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Nursing and the Future of Health Care: The Independent Practice Imperative

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NURSING AND THE FUTURE OF HEALTH CARE: THE INDEPENDENT PRACTICE IMPERATIVE

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I. INTRODUCTION

In recent years an ever increasing problem has emerged within the health care delivery system in the United States: there is a shortage of registered nurses to meet patient care needs. This shortage raises serious public policy concerns about how society will be assured of quality health care and who will provide that care in the future.

An awareness of the problems that have led to the nursing shortage and exploration of alternatives to the present health care delivery system are required in order to remedy the problem. The efforts of the nursing profession to overcome the effects of the shortage could well dictate the future of health care into the next century. As a society, we must be willing to assist by examining alternatives to the present health care delivery system so that nurses continue to provide competent health care, the basis of the public concern.

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The author is a registered nurse with fifteen years experience in neurosurgical and emergency nursing. The assistance and support of Constance McKenna, Mary Ratcliff, John Karris and Professor John Wilson are gratefully acknowledged.

This article is dedicated to Jean P. Ruxton, R.N., Ph.D., educator and mentor, whose vision of professional advancement for nursing was an inspiration to all who knew her. Her dream lives in the hearts and minds of her grateful students.

II. EVOLUTION OF THE PROFESSION

Over the last century, nurses have evolved from their origins as subservient caretakers into health care professionals.[1] However, since most nurses are women, their professional struggle has been profoundly affected by society's attitudes toward the value of women and their work.[2]

The vast majority of modern nurses work in hospitals and their practice involves direct patient care as well as the coordination of medical and ancillary services. Nurses' duties require the exercise of independent judgment and sophisticated technical knowlege.[3] Although nurses' responsibilities have increased, professional recognition has not followed.

Nurses' efforts toward recognition as an independent profession have recently begun to reach fruition.[4] State legislatures are beginning to recognize the professional nature of nursing,[5] and its independence from medicine,[6] in their statutes which regulate nursing licensure and practice.[7]

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1. For a discussion of the professional growth in nursing, *see* Eccard, *A Revolution in White — New Approaches in Treating Nurses as Professionals*, 30 VAND. L. REV. 839 (1977).

2. For a discussion of the impact of these attitudes on the nursing profession, *see* Moskowitz, *Pay Equity and American Nurses: A Legal Analysis*, 27 ST. LOUIS U.L.J. 801, 802 (1983).

3. *Id.* at 802-03.

4. The American Nurses Association Code for Nurses states nurses assume responsibility and accountability for individual nursing judgments and actions, the nurse maintains competence in nursing, and the nurse exercises informed judgments and uses individual competence and qualifications as criteria for seeking consultation, accepting responsibilities and delegating nursing activities to others. AMERICAN NURSES ASS'N, CODE FOR NURSES (1976), *reprinted in* Note, *Nurses' Legal Dilemma: When Hospital Staffing Compromises Professional Standards*, 18 U.S.F. L. REV. 109, 113 (1983).

5. For a discussion of the legislative changes affecting nursing practice, *see* Note, *supra* note 4.

6. *Id.*

7. *See, e.g.*, ALA. CODE § 34-21-1(3) (1975); ALASKA STAT. § 08.68.410(8) (1982); ARIZ. REV. STAT. ANN. § 32-1601 (1982); ARK. STAT. ANN. § 72-746(e) (1979); CAL. BUS. & PROF. CODE § 2725 (West Supp. 1983); COLO. REV. STAT. § 12-38-202(9) (1978); CONN. GEN. STAT. ANN. § 20-87a (West Supp. 1983); DEL. CODE ANN. tit. 24, § 1902(6) (1981); FLA. STAT. ANN. § 464.003(3)(a) (West 1981); GA. CODE ANN. § 43-26-1(3) (1982); HAW. REV. STAT. § 457-2(2) (1976); IDAHO CODE § 54-1402(b) (1979); ILL. ANN. STAT. ch. 111, para. 3405 (Smith-Hurd 1983); IND. CODE ANN. § 25-23-1-1.1(b) (Burns 1982); IOWA CODE ANN. § 152.1 (West Supp. 1983); KAN. STAT. ANN. § 65-1113(d) (1980); KY. REV. STAT. ANN. § 314.011 (Baldwin 1981); LA. REV. STAT. ANN. § 37:913(3) (West Supp. 1983); ME. REV. STAT. ANN. tit. 32, § 2102(2) (1978); MD. HEALTH OCC. CODE ANN. § 7-101(f) (1983); MASS.

However, mere recognition as a profession has not been enough to stem the tide of events that have led to the nursing shortage. This article will explore the diverse nature of the factors that have led to the shortage and the profession's difficulties in meeting the public policy demand for competent health care. Further, the present attempts to remedy the dilemmas, and a recommendation for alternative solutions through the formation of independent nursing practice groups coupled with direct reimbursement for nursing services will be explored.

III. NURSING DILEMMAS

A. THE NURSING SHORTAGE

Even as nursing has been achieving recognition as an independent profession, the number of nurses available to meet the patient care demand has diminished. Applications to nursing schools have decreased[8] and vacancies in nursing staff positions in hospitals have increased.[9] A recent study showed the average U.S. hospital had a vacancy rate in nursing positions of about twenty-five percent and a turnover rate of about twenty percent.[10] Other research has revealed that of the nurses surveyed, eighty percent reported working as a registered nurse (RN) in the past year.[11] However, five years after graduation from nursing school only fifty percent were working fulltime, and twelve

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ANN. LAWS ch. 112, § 80B (Law. Co-op. 1983); MICH. STAT. ANN. § 14.15 (17201) (Callaghan 1980); MINN. STAT. ANN. § 148.171(3) (West Supp. 1983); MISS. CODE ANN. § 73-15-5(2) (1982); MO. ANN. STAT. § 335.016(8) (Vernon 1983); MONT. CODE ANN. § 37-9-102(3)(a) (1981); NEB. REV. STAT. § 71-1,132.05 (1976); NEV. REV. STAT. §632.010(7) (1979); N.H. REV. STAT. ANN. § 326-B:2(V) (1981); N.J. STAT. ANN. § 45:11-23(b) (West 1978); N.M. STAT. ANN. § 61-3-3(A) (1981); N.Y. EDUC. LAW § 6902(1) (Consol. 1979); N.C. GEN. STAT. § 90-158(3)(a) (1981); N.D. CENT. CODE § 43-12.1-02(5) (1978); OHIO REV. CODE ANN. § 4723.06 (Page 1977); OKLA. STAT. ANN. tit. 59, § 567.3(2) (West 1982); OR. REV. STAT. § 678.010 (1981); PA. STAT. ANN. tit. 63, § 212 (Purdon 1983); R.I. GEN. LAWS §5-34-1(d) (1976); S.C. CODE ANN. § 40-33-10(f) (Law. Co-op. 1977); S.D. CODIFIED LAWS ANN. § 36-9-3 (1977); TENN. CODE ANN. §63.7-103 (1982); TEX. REV. CIV. STAT. ANN. art. 4518 § 5 (Vernon 1982); UTAH CODE. ANN. § 58-31-4(4), (5) (1981); VT. STAT. ANN. tit. 26, § 1572(2) (1983); VA. CODE ANN. § 54-367.2(b) (1982); WASH. REV. CODE ANN. § 18.88.030 (1983); W. VA. CODE § 30-7-1 (1980); WIS. STAT. ANN. § 441.11(1) (West 1983); WYO. STAT. § 33-21-120 (1983), *listed in* Note, *supra* note 4, at 110.

8. *See* Lupica, *Pay Equity — A "Cockamamie Idea?" The Future of Health Care May Depend Upon It*, 13 AM. J.L. & MED. 597, 597-98 (1981).

9. *Id.* at 598.

10. *See* Note, *AHA Sees RN Shortage Easing, but Turnover Persists at 20%*, 89 AM. J. NURSING 997 (1989).

11. Roberts, *What To Do About the Nursing Shortage*, HOSPITAL TOPICS, July-Aug. 1989, at 8, 13.

years after graduation only fifteen percent were working fulltime.[12]

The nursing shortage has been attributed to a number of causes. In a profession dominated by women, nurses have traditionally received poor economic compensation for their efforts. Wages earned by nurses are often less than those earned by traditionally male-dominated occupations such as carpenters and bus drivers.[13] Additionally, nurses' entry pay is lower than that of other professions, and salary limits are reached more quickly.[14] For example, a 1986 Department of Labor study revealed the following rates of salary progression[15] for various occupations: attorneys 226.2%, computer programmers 106.1%, engineers 183.6%, purchasing clerks 67%, secretaries 71.8%, general clerks 84.5% and registered nurses 36.4%.[16]

Other factors, most importantly an increasing disaffection among nurses themselves, are also responsible for the growing nursing shortage. A recent study indicated that nurses seek the following characteristics in employment:
1. To be treated as a professional.
2. Interesting and challenging work.
3. Positive environment — cooperative coworkers.
4. Independence — autonomy.
5. Flexibility in scheduling.
6. A sense of performing an important and necessary service.
7. Responsiveness to nurses' needs.
8. Socialization.[17]

Nurses are not finding these factors in their employment. Instead, research has revealed that nurses are dissatisfied with their employment for the following reasons: poor working conditions and salaries that do not reflect nurses' education, skills and

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12. *Id.*

13. *See* Moskowitz, *supra* note 2, at 812.

14. *Id.* at 813.

15. Salary progression refers to the percentage of salary increase over the lifetime of employment in the field.

16. BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, NATIONAL SURVEY OF PROFESSIONAL, ADMINISTRATIVE, TECHNICAL AND CLERICAL PAY (Oct. 1986).

17. Hansen, *Student Retention in Associate Degree Nursing Education*, in HEALTH RESOURCES AND SERVS. ADMIN., U.S. DEP'T OF HEALTH AND HUMAN SERVS., REPORT OF THE NATIONAL INVITATIONAL WORKSHOP 100 (1988) [hereinafter HEALTH RESOURCES].

risks faced;[18] hospital management policies that contribute to the lack of opportunities nurses have to make or contribute to decisions affecting their practice;[19] and inability to provide quality care due to inadequate staffing, rotation to different hospital areas and the presence of non-staff nurses which reduces continuity of care.[20]

These concerns expressed by practicing nurses demonstrate that major factors contributing to the nursing shortage are the nurses' lack of professional autonomy and control over their practice. These are the issues that must be addressed to retain practicing nurses. Other factors are involved in recruiting future nurses.

Nursing's image in society and the media has been stereotyped as feminine, kind and nurturing, characteristics not generally valued in monetary terms in our society.[21] This negative public image has adversely impacted recruitment and retention of nurses.[22] A coordinated public relations campaign has been recommended to counter the negative image of nursing and assist in attracting and retaining nurses[23] and to promote the professional nature of nursing.

B. The Hospital-Nurse Relationship

The effect of nursing's poor public image on recruitment is fairly straightforward. However, nurses' dissatisfaction with their professional practice can only be understood by examining their existing relationship with hospitals and the professional dilemmas that result.

Most nurses are employed by hospitals and, therefore, are involved in an employer-employee relationship with the hospital. Hospital administrators, not the nurse professionals, make many of the decisions that impact the nurses' practice. This can create serious ambiguities for the nurse. If harm befalls her patient as a

18. *See* Lupica, *supra* note 8, at 597.

19. *Id.* at 597-98.

20. Cooper & Brent, *The Nursing Profession and the Right to Separate Representation*, 58 Chi.-Kent L. Rev. 1052, 1077 (1982).

21. *See* Lupica, *supra* note 8, at 599.

22. *See Recommendations*, in Health Resources, *supra* note 17, at 143.

23. *See Executive Summary*, in Health Resources, *supra* note 17, at 4.

result of the employer's decision, the nurse, as the professional, is held responsible as a result of the professional malpractice standard applied to the registered nurse.[24]

Nowhere is this problem more evident than in the area of hospital staffing. The decreased number of available nurses and mounting hospital financial concerns have led to understaffing in patient care areas.[25]

> Unfortunately, there is conflict between nursing standards and reality. On one hand, nurses are held liable for failure to maintain professional and legal standards. On the other, they have no control over administrative staffing decisions. The unhappy, but inevitable, result of the disaccord between nurses' professional and legal standards and the realities of an understaffed hospital is increased exposure to liability for the nurse.[26]

The employer-employee relationship between hospitals and nurses also creates liabilities for the hospital. If the nurse fails to meet her professional duty, and harm befalls the patient, the hospital can be held liable under the doctrine of respondeat superior.[27]

If nurses are unable to control the amount of staff required to provide adequate care to their patients, they can become discontented with both their employer and their profession. However, there are other problems associated with the employer-employee relationship that negatively affect nursing practice.

1. *Malpractice*

In the past there was confusion in the courts as to the appropriate negligence standard to apply to nurses.[28] Some courts applied the reasonable person negligence standard, while others

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24. For a discussion of the professional malpractice standard as it is applied to nurses, *see* Note, *supra* note 4, at 122-23.

25. For a discussion of the legal and professional dilemmas faced by nurses as a result of hospital staffing, *see id.* at 118-20.

26. *Id.* at 121.

27. For further discussion of the doctrine of respondeat superior, *see* Walker, *Nursing 1980: New Responsibility, New Liability*, 16 TRIAL 43 (1980).

28. *See* Note, *supra* note 4, at 122.

applied a professional standard. Recently, however, the trend seems to be to hold the nurse to the higher, professional standard.[29]

This trend became evident in *Fraijo v. Hartland Hospital*[30] where a nurse was held to the professional standard for the harm her actions brought to a patient. The court stated:

> While nurses traditionally followed the instructions of attendant physicians, doctors realistically have long relied on nurses to exercise independent judgment in many situations. . . . A nurse may, of course, be held liable for her own negligence and her employer, the hospital, can be held responsible for the negligence of either employee nurse pursuant to the doctrine of respondeat superior.[31]

The recognition by the courts of nursing as a profession, and the concomitant application of the malpractice standard to nurses, has heightened predicaments in nursing practice. A nurse who accepts an understaffed unit assignment from her hospital-employer may be held to the professional standard if harm should befall a patient as a result.[32]

Although there are no cases that directly address the issue of understaffing and the nurses' liability, a few cases have dealt with it peripherally with differing results. For example, in *Leavitt v. St. Tammany Parish Hospital*,[33] a patient fell while going to the bathroom after the staff failed to respond to her call for assistance. The court found the hospital breached its duty to the patient by having an inadequate number of staff on duty to respond to the plaintiff's needs.[34] Since the nurses were not named defendants, their liability was not directly addressed. However, in dicta, the court stated that the staff knew of the plaintiff's debilitated physical and mental condition and "in spite of this knowledge, they failed to take adequate measures to

29. *Id.*
30. 99 Cal. App. 3d 331, 160 Cal. Rptr. 246 (1979).
31. *Id.* at 342, 160 Cal. Rptr. at 252.
32. *See* Note, *supra* note 4, at 122-23.
33. 396 So. 2d 406 (1981).
34. *Id.* at 408.

avoid this very foreseeable accident. We find this to be a breach of the duty of reasonable care owed to Mrs. Leavitt."[35]

The dicta in *Leavitt* conceptualizes nurses' concerns regarding their legal relationship with hospitals. Even though the hospital breached its duty to the patient by understaffing the nursing unit, the dicta indicated that the nurses themselves were equally liable in spite of the hospital's breach. This leaves the nurse in a precarious situation: she cannot control the hospital's staffing decisions but can be held responsible for the results.

2. *Indemnification*

When hospitals have been held liable for the tortious acts of their nurse-employees, they have been found to have a right to indemnity from that nurse by operation of law.[36] Thus, if a nurse's actions are responsible for a patient's injury, the hospital has a right to recoup its losses from the negligent nurse.[37]

Usually, indemnification is allowed only if one is responsible by imputation of law; the right does not exist if one is involved in the harm-causing act.[38] This principle does not, however, protect the nurse even in cases where the hospital contributed to the harm by understaffing the nursing area. The reason is that the nurse is held to a professional standard in respect to accepting responsibility. If the average prudent nurse would not have accepted responsibility for an understaffed assignment, the nurse who does is held to the professional malpractice standard and is liable for any harm that befalls the patient as a result.[39] Consequently, the nurse's professional decision to accept the understaffed assignment can limit the hospital's responsibility and leave the door open for indemnification from the nurse if harm occurs.

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35. *Id.*

36. *See* Morris, *The Negligent Nurse — The Physician And The Hospital*, 33 BAYLOR L. REV. 109, 136 (1981).

37. *Id.*

38. *Id.*

39. *See* Note, *supra* note 4, at 123.

This leaves the nurse in an uncomfortable bind. If she refuses an understaffed assignment, she could face disciplinary action, including termination, by her hospital-employer. If she accepts the assignment, and harm to a patient results, she is professionally responsible for the harm and can be required to indemnify the hospital should it have to compensate the patient.

3. *Insurance*

To offset the potentially devastating financial effects that can result from malpractice liability, nurses have, in the past, relied on the hospital's liability insurance. However, the judicial trend toward categorizing a nurse's liability as malpractice has made this reliance hazardous. Most general hospital liability insurance policies have an exclusionary provision by which the insurance company disclaims liability for malpractice actions brought against the insured hospital.[40] When a suit involves malpractice by the nurse, the insurance company may have no duty to defend the hospital or pay any award.[41]

Whether or not a nursing act is covered is determined by the nature of the nursing act. If the act is determined to have been a professional service, then there is no coverage through the hospital's insurance policy.[42]

Nurses may seek insurance for themselves. However, there are serious drawbacks to this practice. The acquisition of malpractice insurance may encourage suits naming nurses as defendants instead of, or in addition to, hospitals. Further, the cost of malpractice insurance places another financial strain on these already underpaid professionals.

4. *Licensure Statutes and Sanctions*

There are other dilemmas involved in the nurse-hospital relationship relevant to the nurse's license to practice nursing. Nurses are licensed to practice under the individual states' licensure laws. Recently, as many as forty states have modernized

40. *See* Morris, *supra* note 36, at 138.
41. *Id.*
42. *Id.*

their nursing practice statutes to recognize the expanding and independent role of the nurse.[43]

Licensure provides the nurse the right to practice and access to employment. As such, it is an important property right and is afforded constitutional protections.[44] However, the nurse's right to practice can be sanctioned if the nurse fails to maintain the professional standard of care.

Each state authorizes a review board to oversee the practice of nursing within the state and ensure compliance with the standard of care. These boards are responsible for ensuring the public safety and tend to be strict in their decisions concerning maintenance of the standard of care.

In many cases if the care the nurse provides falls below the standard of care required by the statute, the nurse can be sanctioned even if the cause of the failure was understaffing or other administrative decisions by the hospital.[45] In California, for example, nurses have been sanctioned for failing to maintain the standard of care even though there were concurrent findings that they were working under unreasonable conditions.[46] "The BRN[47] holds nurses strictly accountable for maintaining a professional standard of practice regardless of the adverse working conditions."[48]

Thus the actions of the state nursing board can be very harsh on the nurse involved in an employer-employee relationship with a hospital. The nurse has little control over many of the important decisions that affect her practice. However, should harm befall a patient as a result of the hospital's decisions, the nurse could be sanctioned or even have her license revoked for failure to maintain the standard of care.

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43. Florek, *The Nurse's Role In Diagnosing and Prescribing — Legal Boundaries Of The Registered Nurse Under California's 1974 Nursing Practice Act*, 19 U. WEST L.A. L. REV. 73, 76 (1987).

44. *See* Walker, *supra* note 27, at 46.

45. *See* Note, *supra* note 4, at 125-26.

46. *Id.* at 126.

47. Board of Registered Nursing

48. *See* Note, *supra* note 4, at 126.

IV. PRESENT EFFORTS TO REMEDY THE PROBLEMS

Until the very recent past nurses had little recourse in attempting to remedy their poor pay and their lack of control over decisionmaking. But, in 1974, Congress amended the Taft-Hartley Act[49] to include health care employees under the National Labor Relations Act.[50] As a result, for the first time, health care workers were granted the right to engage in collective bargaining.[51]

This right did not come unencumbered. Among several restrictions, Congress admonished the National Labor Relations Board not to promote proliferation of bargaining units in the health care industry.[52]

This admonition has led to years of controversy over the appropriate composition of those bargaining units. Nurses believe that a bargaining unit composed exclusively of professional nurses is appropriate because their concerns are different from those of other health care workers such as housekeeping staff or laboratory technicians.[53] Nurses are concerned with bargaining for conditions to enable them to provide patient care consistent with professional standards,[54] and they believe they require a separate bargaining unit to address those issues.[55]

However, nurses' efforts to maintain all-RN bargaining units have met staunch resistance from hospitals, and the result has been numerous and varied decisions by the National Labor Relations Board.[56] Consequently, nurses' future ability to form

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49. Labor Management Relations (Taft-Hartley) Act of 1947, § 301(a), 29 U.S.C. § 185(a) (1988).

50. National Labor Relations Act, 29 U.S.C. §§ 151-169 (1988).

51. For further discussion of the history of health care employees and the National Labor Relations Act, *see* Donahue, *Labor Law — The St. Francis II Disparity of Interests Test — Is It Necessary?*, 9 W. NEW ENGLAND L. REV. 303, 306 (1987).

52. The admonition against proliferation has had a significant impact on health care workers' ability to bargain collectively. *See id.*

53. For further discussion of nurses' concerns in collective bargaining and the varied approaches by the National Labor Relations Board and the courts to bargaining unit composition for health care workers, *see* Cooper & Brent, *supra* note 20, at 1077.

54. *Id.*

55. *Id.*

56. *Id.* at 1075.

all-RN bargaining units and affect professional issues remains in question.[57]

The ability of nurses to engage in collective bargaining has had a positive impact on their financial status. Women, in general, have been found to make as much as thirty percent more if they are associated with collective bargaining units,[58] and organized nurses fare better than their non-organized colleagues.[59] However, it is apparent that nurses' economic advances are not enough to bolster their diminishing ranks, and the collective bargaining process has had little success in rectifying other nursing concerns.

In 1985, only fourteen percent of working RNs were organized.[60] This is attributable to the ambivalence in the profession toward collective bargaining.[61] Therefore, to alleviate the concerns of the professional nurse and society's concerns with the nursing shortage, the profession needs to utilize its experience in negotiating with hospitals through the collective bargaining process as it takes the next step in its professional growth.

V. A NEW APPROACH TO PROFESSIONALISM

To address the problem of the nursing shortage and the practical and legal dilemmas related to nursing practice, a fundamental concept regarding the modern health care system must be explored: hospitals exist because patients need nursing care. Patients are admitted to hospitals because their conditions require care beyond what can be provided in the doctor's office or the home. That care requires the observation and assessment of the patient's condition and the application of professional nursing concepts to promote the patient's health and provide a positive patient outcome. This is the care patients come to hospitals for, and it is provided by nurses.

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57. *Id.*

58. *See* Moskowitz, *supra* note 2, at 847-48.

59. *Id.*

60. *See* Lupica, *supra* note 8, at 617.

61. *Id.*

Doctors spend less than two hours per day seeing their patients in the hospital.[62] The rest of the time it is the nurse's care that promotes the health and well-being of the patient.

> The reason for the existence of the modern hospital, mental hospital, nursing home, and home care agency is to provide nursing care. Hospitalization is a call for nursing.[63]

Only when this concept is considered is it possible to place the nursing shortage and nurses' professional struggle into perspective relative to two issues: public policy and economics.

A. Public Policy

Once the premise is accepted that the reason for a hospital's existence is nursing care, then the public policy issues become comprehensible:

> When that care is not available, the capacity of the hospital to produce is compromised. Sure the hospital loses money, and so do physicians, but neither of those is a public policy issue. Access to care and the quality of care are compromised, so the cost/quality equation goes out of balance. *That* is the policy problem.[64]

Public policy is concerned with access to quality health care. When there are not enough qualified nurses available to provide that care, public policy dictates that steps be taken to remedy the problem. Therefore, the concerns of nurses must be addressed to retain practicing nurses and attract future nurses.

B. Economics

Poor pay for nurses is not, of itself, the only problem in this economic equation. In our society money equals power. As long as nurses are kept economically powerless, their ability to effect control over their valuable services is diminished. Concomitantly, as long as nurses' power and control are attenuated, their

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62. Robert Wood Johnson Found., Medical Practice in the United States: A Special Report 34-55 (1982), *reprinted in* Moskowitz, *supra* note 2, at 803.

63. Diers, *Nursing and Shortage: Part of the Problem or Part of the Solution?*, in Health Resources, *supra* note 17, at 10.

64. *Id.* at 14 (emphasis in original).

ability to realize financial gain from their endeavors is equally decreased.

It has been theorized that a long, systematic and successful effort has been made to separate nurses from the profits of their professional efforts.[65] In the 1930s when Blue Cross[66] began negotiating health care contracts, hospitals began lumping nursing service in with charges for room and board to increase their revenues.[67] Later, with the advent of rate setting by Medicare, the nursing budget became a convenient place for hospital losses, not related to nursing care, that needed to be covered.[68] As this practice continued and became institutionalized in the health care system, nursing began to be viewed merely as a budget problem, and nurses' power to affect policy was diminished.[69]

The practice of burying nurses' worth in with the bedpans and maintenance costs has eroded nurses' professional position within the hospital structure and left nurses nearly powerless both in an economic and policy-setting sense. Recently, studies have been undertaken to determine the cost of nursing services. They have focused on separating nursing services from hospital daily room rates in an effort to contain hospital costs and to adequately ascertain the economic value of nursing care.[70] These studies showed that the cost-benefit ratio of hospital care could be significantly improved by billing for nursing services separately from the hospital room rate.[71] Theoretically, this change in billing would give nurses power and status through recognition of their economic worth,[72] which would enable them to gain control over patient care and their profession.

Therefore, to strengthen nurses' ability to regulate their practice and provide quality care, basic readjustments in the economics of the health care delivery system are required.

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65. *Id.* at 17.

66. Blue Cross is a national health insurance company.

67. Diers, *supra* note 63, at 18.

68. *Id.* at 19.

69. *Id.*

70. *See* Walker, *The Cost of Nursing Care in Hospitals*, J. NURSING ADMIN., Mar. 1983, at 13.

71. *Id.* at 18.

72. *Id.*

C. Direct Reimbursement

To effect a change in the public policy and economic issues outlined above, a basic change in the financial structure of the health care delivery system is in order. Nurses should be directly reimbursed for the professional care they provide. If hospitals exist because people need nursing care, then the professionals who provide that care should be able to charge directly for the care they provide, just as doctors do for the medical care they provide.

In 1988 the House of Representatives Select Committee on Aging held hearings which examined the impact of the nursing shortage on the current and future availability of health care for our aging population.[73] Included in its report are solutions for the nursing shortage recommended by the Bureau of Health Professions and the Institute of Medicine,[74] one of which was:

> Reimbursement: Issues regarding delivery of services by nurses and the allied health professions should be clarified and, where appropriate, settled in favor of direct Medicare, Medicaid and private insurance reimbursement for services which are: 1) conducted without the supervision of a physician; 2) not necessarily incident to a physician visit; and 3) provided by appropriately trained and licensed/certified nurses and allied health professionals.[75]

As a result of the hearings and recommendations, Congressman Edward R. Roybal introduced legislation entitled the Nursing Shortage and Nurse Reimbursement Incentive Act of 1988.[76] The bill's purpose was to provide direct reimbursement through Medicare and Medicaid for nurse practitioners, clinical nurse specialists, certified nurse midwives, and nurse anesthetists.[77] Although this bill would only provide direct reimbursement for

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73. *Health Care in the 21st Century: Who Will Be There to Care?: Hearings Before the Select Committee on Aging*, 100th Cong., 2d Sess. 699 (1988).

74. *See* Walker, *supra* note 70, at 20.

75. *Id.* at 22.

76. H.R. 5474, 100th Cong., 2d Sess. (1988).

77. For other legislation authorizing direct reimbursement for advanced nursing practitioners, *see* The Basic Health Care For All Americans Act, S. 768, 100th Cong., 2d Sess. (1989) (introduced by Senator Edward M. Kennedy).

certain advanced nursing specialties, it is a positive step since federal law requires specific authorization for reimbursement of a health care provider.[78]

In February 1988 the Department of Health and Human Services arranged for leaders in the nursing profession to meet and discuss concerns about the nursing shortage and its implications for the nation's health care. The goal of the meeting was to prepare recommendations to ensure an adequate supply of qualified RNs.[79]

To positively affect problems such as nursing's poor public image as a profession and lack of autonomy and influence over administrative decisions, the participants recommended, among other things, the following:

> Establish mechanisms to provide direct payment to nurses for health care services provided by nurses. Recruitment and retention efforts are negatively affected by existing reimbursement policies that fail to acknowledge the professional nurse as the primary care provider to patients with accountability to them across the continuum of care. The group recommended that the Tri-Council for Nursing, composed of the American Nurses' Association, the National League for Nursing, the American Association of Colleges of Nursing, and the American Organization of Nurse Executives, be requested to develop strategies to accomplish this goal of direct payment.[80]

It is apparent from the recent legislative activity that many of the nation's leaders, both public and professional, view direct reimbursement for nursing services as a goal that must be realized if a long-term solution to the nursing shortage is to be attained. Further, a recent survey of state nursing associations' major legislative issues revealed that fifteen state associations

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78. *See* Cohn, *Survey of Legislation on Third Party Reimbursement for Nurses*, 11 J.L. MED. & HEALTH CARE 260 (1989).

79. *See* Report, *Nursing Shortage: Strategies for Nursing Practice and Education*, in HEALTH RESOURCES, *supra* note 17, at 144.

80. *Id.*

were involved in promoting some form of third party reimbursement legislation for nurses.[81]

No state prohibits direct reimbursement for nursing services.[82] Although many private insurers have voluntarily instituted procedures to reimburse nurses directly, some states have found it necessary to pass statutes mandating third party payment of nurses.[83] Nursing groups should take advantage of existing statutes and press for new laws to accomplish the goal of direct reimbursement.

The advantages of direct reimbursement are discernible. When directly paid for, nursing will start to be viewed by the public as something of value. Nursing's poor professional reputation will be bolstered and future candidates attracted to the nursing profession.

Further, direct reimbursement for nursing services could assist in reducing the cost of health care. Recent studies show that nursing accounts for only twenty to twenty-five percent of hospital costs and demonstrate that nursing services are not responsible for the high costs of care.[84]

Another study suggested that "the cost-benefit ratio could be significantly improved by breaking the costs of nursing care out of the daily room charge and billing patients for professional services rendered."[85] This conclusion was reached because it was found that nursing care accounted for only half of a daily room charge in the intensive care unit and twenty percent or less of total hospital charges studied in other areas of the hospital.[86]

The study also noted that consumers would benefit from separating nursing charges from hospital charges. It would eliminate payment for services not received and subsidization of

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81. *See* Note, AM. NURSE, Jan. 1986, at 33.

82. *See* Cohn, *supra* note 78, at 260.

83. *Id.*

84. *See* McCloskey, *Implications of Costing Out Nursing Services for Reimbursement*, 20 NURSING MGMT. 44, 45 (1989).

85. *See* Walker, *supra* note 70, at 18.

86. *Id.*

other patients who consume substantially greater amounts of nursing care.[87]

Equally important to cost containment is the concept that with economic independence will come a higher level of autonomy for nurses. They will be able to participate in and influence the administrative decisions that affect patient care.

> The operational barriers to attaching dollars to nursing service are already down. The public policy issue is that nursing may need the help of legislation or regulation to make it happen over the sloth or resistance of administrators or others. Now that the government has taken the position of being a "prudent buyer," we are in a position to help — to be part of the solution, not part of the problem.[88]

D. Independent Practice Groups

Full realization of the advantages of direct reimbursement and the liabilities to the nurse and hospital inherent in the employer-employee relationship[89] will require a realignment of the traditional association between the hospital and the nurse. Since it is the professional nurse who is responsible for maintaining the standard of care, direct reimbursement will assist the professional in making the decisions necessary to preserve that standard. Expenditures made for the appropriate care in any given case will be compensated by the patient or third party payor. Thus, the traditional employment relationship between hospitals and nurses will become superfluous.

The employer-employee relationship between hospitals and nurses must be altered for the benefit of both the public and nurses. Independent nurse practice groups should be established to replace the conventional employment relationship. Nurses should affiliate in groups and contract with a hospital to provide the nursing services in a particular patient care area,[90] much as

87. *Id.*

88. Diers, *supra* note 63, at 21.

89. *See* Note, *supra* note 4, at 109.

90. For the purposes of this article, a patient care area will be defined as the floor or specialty unit, such as intensive care or a medical ward, where patient care is provided by registered nurses or by ancillary personnel supervised by RNs.

physicians do now in areas such as radiology, the laboratory or the emergency room.

The advantages of independent practice groups are that the professionals themselves would be making the patient care and staffing decisions that are their responsibilities in the delivery of appropriate health care. And they would reap the benefit of their efforts through direct reimbursement. Further, the autonomy inherent in this relationship would give nurses the economic and political power necessary to affect policy and decisionmaking and enhance nursing's stature as an independent profession, thereby attracting others to the field.

The hospital would benefit as well. Contracts with independent nursing groups would sever the employer-employee relationship between hospitals and nurses, thereby relieving the hospital of liability for any negligent professional acts under the doctrine of respondeat superior.[91] Instead the nurses would be independent contractors and the hospitals' liability would be limited.[92] Further, with the nurses handling the professional decisions relating to patient care, the hospital would be in a better position to manage the support services it provides to assist direct patient care. Also, an improved collaborative relationship between nurses and physicians could develop which would enhance patient care.

Most importantly, the public policy concern for competent health care and cost containment would be furthered. With the professional RN making the decisions regarding the appropriate care required for a particular patient, the public could be better assured of receiving care which met the professional standard.

Each patient could be assured that the decisions being made regarding his care would be based on his or her particular needs, free of concerns for the hospital's budget. This elimination of the conflict between professional standards and institutional needs would have a strong positive effect on the public policy concern for competent health care.

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91. *See* Walker, *supra* note 27, at 43.
92. *Id.* at 44.

Cost containment would be effectuated in two ways. With nursing service billing removed from the hospital's control, hospitals would have to manage their resources more efficiently and thus reduce hospital costs. In addition, charging each individual patient only for the nursing services he or she actually received, rather than an average cost of care, would result in greater accountability and, most likely, in greater efficiency as well.

VI. MODELS FOR INDEPENDENT PRACTICE GROUPS

Independent nursing practice groups could conceivably be structured in a number of ways depending on the developmental state of direct reimbursement for nursing services. Should direct reimbursement of nurses by Medicare and insurance companies occur, then the development of independent practice groups should become a relatively easy task.

In a direct reimbursement situation, independent practice groups could be accomplished through existing incorporation statutes for health care providers.[93] After incorporation, the group could then enter into contract negotiations with a hospital to provide nursing services in a particular patient care area.

The group would contract to provide all nursing services in the patient care area and retain control over staffing, quality assurance and all professional decisions. For these services the group would bill the patient's insurance, and be reimbursed directly, for all nursing services provided.

The hospital, in this scenario, would retain control over the physical plant, equipment and ancillary services and agree to make them available to the nursing group for patient care. The hospital would then bill the patient's insurance for all of its services utilized by the patient.

The nurses, as exclusive care providers for a given patient care area, would retain control over the decisions that impact patient care. They would control the staffing required to care for any given patient load and the application of professional nursing care standards to meet patient needs. Furthermore, they

93. *See, e.g.*, CAL. BUS. & PROF. CODE § 2775 (West 1974).

would be directly reimbursed for the care they provide. The resulting increase in nurses' autonomy and control over their practice and the perception of nursing as something of value should go a long way to alleviate the nursing shortage.

Even if direct reimbursement does not become a reality in the near future, independent practice groups could still incorporate and contract with hospitals to provide nursing services in a given patient care area. However, another arrangement would have to be made to provide for payment for the group's services. This could be done in a number of ways.

One way would be to provide in the contract between the group and the hospital that the hospital essentially act as the conduit between the group and the third party payors. Here the hospital would bill separately for its services and for the services provided by the nursing group. The group would report its service charges to the hospital to be incorporated in the bill sent to the insurance company or Medicare. This would allow the hospital to be paid for the services it provides and the group to be reimbursed for its separate services to the patient.

Another possible arrangement between nursing groups and hospitals would be to contract for the provision of nursing services in a particular area for a set payment and time period. For example, a nursing group could contract with the hospital to provide services in an area for one year at a set rate of payment or lump sum.

This would require that the nursing group be able to predict accurately the economic resources necessary to provide care in a particular area for the set time. However, it could foster more efficient use of limited health care resources. Further, it would allow hospitals to know in advance what their contract costs for nursing services would be and allow them to plan their use of resources accordingly.

Whatever model is used to reimburse independent nursing groups the conceptual goals would remain the same: "diminish the professional-bureaucratic conflict, promote accountability of

the individual nurse, and provide an atmosphere where professionals can work in a collaborative rather than a subordinate way."[94]

Independent practice groups are being considered by those studying the nursing shortage as a possible long-term solution. For example, in California, the RN Special Advisory Committee[95] included in its recommendations to alleviate the nursing shortage the following:

> 11.4 Nursing organizations should request funding from federal agencies and philanthropic foundations to pilot projects that establish independent group nursing practices in which the group contracts to provide nursing services within a self-administered professional organization.[96]

Independent practice groups will enhance nursing's autonomy and its public image, which will serve to assist in retaining nurses presently practicing and attract others to the profession. More importantly, the groups will ensure that patient care decisions will be made according to professional ideals and practices to meet the public policy demand for competent health care.

VII. MEETING THE CHALLENGE

In the best of worlds, it could be expected that hospitals and insurance companies would be willing to cooperate with the nursing profession in its effort to fully realize its potential through independent practice groups and direct reimbursement. However, since hospitals have long benefited from nursing's efforts, it is unrealistic to believe that hospitals would allow their present relationship with nurses to be altered without a challenge.

It has been postulated that nurses' efforts to gain independent practice and third party reimbursement cause alarm among hospitals and physicians.[97] They fear that they will lose power if

94. Roe, *Incorporation — An Alternative for Hospital Nurses*, 22 NURSING F. 142, 145 (1985).

95. This is a committee formed by the State of California's Board of Registered Nursing to study the nursing shortage and develop recommendations for its alleviation.

96. CAL. BD. OF REGISTERED NURSING, DEP'T OF CONSUMER AFFAIRS, RN SPECIAL ADVISORY COMMITTEE PROPOSED RECOMMENDATIONS (1990).

97. *See* McCloskey, *supra* note 84, at 48.

nursing succeeds,[98] that nurses will become uncontrollable, or that nurses will remove some of the business, money and prestige from physicians.[99]

Should hospitals, physicians and/or insurance companies act on those fears and attempt to interfere with nurses' endeavors to compete in the health care market through independent nursing groups, nurses might find relief in the courts through the Sherman Act,[100] which precludes the unreasonable elimination of competition between market participants.[101] If hospitals, physicians or insurance companies were to refuse to deal with nurses' attempts to set up independent practice groups, they could be found to be participating in an illegal boycott.[102]

> A boycott is defined as an arrangement where one group refuses to deal with another group, thereby eliminating actual or potential competition or obtaining the competing group's patronage on terms favorable to members of the boycotting group (concerted refusal to deal). . . . This economic weapon is employed by physicians or hospitals who refuse to provide non-physician providers with access to facilities or services, or by insurers who refuse to reimburse providers or patients for health care delivered by non-physician providers.[103]

To take advantage of the Sherman Act, a plaintiff must define the market, demonstrate that competition exists,[104] and show that substantial harm to competition resulted from an agreement between the offenders.[105] It seems apparent that if nurses formed independent practice groups, they would be in competition with the hospitals in regard to the nursing service area of the health care market. Therefore, if hospitals combined

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98. *Id.*

99. *Id.*

100. 15 U.S.C. §§ 1-7 (1988).

101. *See* Kelly, *Nurse Practitioner Challenges to the Orthodox Structure of Health Care Delivery: Regulation and Restraints on Trade*, 11 AMER. J.L. & MED. 202, 211 (1986).

102. *Id.* at 214.

103. *Id.*

104. *Id.* at 216 n.131.

105. *Id.* at 218.

with insurance companies or physicians to prevent independent nursing practice groups from receiving hospital privileges or reimbursement, an illegal boycott might be found.

It is to be hoped that resort to the courts would not be required. The preferred avenue to implement independent practice groups would be through negotiation. Hospitals and nurses have learned to negotiate with each other in the collective bargaining process. If each group utilized its negotiating skills, agreements could be reached for the implementation of independent practice groups to the benefit of both parties.

VIII. CONCLUSION

During the course of the last decade this nation has faced an ever-increasing crisis: there are not enough available nurses to meet our growing health care needs. To deal with this crisis new ideas must be formulated to promote nursing practice and attract qualified individuals to the nursing profession.

To accomplish these goals a reorganization of the health care delivery system is necessary. Independent nursing practice groups, coupled with direct reimbursement for nursing services, will promote the professional goals of nurses and address the public concern for competent health care.

It is time to place the decisionmaking process regarding nursing services into the hands of the professionals responsible for those services: the nurses. Furthermore, it is time to reward those professionals directly for the care they provide. If quality nursing care is valued in this society, then the revenue generated by that service should flow directly to the providers.

Only when the nursing profession becomes an independent force, both economically and administratively, can the public better realize its concerns for quality health care. Hospitals exist because people need nursing care. The decisions affecting that care must be made by the educated and experienced professionals responsible for providing it. Independent nursing practice groups will allow nursing to realize its professional goals and responsibilities and meet the nation's health care needs into the future.