private partnership. This public and private partnership recommendation was in sharp contrast to the position of many Americans who were supporting the Canadian-style system of a government-managed, single-payer plan. The Canadian system functions as a provincial government-managed insurance reimbursement system, not as an employer of physicians. It is more similar to US Medicare and Medicaid programs than to the British and German health care systems.

The agenda's position on the partnership was an important and courageous distinction. The partnership recommendation was a reflection of the political diversity represented on TFCQA. The agenda contained broad language that reflected serious debate and compromise among the members. One participant remembered the debates on TFCQA as passionate and even ferocious. The chair of TFCQA was respected by the members for her ability to decide that the task was completed, although members were still actively debating. When asked how she knew it was finished, she responded in this way:

When arguments are insoluble dilemmas, you move on. It had to stop somewhere. It stopped with me. I worked with someone who is a wordsmith to ... very strategically, say the things in a way that allowed everyone to save face-and that could perhaps be interpreted in many ways-each to their own preference. But you've got to move on. Someone has to be responsible and say ... "We're moving on," or "Print it that way. Come on, we're finished!" <sup>1</sup> (p59)

The ANA is the largest nursing organization, and it sees its responsibility as representation of all nurses. It fulfilled the responsibility of writing a comprehensive plan that was well developed through study and debate. While the ANA was working on *Nursing's Agenda for Health Care Reform*, some leaders of the NLN were working independently on another plan.

"We [at NLN] started writing what we called an agenda-a health care agenda. I actually had my own piece before that and had presented it ... but it really became the bare bones of what *Nursing's Agenda* was." <sup>1</sup> (p60) This quotation illustrates one of several different persistent understandings of where and how *Nursing's Agenda for Health Care Reform* originated. The multiple opinions on the agenda's origin are undoubtedly the result of members of multiple nursing organizations originally working independently to define problems and remedies for the national health care system. Later, as those organizations brought their ideas to a larger nursing group, each retained a sense of ownership for the agenda because it retained the original concepts defined by each independent organization.

The ANA leadership recognized that other nursing organizations needed

involvement in the agenda. Agreement within the nursing profession would be a strong political asset. The ANA's next step was to take the agenda to the council that represents four nursing organizations, known as the Tricouncil for Nursing.

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## The Tricouncil

The Tricouncil consists of representatives from AACN, ANA, NLN, and the American Organization of Nurse Executives (AONE). The Tricouncil originated with the first three organizations in 1982. In 1985 AONE joined the group, but the name Tricouncil was retained in spite of there being four members.

Was there a lot of conflict at the Tricouncil over this document? There seems to have been conflict just as there was previously within the ANA, but nothing that was a major deterrent to eventual agreement. The management of conflict was practical and goal oriented. Some participants even reported there was no major conflict. Conflict was certainly perceived differently by the participants. One participant stated, "Oh there was a great deal of conflict, but it was just worked through." <sup>1</sup> (p61) Other participants had different assessments. "There wasn't conflict. We did not move in the fashion which had hampered us in the past. We listened to everything but incorporated selectively. We told people why, when a major point could not be accommodated. But that was versus our usual [previous] way of operating-to try to have every thing perfected through consensus seeking." <sup>1</sup> (p61) A third participant explained this way: "I don't really think there was conflict. I think nursing was ready for this. And I think the fact that we didn't challenge the private sector meant that people who were more associated with Republicans or Democrats didn't feel that they were threatened by it." <sup>1</sup> (p61)

One participant summarized the Tricouncil involvement this way:

Way before he [President Clinton] was even elected, the NLN and the ANA were each working on their own independent statements and were quite competitive with each other about whose would prevail. At one point, they brought this issue to the Tricouncil. There was one very consequential meeting in Chicago that was hosted by the AONE. At that point, the AONE attempted to serve as a moderator between the two groups for all of us. The NLN was including issues related to education ... and so AACN was concerned about ... the NLN statement. At that point, the agreement was made that NLN and ANA would go away together some place and come to some agreement about a uniform statement that all of the Tricouncil groups could sign onto. They went off ... to try to hammer it out and have a statement. That statement then was brought back to the Tricouncil. <sup>1</sup> (p62)

The Tricouncil received the document agreed upon by the ANA and the NLN. The NLN and AACN agreed about the educational issues. The document was accepted as ready for the next step of building agreement among as many nursing organizations as possible. But a very disappointing development occurred. The AONE representatives told the Tricouncil that they would not be signing in agreement with the agenda. It was a very significant blow to the group. After all the work to build a document that recognized everyone's position, one of the four membership organizations would not sign in agreement. One reaction to that development is given below.

Once we all got back together it became clear that AONE never had any ability to sign on to this thing because they were getting heat from the American Hospital Association [AHA] about some of the tenets of this *Nursing's Agenda for Health Care Reform*. And so the AONE played separate and never really did sign on-ever. I don't think it was a surprise to anybody because AONE is not an independent organization. They are a subsidiary of AHA, and they just do not have

the ability to come down hard on some issues. They have to always be watched by  
AHA. <sup>1</sup>(p62)

The AONE did not fail to sign because of any particular language or section of the agenda. It was not something that could be fixed. They just were not going to participate as a signatory organization. So the Tricouncil moved on with acceptance of the agenda by three out of the four membership organizations.

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Summit: everything came together

After the Tricouncil acceptance by majority not consensus, a nursing summit meeting was called in order to get as many nursing organizations as possible to concur with the agenda. The summit was held in Chicago and was attended by representatives of about 22 nursing organizations. The participants described their memories of that summit meeting and its long-term effects.

It was clear that for nursing to really get anything, we had to speak with one voice-the thing we'd been talking about for so long.... A group of maybe 60 people came together in a hotel in Chicago.... We wanted a commitment from all the organizations [represented] in the room that before we left Chicago they were going to sign on to a basic plan that they were going to support. It was going to be a coalition that would not unravel! It really lasted until today. I mean the coalition frays from time to time ... depending on what the issue is. But since the summit, there have been additional summits on other issues. It provides an excellent example of how nursing has come of age. All those people from their various vantage points were pushing the agenda. <sup>1</sup>(p63)

It was not easy to overcome apathy and resistance, but the nurses that did made a major difference. Politicians can be very impressed by large numbers of voters taking a unified stand. The accomplishment was unprecedented in nursing. These varied nursing organizations had no unifying single power of authority that joined them together. Many members of clinical organizations remained disinterested in politics and had to be persuaded by their more visionary colleagues to agree to the agenda. The agreement of the majority of nursing organization members to join in with other nursing organizations, take a political stand, and follow through on that commitment was a sign that this was indeed a new era for the profession. It is also a testimony to the individual nurses that persevered to bring about that commitment from their colleagues.

The period of winter 1989 to spring 1992 was a productive and significant time of change for nursing. Nursing leaders changed the profession from isolated concerned individuals and small groups to one large identifiable profession, speaking out in a clear document that prescribed treatment for the country's ailing health care system. During that process, nursing organizations developed new relationships with each other that were less competitive and more collaborative. Organizational interactions evolved from severe frustration caused by failure to reach consensus to an understanding of each others' differences. Those differences not only were better tolerated but also were transcended through emphasis on points of agreement and the use of broad language that appeased strong feelings and postponed conflict. ANA moved its headquarters from Kansas City to Washington, DC, in the spring of 1992. ANA emerged as nursing's coordinator of social policy statements and political activism, with a basis in the nation's capital.

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Political campaign of 1992: helping elect a President

"That brought us to 1992, where we made two major [political] decisions. One was to endorse candidate Clinton. It was a very public endorsement, a very active support of his candidacy for President. The second thing we did ... was to really invest in a new grass roots program for the association.... We helped elect a

President and we created a grass roots network to impact the areas of government we needed to impact." 1 (p67)

*Nursing's Agenda for Health Care Reform* was published and made available through ANA and state nurses associations. Nurses used the agenda to educate and to evaluate candidates for election. A slide presentation was developed with a printed script and was distributed to the state organizations. The new grass roots network within ANA, called Nurses Strategic Action Team (N-STAT), enlisted intense political activism from its members who promised to respond within a 24-hour period of notification from ANA with a letter or phone call to their members of Congress. "We could thereby generate a thousand to twenty thousand letters at the drop of a hat." 1 (p67)

George Bush was the Republican incumbent President running against Clinton in 1992. ANA, using *Nursing's Agenda for Health Care Reform* for screening and educating, wanted to interview all candidates. However, incumbents are traditionally less open to interviews, and the Republican party was taking a position that there was no health care crisis. That position and the refusal to meet with representatives of nursing were not well received at ANA. "George Bush wouldn't even meet with our PAC.... What kind of advice were they [Republican advisors] giving President Bush about the problems in health care in '91 and '92? Was he just going to say-which is what the doctors were saying-that there were no problems?" 1 (p96)

That is probably exactly what advisors were telling the President. ANA endorsed only candidates that listened to the contents of the agenda and agreed with its position. The election of 76% of the 260 ANA endorsed candidates was a political triumph. ANA's early and well-publicized endorsement of the Clinton/Gore candidacy was a major political risk that ended well, with the election of that team.

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Transition: this time, nursing will be at the table

"We heard a lot about Medicare but that was before both our times. We heard from some of the more elder stateswomen of nursing-that, yes, ANA was out front and supportive of Medicare but was never granted a seat at the table. That was not going to happen in health care reform. And that almost became a mantra, you know. We did hear that a lot. 'This time nursing will be at the table.'" 1 (p67)

Political appointments are a result of long hours of donated time and energy, political networking, achievement in the field, and monetary donations. In a presentation at the ANA Public Policy Conference in Washington, DC, in November 1997, three nurses gave advice based on their personal experience on how to receive a political appointment. 29 They described years of voluntary work in local and state campaigns; working in nursing compatibly with public policy officials; and influencing public policy through speech, writings, presentations, and active community and professional organization participation. They linked their clinical work closely to an astute knowledge of patient situations and their relationship to public policy. When a position became available, especially if candidates were elected who knew and respected them or a politically connected person who knew them, they placed their own name into competition for the position. The competition includes soliciting letters of support from politically connected people and from professional organizations, in addition to the usual resume, letters of reference, and interviews.

The appointments to the President's Task Force for Health Care Reform were not a result of good fortune. ANA representatives made it very clear to the transition team of the President-elect that nurse appointments were an expectation. These expected appointments were to government positions, health

care advisory roles on the transition team, and the promised future President's Task Force on Health Care Reform. An ANA staff member described the early days after the election:

There's a time, especially when you change parties and have a new President, a whole transition team is built. The first day after Clinton was elected, we had people already... calling ANA about wanting to be on the transition team. We started something called our federal employment project ... to identify nurses across the country that had both policy and political background.... We could identify the nurse experts in the country, because we had a running list.... We had the names ready to go. <sup>1</sup>(p68)

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The President's Task Force on Health Care Reform: the largest task force in history

When President Clinton was inaugurated on January 20, 1993, the nursing decisions about who would be representing nursing on the Task Force on Health Care Reform essentially were already made. As the task force grew and began its work, ANA was the center of nursing's participation, coordinating the nursing efforts and providing all kinds of support to the nurses on the task force. Nurses were appointed as consultants to one of the eight cluster teams and as cochairs and members of other cluster teams. Some nurses worked in the White House throughout the entire reform efforts. Others came into Washington periodically for cluster team meetings. Later, as the task force grew, people were called before the cluster teams and 34 working groups to testify about specific health care issues. Nurses were among the leaders deciding who would testify, and nurses were included in the health care professionals who were called to testify.

The people appointed to the Task Force were ANA members, and members of other organizations. We had nurses that worked in the White House on the Task Force. We had nurse experts appointed to different panels. We gave testimony. We helped other nurses give testimony to the cluster teams and working groups. We worked with a lot of the Task Force members who were government employees and federal employees.... We spent a lot of time working with them on some of the ideas. We drafted language that the Task Force could use. We were given the opportunity to critique the actual reports [leaked copies] that came from the Task Force. We spent a lot of hours, often through the night, with draft copies of the Task Force reports, rewriting them and resubmitting the changes to ensure the inclusion of nurses. We worked very closely with Ira Magaziner and his staff on those issues. We identified about 10 issues from Nursing's *Agenda* we thought were absolutely critical to be included in the Task Force report. We participated in a lot of coalitions to sort of build a public momentum for the acceptance of health care reform. They were not exclusively nursing by any means. It included small business people, unions, women's groups.... Family USA and AARP. We invested a huge amount of energy as well as money-really trying to build a public that was ready to accept health care reform. <sup>1</sup>(p70)

The work of the nurses on the task force was actively supplemented by ANA nurses and staff, by nurses in academia, and by others who were active in the Tricouncil and its member organizations. There were nurses on the staff of congressmen and senators, ranging in position from intern to chief of staff, who were very active in advisement about health care issues. All the networking that took place while the agenda was being developed continued throughout the efforts to write national health care policy. The nurses on the task force called in nurses to serve as members and to testify about their clinical specialties. These calls were on short notice and required the nurses to pay for their own expenses. Nurses were very willing to do this. People on the task force also were not paid for their participation.

In the early days of the Clinton administration, the White House staff received publicity about their long hours of work and lack of meals and sleep. It was

considered to be an expectation of their jobs, and they carried over that expectation to the members of the task force. An ANA staff person described the expectation this way:

Time lines were very unrealistic. They [task force leaders and their staff] came in and said they want to do a complete proposal for health care reform in the first hundred days. They divided people up into work groups and really ran it much as they had run the campaign. People were to drop everything and work around the clock. Meetings were scheduled at 8:00 AM Easter Sunday and 5:00 PM on Passover! But I was thrilled, like everyone, to be part of it because it was so much the game in town. <sup>1</sup>(p71)

As the task force began its work, its members saw new reasons for more work groups and different kinds of functions and membership. Johnson and Broder <sup>13</sup> mention some political reasons for the growth of the task force, but there were also other reasons. A nurse participant who was a member of the Health Professions Review Group of the task force described its formation and functions this way:

Maybe 6 or 8 weeks into the development of the Task Force, the Health Professions Review Group was formed by a nurse, an osteopath and two physicians. It was composed of 47 members. The group was very diversified, because the organizers looked for diversity. They had 14 nurses, 19 or 20 physicians, clinical psychologists, an EMT [emergency medical technician], a chiropractor, pharmacists, and social workers. The group was also diversified in terms of parts of the country, racial mix and ethnic background. One of the nurses was a Native American from the Creek Nation in Oklahoma. There were staff nurses. There were people representing different unions. One of the physicians was Hispanic and worked with homeless populations in Miami. The group's role was to respond to the work of the other working groups. We were one of the working groups, but also, the other working groups came to us, a group of health professionals, and bounced off of us what they were doing, to get our feedback. We were more a reactive group, although in the process of our feedback, we were helping to evolve the policy. We met over about a 4-month period. We'd come to Washington for 2 or 3 days and it would be very intense. Our meeting would be geared toward what was happening with the focus of other groups' work at that time. We looked at a lot of issues. We looked at the public health piece, enabling services, barriers to practice, financing mechanisms for providers, and collaboration. We had people in our group that were real health policy experts. We had a very, very knowledgeable group of folks, many of whom spoke from their personal experience. We had a social worker that is from a very underserved area. I represented the maternal child health perspective from a rural area. That was the way our group was structured. It was unique. After we were formed and were working for a while, then they did the same thing with lawyers, and with business groups. The Task Force wanted to get feedback from the experts in disciplines that would be most affected by the proposals. <sup>1</sup>(p72)

The nurse who was cochair of the Health Professions Review Group on the task force talked about the group's origins and functions from her perspective.

There was a group that came together to work with the First Lady. We offered, and they took us up on it, to put together a group of health care practitioners-not just people who were representing organizations-but a group of practitioners who would review a lot of the working papers and would give their input from their own personal experiences. It ended up being an over 45-member group. I have to say that I made the effort to get other than physicians and nurses on it. I made sure there were social workers, physical therapists, dentists, hospital administrators, clinic directors-as many professionals as we could have-and still make it workable. We invited others to come in at their own expense, and testify. They spoke on a selected topic to key domestic policy staff. We brought in more than a couple thousand people who were daily practitioners who wanted to have people hear what they had to say. We held briefings with sometimes 50, 60 people

in a day who would fly in at their own cost to give us feedback on a particular topic like maternal and child health or special populations. Then we wrote our findings up and gave them to the domestic policy council. So despite what one LA newspaper article said-that there weren't practitioners involved-there were, in fact, practitioners involved. We made our best effort to reach out to as many health professionals as we could. I was amazed at the way people would drop everything they were doing and come in to give some input on a particular topic.

1 (p73)

The nurse cochair of the Health Professions Review Group explained the necessity of having a diverse representation to critique policy development, and the means of ensuring that diversity occurs. Her belief is that nurses will advocate for diversity by requesting their own participation and by insisting on representation of other groups. Having nurses in places where they can speak out to influence participation is important.

There were a couple of nurses in the public affairs staff of the White House. There were nurses' associations and others pushing to be involved. From the outside there were nurses on the hill [congress people and staff] and others pushing. You've got to have people in a lot of different places ... reinforcing what the discussion is, and naming who we need to reach out to and who we need to have on the list. If you're at a meeting in which someone says we're going to make sure we get the deans of the schools of medicine in because we'd like their input, somebody has to be there to say we're going to get the deans of the nursing schools, too. You have to make sure that the Black nurses, Hispanic nurses and Asian nurses are also involved in this-because of the importance of the special population needs. It takes outreach to get the best possible health care and culturally acceptable health care. 1 (p74)

Another nurse cochair described her experiences on another subgroup of the task force:

I was the executive branch nurse representing Health and Human Services who was engaged in health care reform. My role was in the workforce area, so all of the issues around nursing as a profession, the utilization of the nursing workforce, the development of nursing supply, were considered in the group that I was part of. It was the first time in this country that there was this massive assessment of health policies under consideration and there was an executive branch nurse present. 1 (p74)

A nurse from an academic center was employed as a senior consultant to the Clinton administration. She worked as a consultant to the cluster that worked on infrastructure. This is how she described her position:

I was a senior consultant to the Clinton administration with the cluster on infrastructure and their work. Several components of it were the health care workforce, malpractice insurance and fees, information systems, and quality assurance. I worked closely with a physician attorney. He was a full-time cluster leader. I was a major outside consultant. I actually worked for and was paid in a formal way by the Clinton administration, to work as a consultant with the task force. But I did not give up my role at the university. I just sort of shuttled back and forth. 1 (p74)

This nurse went on to describe the work on the task force as a culmination of nurses working together, having come from different fields in nursing, but focusing together on the broad nursing and patient issues that needed to be in national health care policy.

I think this was nursing's most effective example of using nurses that were located strategically in different sectors, to triangulate on an agenda and to get it into health care reform. I came from a university base as a consultant to establish the agenda.... I've done things besides nursing, so I think I was considered and accepted as being a reasonably neutral person at the table-neutral, but knowledgeable about data-based demonstrations. There was the President of the ANA, and the nurse from the Division of Nursing on the inside of the executive branch. So the three of us did a pretty good job of playing both inside and outside to one another to put whatever pressure was required to get nursing issues on the Task Force agenda. Often, even though they were on the agenda at one point, they'd be dropped off at another point. So someone would have to intervene to get them back on there. That's the first time in my professional career in nursing, that there were three major people inside the government, but from outside the government, and in the major nursing lobby, that pushed these things all together. It worked pretty effectively. 1 (p75)

This nursing leader described the need for critical and strategic thinking about deciding where to be placed on the task force, how to be most effective when there, and how to continue the effectiveness. She did not limit her participation to discussion on nursing issues only, but she recognized that as an intelligent experienced person she had more than that to offer. In spite of her experience, she acknowledges that it was difficult and intimidating to do that.

A lot of political influence and policy influence [depends on] being recognized as being a player. That means speaking up at meetings on topics other than nursing and figuring out a strategy to speak up. It's not easy. It's intimidating going to meetings with members of the Cabinet, and lots of experts in their own field. And [you need to] plow in, and also figure out a way to debate on as much of an objective basis as possible-not a personal basis. 1 (p76)

The benefits of being conversant on other people's issues and the broader issues of health care beyond nursing had a long-range positive effect. The participant explained why she was glad that she "plowed in" and participated in the overall debates.

Another thing that happened in health care reform was the bringing together of the famous 500 people-the largest task force in history! It was actually a very impressive group of people that were intellectual leaders, and organizational leaders. You had all these people, and a chance to influence their thinking about nursing, whatever happened to health care reform. You had to argue your point to Ira Magaziner, and Paul Starr, and everybody else, including health economists who couldn't care less about nursing. The more effective the nurses were at the table ... had a sort of multiplier effect. The nurses that were in the smaller group would convince someone like a physician attorney who was a cluster leader and was involved in the inside meetings. He really bought Nursing's *Agenda*, even though he wasn't a nurse. He took that *Agenda* on [as his own] for health care reform and he still takes it on today. So here you have a very smart physician attorney, now at a university who writes on the regulation of health professionals and who is working on state practice acts. So there are all these multiplier effects, when you start impressing smart people in other fields.... The Task Force was one of the first times that all these other disciplines got to see nursing in action, and nursing was impressive. They learned something. I can see it reflected in their work, now. They pay more attention to nurses than they did before. 1 (p76)

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#### Power relationships and conflict on the task force

Appointment to the task force was a major accomplishment for nursing, but being there was only the beginning. Nurses had to persevere in assertiveness and vigilance to maintain an influential presence. The task force brought so many people from so many disciplines together; one can only imagine how many opportunities for conflict and misuse of power existed. The intention of President

Clinton was, apparently, to reduce the political maneuverings in the beginning, limiting the political power plays, insofar as possible, to the congressional debate. In retrospect, the congressional debate and the accompanying political and special interest maneuvers were so malicious and lethal that postponement may have been the only way to limit them. That approach, however, had and still has many critics. The nursing representatives had a large responsibility. In addition to the usual potential for conflict within nursing and among disciplines, they had the task of representing nursing in a new level of hostile political environment during the task force's development of the President's plan and afterward when the legislation was presented to the legislators.

There were certainly power dynamics being played out in our group of all health professionals. But the nurse cochair set the tone. She role-modeled the collaborative relationship. I knew that the physicians clearly saw themselves in charge of the group, but she was the one who made them aware of a lot of the other issues and the need for other inclusions. We'd get into some very heated discussions about issues. The physicians were concerned about the issues of malpractice that were part of the health care reform proposal. There were lots of issues about setting limitations on liabilities and awards for malpractice. That was probably their biggest sticking point. Our concerns were barriers to practice, particularly for advanced practice nurses. Interestingly, for the physicians in our group of 47 people, that wasn't a big deal. They were not concerned about nurse practitioners taking over their practice. So some of the turf battles that played out later in the press between the AMA and the ANA were not a big deal in our Health Professionals Group. On the other hand, our issues were not a big deal in that the physicians did not particularly care about them. Consequently, the nursing perspective was not well stated in the group's statements.... We did a lot of background work ... then we created the statements and we wrote them up for the whole group. <sup>1</sup> (p78)

There was only one dentist in one group. She repeatedly told members about the physiologic reasons why dental health was needed in a comprehensive plan. Eventually she would "periodically pop up and say, remember that the teeth are part of the body, and everyone would kind of laugh. She did it in a good way. She was clearly powerless to start with, but she kept reminding people, to the point that she increased everyone's awareness." <sup>1</sup> (p79)

On September 22, 1993, when President Clinton announced his intent to submit the Health Security Act, the task force was nearing completion of its task. They used much more time than originally planned, had been subjected to accusations of secrecy and illegalities, and had grown to be much larger than anyone ever anticipated.

The opponents of the Health Security Act included politicians, insurance companies, the AHA, small business associations, and pharmaceutical companies. The Health Security Act was misrepresented as a government takeover of health care. It was strongly opposed by those who feared government control and by those who would lose the huge income and profits they made from private sector control. The people who wanted a government-controlled health care system were also opposed to the Health Security Act. They lobbied for a Canadian-style system.

Insurance company spokespeople publicly expressed interest and agreement with the need for reform but actually worked cleverly to destroy the President's plan. Their success at destruction has been attributed largely to the Harry and Louise commercials that marked a turning point of the health care debate. All of the participants talked about those commercials and about their phenomenal influence on the public.

The foray lasted about 1 year. In September 1994, the congressional debate was declared over. Congress adjourned on October 7, 1994, with no health care

legislation whatsoever. "We put so much energy into it! It's too bad we don't have one single more person covered or with access to insurance than we did when we started!" 1 (p90)

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INTERPRETATION AND DISCUSSION

Praxis, in the sense of beliefs turned into action, or "Do I know what I do and do I do what I know?" 30(p5) can be part of the knowledge gained from the participants. Just as the words from an oral history add a personal dimension to hearing about an experience, as in having your sister or a friend tell you about it, transferability also can be personal and practical. Hearing that an experienced, well-published nurse researcher and academic was a paid consultant to the White House on health care policy can be impressive and inspiring. But when her words tell you that speaking up at meetings was not easy and was in fact intimidating, her experience may seem more like one of your own. When she states, "And [you need to] plow in, and also figure out a way to debate on as much of an objective basis as possible-not a personal basis," it can sound like sisterly advice. It can help you learn to know what you do and do what you know. Interpretations are discussed here in the spirit of praxis. Interpretation answers the question, "What is it all about?" or "So what?" The feminist answer is, the personal is political.

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Celebrate nursing's accomplishments

The United States had three major social policy accomplishments in the 20th century: voting rights for women, Social Security, and its extension in Medicare. The last major opportunity for social policy of the century was health care reform. Nursing as an organized profession was not only officially there preparing the legislation, but in a very large way it shaped the actual identification of the problem and participated effectively in making it a national subject of debate.

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Learn about power and conflict from the participants' experiences

The participants are accustomed to dealing with power and power relationships. Their strategies for dealing with power are summarized in Table 2. The examples from the participants' experiences before and during the task force are merged into actions in response to hypothetical problems that nurses might experience as individuals or within work groups.



Table 2

Some degree of political knowledge and practice is seen as an expectation of practicing nurses. For those nurses who choose to go beyond the minimum activist role, the process is seen as gradual growth with learning facilitated by taking risks, working in groups, and coaching each other. Women need to gain knowledge in both traditional leadership/power acquisition methods and feminine/feminist leadership and power sharing methods to achieve effectiveness in advocating for policy based on the ethic of care. 27 Most of the participants in this study demonstrated a working knowledge and merging of both systems. It does not appear that they consciously or deliberately chose different methods in a strategically developed plan, or even demonstrated exceptional expertise in either method. The beginning body of knowledge within the nursing profession about both leadership styles needs nurturing, analysis, and application within research, education, and practice settings.

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Dispel misinformation about the reform efforts

In the continuing effort to bring about effective health care legislation it is necessary to recognize that both misinformation and confusion among Americans played a large part in the defeat of the Health Security Act. The Act proposed a

partnership between government and private health care insurers. It was not a government-run program. Health care professionals were a dominant part of the authorship. The authors also relied heavily on input from practicing health care professionals, health care consumers, and a variety of other professionals such as economists, lawyers, and even insurers. The diversity of the US citizenry was well represented.

The Act was long because it was comprehensive. It was a result of rational-comprehensive decision-making theory, <sup>31</sup> also described as a rational public policy development approach. <sup>32</sup> Social Security and Medicare, relatively sweeping reforms, were results of the rational approach. Most social policy changes in the United States are based on incremental theory. Incremental social policy is easier to accomplish because it does not challenge those with vested interest in the status quo to defeat it. Most social policy in the United States has been based on incrementalism, developed slowly, and achieved minimal success in comparison to other industrialized countries. US incremental health care legislation has proved to be ineffective. The current US health care system is unworthy of both a mature democracy and a thriving capitalistic economy.

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### Continuing advocacy for health care for all Americans

In the year 2000 there are many millions of Americans without health care insurance. The American problem of access to health care has worsened. There is a need for nurses to continue political advocacy. *Nursing's Agenda for Health Care Reform* remains a useful guide for a basic standard of care and planned change, but a partnership between government and private insurers is no longer recommended by ANA. The Board of Directors of ANA approved a recommendation from constituents for support of a national government single-payer system.

The years from 1989 to 1994, including the infamous 1993 to 1994 year of debate, provided positive steps forward for health care reform. The ensuing years of decline of the health care system have raised the consciousness of many formerly uninformed, apathetic, or confused Americans. The means of accomplishing national health care reform are available. Nursing has the resources and the expertise to continue its leadership role toward that goal. There is a place for every nurse in this continuing struggle. Each nurse needs to be

\* an active, informed voter who knows the names of legislative representatives

\* a dues-paying member of the professional organization, in addition to clinical or specialty nursing organizations

\* a colleague of not only nurses but also other health care professionals with whom health care policy is discussed in an informed and intelligent manner

Varying degrees of individual political activism will continue to be part of nursing, but the threshold has been raised. Each nurse needs to stretch his or her political self a little and take an increasingly active and knowledgeable professional role in this American democracy.

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Key words: feminism; health care reform; oral history; political advocacy; postmodernism

IMAGE GALLERY

Select All

Year	Month	Event
1988-1989		ANA Task Force on Cost, Quality, and Access begins in September 1988 and continues its work throughout 1989.
1991	January	Executive approval of Nursing's Agenda for Health Care Reform.
1991-1992	February	Nursing's Agenda for Health Care Reform is published. Nursing's Agenda for Health Care Reform is used by nurses for education and evaluation of national candidates for Congress and Senate.
1992	April	ANA moves its headquarters to Washington, DC.
	May	Senate meeting on Nursing's Agenda for Health Care Reform.
	August 12	ANA announces endorsement of Clinton/Gore candidacy in Peabody, California.
	November	Clinton/Gore elected. 10% of congressional and senatorial candidates endorsed by ANA are elected.
		President-elect Clinton's transition team begins its work. ANA recommends various legislative appointments to Presidential transition team using ANA Federal Appointments Project Database.
1993	January 20	Inauguration of President Clinton.
	January 25	President Clinton formally announces that his wife, Hillary Rodham Clinton, will head a Task Force for Health Care Reform.
	March 3	Hillary Rodham Clinton, White House staff, and advisors meet with nurses at White House.
	September 22	President Clinton announces plan for health care reform. President and Hillary Clinton speak in Statuary Hall.
	October 27	Hillary Clinton presents Health Security Plan in testimony to the Congress.
	November	Hary and Louie commercials begin. Congressional and Senate health care bills introduced and debated.
1993-1994	November 1993 to November 1994	1994 Congressional and Senate health care bills introduced and debated.
1994	October 7	1994 Congressional and Senate health care bills introduced and debated.
	November	1994 Congressional and Senate health care bills introduced and debated.

Table 1

Problem	Action
Your group is fragmented in beliefs and loyalties.	1. Schedule meetings of people who represent varying points of view. Set talking in the night. Everyone brings in all points of view and all positions are clear. 2. Find points of agreement and disagreement. Assign people with varying skills (negotiation) to write a position statement. 3. Review statement together. 4. Agree to disagree on some points. 5. Sign in agreement to the statement. 6. Agree to support the final position. 7. Inform large numbers of members and nominations to the position (grass roots networks).
You or your group occupy a minority status in your organization.	1. Join together. Form coalitions. Maintain unity (example of MLN and ANA, Tennessee, nursing and other health care organizations voting in agreement on Nursing's Agenda for Health Care Reform). 2. Persistence in a goal oriented way (example of women doctors on task force). 3. Volunteer to help on projects and publicize your beliefs on. Because known as a good worker and a loyal ally. You will be asked to participate because of those positions (rather than your inconsistent) powerful position. 4. Be knowledgeable about subjects, practice with friends, then speak out at meetings in confident and articulate manner.
Fellow volunteers in spread about your group's position.	1. Use grass roots network to spread the truth. 2. Use grass roots network to raise money (many small donations can reach a few large donations). Use money for advertisement of truth in a non-threatening manner. 3. Call or letters. Contact colleagues, friends, and organizations about the solution. 4. Elect one person to lead the solution. 5. Work on getting persons of your position. 6. Keep trying.
Your group's position is ignored.	1. Elect one person to lead the solution. 2. Work on getting persons of your position. 3. Keep trying.

Table 2

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