

Response to “The Role of the Nurse Leader in Battling Human Trafficking in Rural Hospitals in Texas”

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Being an expert on the health care and multidisciplinary responses to human trafficking coupled with presenting on this topic as a recent visiting scholar in Texas, it was with great interest that I read “The Role of the Nurse Leader in Battling Human Trafficking in Rural Hospitals in Texas.”¹ The timeliness of this article could not have been better, as it further supports the tenets of the visiting scholar dialogues and presentations. Thank you for the opportunity to express my sincere appreciation of the authors for addressing human trafficking from a nurse leadership perspective. As highlighted in their overview of an extremely complex phenomenon, human trafficking occurs in all communities, including those often described as rural and frontier. In support of the authors’ call to action in responding to human trafficking in rural areas, I would like to take a moment to briefly highlight a few cautionary considerations and encourage additional dialogue on this very important subject.

The authors present a call to action for nurse leaders in all communities to collaborate in addressing human trafficking within their organizations and communities. This call to action is followed by several positive recommendations for nurse leaders to consider acting upon. However, nurse leaders should also be aware of risks for creating a fractured capacity to respond. This may occur when well-intended actions are not fully informed or when initiatives create role conflict and confusion. It may also occur when there is an absence of a system-wide trauma-informed culture or when those who are spearheading the initiative do not engage in multidisciplinary collaboration.

Although the authors identify that there needs to be “an all out effort by the nursing profession,” the nurses cannot do this alone. Collaboration must extend beyond nurses and clinicians within a health care system or setting. Building the capacity to recognize and respond to victims of trafficking is limited if it does not involve multidisciplinary collaborations and community partners to support the unique needs of this patient population once discharged from the hospital. The authors speak to this consideration; however, multidisciplinary collaborations are essential and worthy of further emphasis.

Adding to the foundation provided by the authors, cultural change also requires a system-wide understanding of a trauma-informed response. Becoming a trauma-informed organization enhances the organization’s capacity, and that of all its employees, to meet the complex needs of people who experience all forms of violence and exploitation. When we focus

on one form of violence or exploitation, we do not appreciate how the different forms of violence are interconnected. Creating silos of education, rather than an overarching trauma-informed culture, for sexual assault, intimate partner violence, human trafficking, and the other forms of abuse and exploitation may contribute to a fragmented response to the unique needs of each patient population.

I also appreciate the author’s attention to the concepts of moral courage and moral distress. As the authors acknowledge, it requires courage to uphold one’s ethical responsibilities in addressing controversial or emotionally charged situations and practices. Another related consideration is that of role conflict and role confusion; both well-known phenomena in nursing that can contribute to distress. Role conflict can occur due to internal and external factors, in which there is a conflict between the nurse’s expectation of self and the expectations of others.² Role confusion can occur when the nurse is uncertain about the expectations of others.³ In a climate of change, inconsistent role expectations can lead to role confusion.

If the nurse leader has an expectation of what should be done, but there are barriers or a lack of resources to act on these expectations, this can lead to internal role conflict. Role confusion and conflict can become a system-wide issue as employees and clinicians have expectations of others and themselves that may or may not be supported in the given environment—hence returning to the need for a system-wide, trauma-informed organization with an infrastructure to support an expectation of appropriate interventions and trauma-informed responses for people who experience violence.

To successfully meet the complex needs and appropriately respond to persons who are trafficked, there must be a system-wide cultural change that has both a top-down and a bottom-up buy-in and support. This requires a cultural shift where all employees of the health care facility receive training and education, in which action is expected, and an infrastructure (leadership, policy, physical environment) supports appropriate actions. As identified by the authors, nurse leaders are uniquely situated to take the lead in building awareness and changing system-wide practices, creating policy and practice changes, and contributing to a community infrastructure to better serve persons who are trafficked. I again thank the authors for bringing this to the attention of nurse leaders and encouraging action toward addressing human trafficking in rural areas.

References

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