


Flatlining: How the Reluctance to Embrace Immigrant Nurses Is Mortally Wounding the U.S. Health Care System

Diomedes J. Tsitouras

Maria Pabon Lopez

Follow this and additional works at: <http://digitalcommons.law.umaryland.edu/jhclp>

 Part of the [Health Law Commons](#), and the [Immigration Law Commons](#)

Recommended Citation

Diomedes J. Tsitouras, & Maria P. Lopez, *Flatlining: How the Reluctance to Embrace Immigrant Nurses Is Mortally Wounding the U.S. Health Care System*, 12 J. Health Care L. & Pol'y 235 (2009).

Available at: <http://digitalcommons.law.umaryland.edu/jhclp/vol12/iss2/5>

This Article is brought to you for free and open access by DigitalCommons@UM Carey Law. It has been accepted for inclusion in Journal of Health Care Law and Policy by an authorized administrator of DigitalCommons@UM Carey Law. For more information, please contact smccarty@law.umaryland.edu.

FLATLINING: HOW THE RELUCTANCE TO EMBRACE IMMIGRANT NURSES IS MORTALLY WOUNDING THE U.S. HEALTH CARE SYSTEM

DIOMEDES J. TSITOURAS*

MARIA PABON LOPEZ**

INTRODUCTION

United States hospitals are currently experiencing an unprecedented nursing crisis. Understaffing, inadequate staffing, and a Registered Nurse (RN) shortage are a daily part of the health care experience in this country. Just one example illustrates this point. On July 29, 1998, a young expectant mother went to Kansas's Wesley Medical Center for an elective labor induction.¹ The next day, doctors performed an emergency cesarean surgery and delivered a newborn who was pale and not breathing properly.² The child, Kimberlyn Holt, suffered permanent brain damage at birth. Her care will cost \$8 million over her lifetime.³ At a subsequent trial, two experts testified that Ms. Holt's condition required a one-on-one nursing ratio and intensive monitoring.⁴ The inadequate nursing care "caused or contributed to" Kimberlyn's injury.⁵ Unfortunately, this is not the first time Wesley Medical Center has found itself in legal trouble for its failure to properly attend to patient needs.

In 2000, a heart attack patient's family settled a medical malpractice case against the hospital for \$2.7 million, following a court finding that understaffing

Copyright © 2009 by Diomedes J. Tsitouras and Maria Pabon Lopez.

* J.D., 2009, Indiana University School of Law (Indianapolis, Ind.); M.P.A., Cornell Institute for Public Affairs (Ithaca, N.Y.); B.S., Cornell University School of Labor Relations (Ithaca, N.Y.).

** Professor of Law, Indiana University School of Law (Indianapolis, Ind.); J.D., University of Pennsylvania Law School; B.A. Princeton University (Princeton, N.J.). The authors appreciate the assistance of Mabel Arroyo and Marco A. Moreno, as well as the support of Eleanor D. Kinney, and the very helpful comments of Mary E. Riner.

1. *Holt v. Wesley Med. Ctr.*, No. 00-1318-JAR, 2004 WL 1636571, at *1 (D. Kan. July 19, 2004).
2. *Id.*
3. *Id.*; Ron Sylvester, *Court: Malpractice Suit to Proceed*, WICHITA EAGLE, Mar. 23, 2004, at 1B.
4. *Holt*, 2004 WL 1636571, at *1-3.
5. *Id.* at *2.

was a factor in the poor care she received.⁶ The family alleged that the hospital inadequately staffed its nursing shifts, producing documents from current and former hospital employees “showing that the hospital purposefully understaffed in order to increase profits, thus exposing patients to risk of injury.”⁷ The hospital claimed it did not inadequately staff shifts purposely, but instead was negatively affected by a nursing shortage.⁸ Currently, Wesley Medical Center and its parent company, Hospital Corporation of America, are defendants in a \$50 billion class action lawsuit.⁹ Plaintiffs in that case assert that a Wesley hospital doctor had trouble responding to complications in surgery due to “a shortage of nurses in the operating room during the entire procedure.”¹⁰ Further, once a patient passed away, the patient’s death was not discovered for an hour because “RNs were spread too thin”¹¹

Understaffing of nurses in hospitals like Wesley Medical Center is likely to worsen in future years. By the year 2020, the United States is projected to have a shortage of nearly a million nurses.¹² The current nurse pool is retiring or leaving the profession, and nursing schools are ill-equipped to train such a high number of nurses.¹³ At the same time, an aging baby boomer population will require medical care as they reach old age. The nationwide shortage is related to another issue: inadequate staffing. Studies have shown a strong relationship between inadequate staffing and adverse patient outcomes, including mortality.¹⁴ Policymakers have proposed a number of domestic solutions. These include mandating the minimum number of nurses per patient, increasing nurse education investment, expanding existing outreach programs that target young people, and increasing nurse wages.¹⁵

6. Linda A. Johnson, *Nurse Shortage Could Be Hazardous to Your Health*, ST. LOUIS POST-DISPATCH, Apr. 11, 2004, at E4; Ron Sylvester, *Wesley Settles Patient Lawsuit*, WICHITA EAGLE, July 7, 2000, at A1.

7. Julie Marie Bessette, *An Analysis in Support of Minimum Nurse-to-Patient Ratios in Massachusetts*, 9 QUINNIPIAC HEALTH L.J. 173, 187 (2006).

8. *Id.*

9. Ron Sylvester, *Wesley Suit Over Staffing Reinstated*, WICHITA EAGLE, May 24, 2008, at B1.

10. Ron Sylvester, *Wesley Has Too Few RN's*, WICHITA EAGLE, Apr. 11, 2006, at A1.

11. *Id.*

12. See Arlene Dohm & Lynn Shniper, *Occupational Employment Projections to 2016*, MONTHLY LAB. REV., Nov. 2007, at 86, 112.

13. JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., HEALTH CARE AT THE CROSSROADS: STRATEGIES FOR ADDRESSING THE EVOLVING NURSING CRISIS 5–6, 28 (2002), available at http://www.jointcommission.org/NR/rdonlyres/5C138711-ED76-4D6F-909F-B06E0309F36D/0/health_care_at_the_crossroads.pdf.

14. *Id.* at 13–14.

15. CAL. HEALTH & SAFETY CODE § 1276.4 (West 2008) (codifying California’s minimum nurse-to-patient ratio); Kristin M. Mannino, *The Nursing Shortage: Contributing Factors, Risk Implications, and Legislative Efforts to Combat the Shortage*, 15 LOY. CONSUMER L. REV. 143, 154–55 (2003) (discussing state programs to increase nurse education investment, student recruitment, and mandating nurse-to-patient ratios); Theresamarie Mantese et al., *Nurse Staffing, Legislative Alternatives and Health*

One possible solution is the use of foreign nurses to alleviate the burgeoning shortage. This solution is circumscribed by immigration law, which still remains far behind in meeting the need. Immigration law only authorizes five hundred H-1C visas per year.¹⁶ These visas allow nurses to come to the United States for three years to work in hospitals in health professional shortage areas.¹⁷ This program is currently set to expire on December 20, 2009.¹⁸ Other visa methods such as the EB-3 are also inadequate. Attempts to expand immigration have been met with a cold response from nurse unions and trade associations.¹⁹ This Article argues for the increased use of foreign nurses in U.S. hospitals as a complement to proposed domestic policy solutions, in order to fully alleviate the shortage and to adequately ensure patient safety.

This Article proceeds in four parts. Part I describes the nursing shortage and the related concerns regarding inadequate staffing and adverse patient outcomes. Part II discusses the causes of the shortage and possible domestic policy solutions to the nursing shortage crisis. Part III explains past and current efforts in the United States to use foreign nurses in times of nurse shortage. Part IV concludes this Article by analyzing the challenges associated with the continued nurse migration. This part also calls for an expansion of visa programs in the United States, while at the same time challenging hospitals to develop community-specific strategies for ethical recruitment and retention of foreign nurses. This part concludes with a further call to enhance global investment in nursing care.

I. THE ONE MILLION NURSE CHALLENGE

A. *The Shortage Crisis*

Nursing is a unique and essential occupation in the U.S. health system; however, it receives scant attention. Nurses prevent diseases and educate patients about their treatment plans.²⁰ Nurses are often the only sources of critical

Care Policy, 9 DEPAUL J. HEALTH CARE L. 1171, 1190-91 (2006) (discussing California's program to increase nurse education investment and recruiting young people to pursue a career in nursing).

16. 8 U.S.C. § 1182(m)(4) (2006).

17. *Id.* § 1182(m)(3).

18. Nursing Relief for Disadvantaged Areas Reauthorization Act of 2005, Pub. L. No. 109-423, § 2, 120 Stat. 2900, 2900 (2006) (providing express expiration of the program "[three] years after the date of the enactment," which occurred on December 20, 2006).

19. Enid Trucios-Haynes, *Temporary Workers and Future Immigration Policy Conflicts: Protecting U.S. Workers and Satisfying the Demand for Global Human Capital*, 40 BRANDEIS L.J. 967, 994 (2002) (discussing opposition by labor organizations); Celia W. Dugger, *U.S. Plan to Lure Nurses May Hurt Poor Nations*, N.Y. TIMES, May 24, 2006, at A1 (discussing opposition from the American Nurses Association); Victor Godinez, *Hospitals See Nurse Visas as "Band-Aid" on Shortage*, DALLAS MORNING NEWS, Apr. 29, 2001, at 1H (discussing opposition from the Service Employees International Union to expanding the H-1C program beyond the current ceiling of 500 visas per year).

20. Bessette, *supra* note 7, at 176.

communication with patients, as doctors are often too busy to spend enough time with each individual patient.²¹ Thus, an inadequate amount of nursing care in the labor market is likely to present significant challenges to the delivery of safe and high-quality care.

While the United States has experienced nursing shortages for the past fifty years, the present shortfall is predicted to worsen. The American Hospital Association estimates hospitals in the United States may need as many as 116,000 nurses to fill vacant positions.²² Current federal government projections show that the shortage could soar to as many as one million nurses by 2020.²³ The demand for nurses is expected to increase due to an 18% increase in population, a larger proportion of elderly people, and medical advances that will increase the need for nurses.²⁴ The population of persons sixty-five and older will increase by over half.²⁵ This is significant because older persons are much more likely to need nursing care. A person between sixty-five and sixty-nine has a 74% chance of developing illness.²⁶ By the time an individual is eighty-five, the likelihood grows to 88%.²⁷

The nursing shortarge is a result of various factors, including the fact that fewer young people are interested in nursing as a career, as well as the decreasing number of nursing school graduates, inadequate working conditions, and insufficient wages.²⁸ One particularly concerning factor is the few number of young people entering the profession. A 1999 study of students found that one in twenty

21. See Joe Graedon & Teresa Graedon, *Finding the Key to Health Care*, BUFFALO NEWS, Oct. 18, 2006, at C3; see also Helen Dennis, *Don't Be Afraid to Question Doctor's Orders*, DAILY BREEZE, (Torrance, Cal.), Nov. 16, 2006, at B2.

22. AM. HOSP. ASS'N, THE 2007 STATE OF AMERICA'S HOSPITALS—TAKING THE PULSE, at slide 6 (2007), <http://www.aha.org/aha/content/2007/PowerPoint/StateofHospitalsChartPack2007.ppt> (last visited Nov. 24, 2009).

23. See Dohm & Shniper, *supra* note 12, at 112 (citing a Bureau of Labor Statistics projection of over a 1,001,000 nurse shortfall by 2016). The Bureau of Health Professions estimates the shortage to be 808,416 nurses by 2020. NAT'L CTR. FOR HEALTH WORKFORCE ANALYSIS, U.S. DEP'T OF HEALTH & HUMAN SERVS., PROJECTED SUPPLY, DEMAND, AND SHORTAGES OF REGISTERED NURSES: 2000–2020, at 13 (2002), available at http://www.ahca.org/research/rnsupply_demand.pdf.

24. NAT'L CTR. FOR HEALTH WORKFORCE ANALYSIS, U.S. DEP'T OF HEALTH AND HUMAN SERVS., *supra* note 23, at 2–3.

25. KEVIN KINSELLA & VICTORIA A. VELKOFF, U.S. CENSUS BUREAU, AN AGING WORLD: 2001, at 131 (2001), available at http://www.ahcancal.org/research_data/staffing/Documents/Registered_Nurse_Supply_Demand.pdf.

26. Jennifer L. Wolff et al., *Prevalence, Expenditures, and Complications of Multiple Chronic Conditions in the Elderly*, 162 ARCHIVES INTERNAL MED. 2269, 2271 (2002).

27. *Id.*

28. Howard S. Berliner & Eli Ginzberg, *Why this Hospital Shortage Is Different*, 288 JAMA 2742, 2743 (2002); see also U.S. GEN. ACCOUNTING OFFICE, NURSING WORKFORCE: EMERGING NURSE SHORTAGES DUE TO MULTIPLE FACTORS 6–10 (2001), available at <http://www.gao.gov/new.items/d01944.pdf>. The General Accounting Office was redesignated as the Governmental Accountability Office in 2004. GAO Human Capital Reform Act of 2004, Pub. L. No. 108-271, §§ 1(a), 8(a), 118 Stat. 811, 811, 814 (2004).

female and less than one in one hundred male college freshmen selected nursing as a career.²⁹ Furthermore, many older nurses are retiring or leaving the profession early. The average RN age was 46.8 in 2004, an increase from 45.2 in 2000.³⁰ Inadequate staffing compounds this problem. When shifts have a smaller force, the existing staff picks up the slack and becomes burned out, thus contributing to more nurse attrition.³¹ This cycle has led many nurses qualified to practice to drop out of the profession altogether. In fact, over 490,000 qualified nurses currently do not work in nursing.³²

The lack of nurses contributes to chronic staffing problems.³³ Sixteen-hour shifts and mandatory overtime are not uncommon.³⁴ Personnel shortages are typical in a modern economy.³⁵ Normally, the free market is equipped to deal with the challenge.³⁶ When demand for an occupation rises, the wage also rises and attracts more workers into the market.³⁷ This alleviates the shortage. Health care economics, however, is never so simple.³⁸ Medicaid cuts, greater managed care and lower insurance company reimbursement rates leaves hospitals strapped for cash.³⁹

29. JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., *supra* note 13, at 24.

30. BUREAU OF HEALTH PROFESSIONS, U.S. DEP'T OF HEALTH & HUMAN SERVS., THE REGISTERED NURSE POPULATION: FINDINGS FROM THE MARCH 2004 NATIONAL SAMPLE SURVEY OF REGISTERED NURSES 12 (2004), available at <http://bhpr.hrsa.gov/healthworkforce/rnsurvey04/> (follow "Printer-friendly 2004 NSSRN Report" hyperlink).

31. See Linda Aiken et al., *Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction*, 288 JAMA 1987, 1990 & tbl.4 (2002).

32. NAT'L CTR. FOR HEALTH WORKFORCE ANALYSIS, U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 23, at 7.

33. See 147 CONG. REC. E2274 (daily ed. Dec. 13, 2001) (statement of Rep. Murtha).

Congress made the following findings . . . :

- (1) There are hospitals through the United States that have inadequate staffing of [registered nurses] to protect the well-being and health of patients.
- (2) Studies show that the health of patients in hospitals is directly proportionate to the number of [registered nurses] working in the hospital.
- (3) There is a critical shortage of [registered nurses] in the United States.
- (4) The effect of that shortage is revealed in unsafe staffing levels in hospitals.
- (5) Patient safety is adversely affected by these unsafe staffing levels, creating a public health crisis.
- (6) [Registered nurses] are being required to perform professional services under conditions that do not support quality health care or a healthful work environment for [registered nurses].

Helen J. Stampalia, *Inadequate Staffing Kills*, 25 QUINNIPIAC L. REV. 173, 197-98 (2006).

34. Ann E. Rogers et al., *The Working Hours of Hospital Staff Nurses and Patient Safety*, 23 HEALTH AFF., July-Aug. 2004, at 202, 202-03.

35. See VICKY LOVELL, INST. FOR WOMEN'S POLICY RESEARCH, SOLVING THE NURSING SHORTAGE THROUGH HIGHER WAGES 8, 13-14 (2006), available at <http://www.iwpr.org/pdf/C363.pdf>.

36. *Id.* at 10-12.

37. *Id.* at 10-11.

38. See *id.* at 11-12 (discussing the inconsistency between the health care community's response to pharmacist shortages and nursing shortages).

39. See LAURIE KAYE ABRAHAM, MAMA MIGHT BE BETTER OFF DEAD 128 (1993) (explaining how Medicaid cuts affected one particular hospital); GEORGE C. HALVORSON & GEORGE J. ISHAM, EPIDEMIC OF CARE 63-65 (2003); LOVELL, *supra* note 35, at 7.

Thus, it is not surprising that nurse median salaries fell from 1996 to 2000 in the midst of a shortage.⁴⁰

B. Inadequate Staffing and Adverse Patient Outcomes

The lack of nurses negatively affects patient care. A study in the *New England Journal of Medicine* has shown a direct link between lower staffing and the quality of care.⁴¹ It found that patients are more likely to die in hospitals with reduced numbers of assigned nurses.⁴² Another study confirmed this result.⁴³ It focused on the nurse hours required for patient safety.⁴⁴ The 393 staff hospital nurses surveyed reported making mistakes 199 times.⁴⁵ Almost one third of the surveyed nurses reported making at least one error, including chart mistakes and medication mishaps.⁴⁶ The likelihood of error increased with the increased number of hours worked.⁴⁷ Further, research at the University of Pennsylvania showed that hospitals with low nurse-to-patient ratios have a 31% increased chance of patient death.⁴⁸ Every additional patient added to the ratio increased mortality by 7%.⁴⁹ Finally, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) concluded that hospitals with fewer nurses put patients in danger.⁵⁰ The JCAHO examined almost two thousand hospital reports of patient deaths and injuries and found that a lower staff level was a factor in one quarter of cases.⁵¹

In addition to affecting patient care, inadequate staffing is also a financial burden for hospitals. An analysis of 799 hospitals in eleven states concluded that raising RN hours and increasing the proportion of RNs while decreasing Licensed Practical Nurses would save patients over four million days in the hospital.⁵² Further, urinary tract infections, hospital-acquired pneumonia, upper gastrointestinal bleeding, shock, and cardiac arrest all declined.⁵³ As many as 6754 lives could be saved.⁵⁴ The net cost of more nurse hours would only increase the

40. LOVELL, *supra* note 35, at 9.

41. Jack Needleman et al., Special Article, *Nurse-Staffing Levels and the Quality of Care in Hospitals*, 346 *NEW ENG. J. MED.* 1715 (2002).

42. *See id.* at 1718.

43. Rogers et al., *supra* note 34, at 206.

44. *Id.* at 203.

45. *Id.* at 206.

46. *Id.*

47. *Id.*

48. Aiken et al., *supra* note 31, at 1988, 1991.

49. *Id.* at 1991.

50. JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., *supra* note 13, at 6.

51. *Id.*

52. Jack Needleman et al., *Nurse Staffing in Hospitals: Is There a Business Case for Quality?*, *HEALTH AFF.*, Jan.–Feb. 2006, at 204, 205–07.

53. *Id.* at 207–08.

54. *Id.* at 208.

hospital's budget by 1.5%.⁵⁵ Moreover, the study may have underestimated staffing benefits such as diminished liability from patient death, improved hospital image, fewer blood borne infections, ulcers, and medication errors.⁵⁶

II. SHORTAGE CAUSES AND THE LIMITATIONS OF DOMESTIC POLICY SOLUTIONS

Most approaches aimed at solving the nursing shortage have a domestic focus. These include enhancing nursing educational investment, boosting nurse pay, and improving hospital working conditions. While these are all significant parts of a comprehensive solution, any strategy that excludes foreign nurses will likely be inadequate because the need for nurses in the United States exceeds the available supply of domestic nurses.

A. Nursing Education

Very few young people are entering the nursing profession. In 2006 and 2007, enrollment in nursing schools in the United States increased by only 4.98%.⁵⁷ These schools turned away 30,709 qualified applicants from baccalaureate and graduate programs.⁵⁸ This stemmed from insufficient personnel, clinical sites, and classrooms.⁵⁹ Nearly three quarters of schools have experienced a nursing faculty shortage.⁶⁰ The Health Resources and Services Association estimates that in order to meet demand, the United States must graduate approximately 90% more nurses than current baseline projections.⁶¹ Thus, it is unlikely that graduating more nurses alone will solve the problem.

Kentucky, Florida, and California have provided grants, loan repayments, and scholarships to nursing programs.⁶² Congress has also attempted to boost investment in nursing education, but has been only marginally successful.⁶³ The

55. *Id.*

56. *Id.* at 209–10.

57. Press Release, Am. Ass'n of Colls. of Nursing, Enrollment Growth Slows at U.S. Nursing Colleges and Universities in 2007 Despite Calls for More Registered Nurses (Dec. 3, 2007), available at <http://www.aacn.nche.edu/Media/NewsReleases/2007/enrl.htm>.

58. *Id.*

59. *Id.*

60. AM. ASS'N OF COLLS. OF NURSING, NURSING FACULTY SHORTAGE FACT SHEET (2009), available at <http://www.aacn.nche.edu/Media/pdf/FacultyShortageFS.pdf>.

61. HEALTH RES. & SERVS. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERVS., WHAT IS BEHIND HRSA'S PROJECTED SUPPLY, DEMAND, AND SHORTAGE OF REGISTERED NURSES? 10 (2004), available at <http://bhpr.hrsa.gov/healthworkforce/reports/behindmprojections/2.htm> (follow "Report in Adobe/pdf" hyperlink).

62. Mannino, *supra* note 15, at 154–55.

63. In 2007, the Nurse Education, Expansion, and Development Act (NEED Act) was introduced in both the Senate and the House. S. 446, 110th Cong. (2007); H.R. 772, 110th Cong. (2007). The NEED Act would have authorized capitation grants to nursing schools to increase faculty and students. *Id.* The Act was never voted on by either chamber.

Nurse Reinvestment Act of 2002 is one such example.⁶⁴ After being signed into law by President George W. Bush on August 1, 2002,⁶⁵ its funding has failed to make a meaningful impact on the nursing shortage.⁶⁶ The Nurse Reinvestment Act establishes nurse scholarships, provides for loan cancellation for nurse faculty, assists hospitals with retention, and encourages career ladders.⁶⁷ It also establishes a National Nurse Service Corps, which provides tuition, a stipend, and expenses for students who agree to work in a shortage area for two years.⁶⁸ While Congress and the President agreed further investment was needed,⁶⁹ actual appropriations have been inadequate.⁷⁰ Thus, “to the credit of its supporters [the Nurse Reinvestment Act] has received some funding, though not much relative to other federal programs, and not enough to have a meaningful impact.”⁷¹ President Bush proposed cutting nursing workforce programs from \$157 million in 2008 to \$110 million for the 2009 fiscal year.⁷² The President also proposed elimination of the \$62 million for the Advanced Education Nursing Program.⁷³ Nursing unions and organizations lobbied to increase funding to at least \$200 million.⁷⁴ Current

64. Nurse Reinvestment Act of 2002, Pub. L. No. 107-205, 116 Stat. 819.

65. *Id.* at 811.

66. Rob Elgie, *Politics, Economics, and Nursing Shortages: A Critical Look at United States Government Policies*, 25 NURSING ECON. 285, 288–89 (2007). (“The [Nurse Reinvestment Act] is a continuance of such government [subsidies] that after more than 40 years obviously have not worked.”).

67. Am. Ass’n of Colls. of Nursing, *Nurse Reinvestment Act at a Glance*, <http://www.aacn.nche.edu/media/nraataglace.htm> (last visited Nov. 24, 2009).

68. *Id.*

69. Elgie, *supra* note 66, at 285; Lawrence M. O’Rourke, *Congress Prescribes Answer for Nursing Shortage Federal Scholarships and Loans Would Be Offered*, FRESNO BEE, July 20, 2002.

70. See Elgie, *supra* note 66, at 288–89; Press Release, Nat’l League for Nursing, *President’s 2009 Budget Cuts Will Increase Nurse and Nurse Educator Shortages NLN Again Decries Continued Inadequate Funding of Nurse Workforce Development and Supports a Minimum of \$200 Million in Funding for Title VIII FY 2009 Appropriations* (Feb. 4, 2008), available at http://www.nln.org/newsreleases/budget_02042008.htm [hereinafter 2008 Press Release, Nat’l League for Nursing]; Press Release, Nat’l League for Nursing, *President’s Budget Unacceptable in the Face of Nurse and Nurse Educator Shortages* (Feb. 5, 2007), available at http://www.nln.org/newsreleases/pres_budget2007.htm. *But see* Press Release, Nat’l League for Nursing, *NLN Lauds President’s 2010 Budget Proposal \$125 Million for Title VIII Nursing Education Loan Repayment Program: 40 Percent More Requested for Nurse Faculty Loan Program* (May 8, 2009).

71. Ctr. for Nursing Advocacy, *What Is the Nursing Shortage and Why Does It Exist?* http://www.nursingadvocacy.org/faq/nursing_shortage.html (last visited Nov. 24, 2009).

72. 2008 Press Release, Nat’l League for Nursing, *supra* note 70; Press Release, Office of Sen. Barbara Mikulski, *President’s Budget Drastically Cuts Nursing Programs Despite National Shortage* (Feb. 5, 2008), available at <http://mikulski.senate.gov/Newsroom/PressReleases/record.cfm?id=292001>.

73. Press Release, Office of Sen. Barbara Mikulski, *supra* note 72.

74. *Departments of Labor, Health and Human Services, Education and Related Agencies Appropriations for 2009: Hearings Before the Subcomm. of the Comm. on Appropriations*, 110th Cong. 217–18 (2008) (statement of Jeanette Lancaster, President, American Association of Colleges of Nursing); Written Testimony from the Ams. for Nursing Shortage Relief to the Subcomm. on Labor, Health & Human Servs., Educ. & Related Agencies, Comm. on Appropriations, U.S. House of Representatives 4 (Mar. 31, 2008).

attempts are comprehensive health reform also include policies aimed at developing the nursing workforce.⁷⁵ Legislation pending in Congress would building on the Nurse Reinvestment Act by expanding loan amounts and training to faculty.⁷⁶ However, even with reform, these efforts are inadequate to provide for the estimated 90% increase in nursing graduates needed to alleviate the shortage in twelve years.

B. Nursing Pay and Working Conditions

Insufficient pay is one reason the nursing shortage persists. For example, one research study determined that a wage increase as small as 3.2% to 3.8% would lead to a 6.2% growth in nurse graduation rates.⁷⁷ While pay did not change over the 1990s, the increases that occurred between 2001 and 2003 were followed by 183,500 nurses entering the labor market.⁷⁸ Hence, if nurses were paid at a higher rate, those currently not working would likely enter the market and the shortage would diminish. Further, the number of nurses leaving the profession would likely decrease. However, hospitals have not resorted to pay increases as a solution. Instead, they have utilized one-time hiring bonuses, temporary workers, and overtime to meet their staffing needs.⁷⁹

Nurse pay has unique characteristics. First, it levels off after only a few years upon entering the workforce, and is not always commensurate with a nurse's education.⁸⁰ Further, unlike other hazardous health professions, there is little additional compensation for the exposure to assault, blood-borne pathogens, and work-related allergies.⁸¹ There are several theories attempting to explain the stagnation of nurse pay. These include inadequate labor market mobility, collusion among local hospital administrators, gender bias, and excessive nurse loyalty to employers.⁸² Further, since the managed care reforms of the 1990s limited health care spending, hospitals have faced mounting challenges in balancing their books.⁸³ In fact, the managed care system has been linked to less RN employment and

75. See Affordable Health Care for America Act, H.R. 3962, § 2221, 111th Cong. (2009) (as passed by House, Nov. 7, 2009).

76. *Id.*

77. Joanne Spetz & Ruth Given, *The Future of the Nurse Shortage: Will Wage Increases Close the Gap?*, HEALTH AFF., Nov.–Dec. 2003, at 199, 202.

78. LOVELL, *supra* note 35, at 4, 9–10 & fig.1.

79. *Id.* at 7–8.

80. *Id.* at 12. This is one reason why nurses may not have high retention or leave hospitals for other less stressful working environments. *Id.* at 14–15.

81. *Id.* at 12.

82. *Id.* at 12–13.

83. MIREILLE KINGMA, NURSES ON THE MOVE: MIGRATION AND THE GLOBAL HEALTH CARE ECONOMY 32 (2006); Yang K. Kim et al., *The Influence of Hospital Integration on Hospital Financial Performance*, J. HEALTH CARE FIN., Fall 2004, at 74.

earnings.⁸⁴ The special traits of nurse pay may be one reason why it has not increased to alleviate the shortage.

In addition, nursing salaries can be as much as one-fifth of a hospital's budget.⁸⁵ It is estimated that total RN expenditure would have to double over the next ten years to prevent the shortfall.⁸⁶ Hence, increased pay is unlikely to be advanced as a solution.

Working conditions also influence the strength and numbers of the nurse workforce. The connection between the lack of staffing and nurse burnout is well known.⁸⁷ With fewer staff, nurses must attend to more patients. They become more fatigued and experience increased stress levels. Some of these nurses eventually resign from their positions. Furthermore, even RNs new to the profession experience burnout. A survey of newly licensed RNs found that 13% had already changed their jobs and over a third felt ready to change jobs after just one year in practice.⁸⁸

Both the states and the federal government have attempted to address this challenge. California became the first state to enact mandatory nurse-to-patient ratio legislation.⁸⁹ The law, signed by Governor Gray Davis on October 10, 1999 and effective on January 1, 2002, required that hospitals have no more than six patients per nurse for general, medical/surgical, and neonatal units, and one patient per nurse in operating rooms.⁹⁰ The California Hospital Association fought this measure vigorously, claiming that it would cost \$400 million and force hospital closures.⁹¹ The California Nurses Association disputed this projection, arguing that the additional staffing costs would be recouped by patients leaving the hospital

84. P. I. Buerhaus & D. O. Staiger, *Managed Care and the Nurse Workforce*, 276 JAMA 1487, 1491 (1996).

85. *Finding a Cure to Keep Nurses on the Job: The Federal Government's Role in Retaining Nurses for Delivery of Federally-Funded Health Care Services: Hearing Before the Oversight of Government Management, Restructuring, and the District of Columbia Subcomm. of the S. Comm. on Governmental Affairs*, 107th Cong. 108–09 (2001) (statement of Ann O'Sullivan, President, Illinois Nurses Association on behalf of American Nurses Association); see generally *Time Is Money—Labor Analysis Toolkit*, HEALTHCARE FIN. MGMT., Nov. 2002, at 1, 1–7 (discussing budget allocation in health care facilities).

86. Spetz & Given, *supra* note 77, at 202.

87. Aiken et al., *supra* note 31, at 1987.

88. Christine Kovner et al., *Newly Licensed RNs' Characteristics, Work Attitudes, and Intentions to Work*, AM. J. NURSING, Sept. 2007, at 63, 68.

89. Stefanie Berman, *Health Care: Mandatory Nurse-to-Patient Staffing Ratios in California*, 30 J.L. MED. & ETHICS 312, 312–13 (2002).

90. See 1999 Cal. Stat. 92 (West) (codified at CAL. HEALTH & SAFETY CODE § 1276.4); 2000 Cal. Stat. 97 (West) (codified at CAL. HEALTH & SAFETY CODE § 1276.4); CAL. CODE REGS. tit. 22, § 70217 (2008); Berman, *supra* note 89, at 312.

91. Berman, *supra* note 89, at 312.

sooner, by savings from not hiring additional temporary nurses, and from less attrition due to burnout.⁹²

Hospitals sued to stop the legislation from going into effect and failed.⁹³ With pressure from these facilities, Governor Arnold Schwarzenegger attempted to implement regulations not in accordance with the statute, unilaterally changing emergency room and medical/surgical unit requirements.⁹⁴ A court found that the Governor overstepped his authority and blocked his changes.⁹⁵ Initial reports are inconclusive as to whether the mandatory nurse-to-patient ratios have been successful. Early signs are encouraging. There has been a 60% increase in license applications from out-of-state nurses seeking work in California, and job satisfaction has also improved.⁹⁶ Staffing requirements have also prompted the state to invest more in nurse education.⁹⁷ The state of California spent \$18 million for nurse education partnerships with health facilities, apprenticeships, and additional faculty recruitment.⁹⁸

Although the California Nurses Association disputes these findings,⁹⁹ there is some evidence that emergency room wait times and ambulance diversions have increased.¹⁰⁰ One study showed that higher nurse-to-patient ratios had little effect on adverse patient outcomes.¹⁰¹ Other states have proposed similar legislation; however, none has been enacted as of this writing.¹⁰² Some have pursued a wait-

92. *Id.* at 312–13.

93. *California's Historic RN-to-Patient Hospital Staffing Ratios Upgraded Again with New Year*, BUS. WIRE, Jan. 2, 2008.

94. *Id.*

95. Allison N. Carroll, *Mandatory Nurse to Patient Ratios: Can Ratios Bring Better Healthcare to Kentucky*, 44 BRANDEIS L.J. 673, 682 (2006); Robert Salladay & Jia-Rui Chong, *Judge Backs Nurses over Staffing*, L.A. TIMES, Mar. 4, 2005.

96. Joanne Spetz, *Nurse Satisfaction and the Implementation of Minimum Nurse Staffing Regulations*, 9 POL'Y POL. & NURSING PRAC. 15, 16 (2008); Stampalia, *supra* note 33, at 201.

97. See Mantese et al., *supra* note 15, at 9.

98. *Id.*

99. MASS. HOSP. ASS'N & MASS. ORG. OF NURSE EXECUTIVES, A REASONED APPROACH TO NURSE STAFFING: A TEAM APPROACH BASED ON PATIENT NEED (2007), available at http://www.monedev.org/pdf/PS_2007_Toolkit.pdf.

100. CAL. NURSES ASS'N, RN STAFFING RATIOS: HOSPITAL CLOSURES AND THE STAFFING RATIO LAW—THE REAL STORY (2005), available at http://www.calnurses.org/assets/pdf/ratios/ratios_hospt_closures_0105.pdf.

101. See Linda Burnes Bolton et al., *Mandated Nurse Staffing Ratios in California: A Comparison of Staffing and Nursing-Sensitive Outcomes Pre- and Postregulation*, 8 POL'Y POL. & NURSING PRAC. 238, 239 (2007) (stating research findings that improved staffing ratios had an insignificant effect on patient falls and bed sores).

102. See Am. Nurses Ass'n, *Nurse Staffing Plans and Ratios*, http://www.nursingworld.org/MainMenuCategories/ANAPoliticalPower/State/StateLegislativeAgenda/StaffingPlansandRatios_1.aspx (last visited Nov. 24, 2009). Arizona, Ohio, Michigan, Illinois, Michigan, Oregon, Massachusetts, New York, and Texas have all attempted to enact mandatory nursing ratios. *Id.*

and-see approach, awaiting data on the link between nursing ratios and adverse patient outcomes.¹⁰³

At the federal level, the proposed Registered Nurse Safe Staffing Act (RNSSA) would have required minimum levels of nursing without setting specific ratios.¹⁰⁴ Instead, the RNSSA would have set up staffing plans, which mandate hospital staffing levels commensurate with levels of care and other factors.¹⁰⁵ Unlike California, staffing plans leave the actual ratios up to the individual hospitals. Nurse-to-patient ratio adjustments should be part of any long-term solutions. However, they alone will not be enough to overcome the need for more nurses nationwide.

The Magnet Program is another approach that could improve working conditions for nurses. The program emerged from a study conducted by the American Nursing Association (ANA) in 1983.¹⁰⁶ The ANA identified 41 out of 163 hospitals studied that exhibited certain key success factors in attracting nurses and retaining them.¹⁰⁷ Some of the factors include policies encouraging greater nurse autonomy, enhanced nurse feedback channels, improved cooperation with physicians, and creation of sufficient staffing plans.¹⁰⁸ The American Nursing Credentialing Center (ANCC) now officially recognizes these factors for granting "Magnet Nursing Services Recognition for Excellence in Nursing Services."¹⁰⁹ Recently, the ANCC created a new generation Magnet Program, requiring an examination of factors such as transformational leadership, structural environment, exemplary professional practice, new knowledge and improvements, and empirical quality results.¹¹⁰

The Magnet Program benefits nurses because the program improves the U.S. News and World Report Best Hospitals ranking, decreases temporary labor costs, and enhances nurse retention.¹¹¹ Critics, however, are more skeptical. They claim

103. Mantese et al., *supra* note 15, at 1174–77 (listing Florida, Connecticut, Delaware, Kentucky, Oregon, Missouri, Rhode Island, and New Jersey as states in this category).

104. Registered Nurse Staffing Act of 2007, S. 73, 110th Cong. § 3(b) (2007).

105. *Id.*

106. Elgie, *supra* note 66, at 290.

107. *Id.*

108. *Id.*

109. Am. Nurses Credentialing Ctr., ANCC Magnet Recognition Program, <http://www.nursecredentialing.org/Magnet/ProgramOverview.aspx> (last visited Nov. 24, 2009).

110. AM. NURSES CREDENTIALING CTR., A NEW MODEL FOR ANCC'S MAGNET RECOGNITION PROGRAM 5–6 (2008), available at <http://www.nursecredentialing.org/Documents/Magnet/NewModelBrochure.aspx>.

111. Am. Nurses Credentialing Ctr., Why Become Magnet Recognized?, <http://www.nursecredentialing.org/Magnet/ProgramOverview/WhyBecomeMagnet.aspx> (last visited Nov. 24, 2008); see also Michael Romano, *A Strong Attraction: As Hospitals Seek 'Magnet' Status to Retain Nurses and Improve Care, Some See the Program as Little More than a Pricey Marketing Gimmick*, MOD. HEALTHCARE, Dec. 16, 2002, at 28.

the *Magnet* designation is too ambiguous, and not worth its high application cost, roughly \$50,000 at present.¹¹² Very few health care organizations are granted Magnet status. As of this writing, only 354 health organizations have qualified in forty-four states, the District of Columbia, Australia, Lebanon, and New Zealand.¹¹³ While Magnet status gives hospitals incentives to create a supportive work environment, Magnet status by itself is not a solution.¹¹⁴

III. THE USE OF IMMIGRATION LAW AND POLICY TO ALLEVIATE NURSING SHORTAGES

A. Past and Existing Efforts to Utilize Immigration Law and Policy

Foreign nurse recruitment to the United States is not a new phenomenon. For fifty years, the United States has regularly accepted nurses to ease shortages.¹¹⁵ Since 1948, the United States has facilitated entry for Filipino and other foreign nurses through a formal Exchange Visitor Program.¹¹⁶ A 1953 issue of the *American Journal of Nursing* described the program's benefits, proclaiming: "Nurses can be proud of their international activities. Exchange visits are part of our reciprocal 'lend lease' program for sharing knowledge and promoting understanding."¹¹⁷ Later efforts were also significant. The Immigration Act of 1965 made it easier for skilled immigrants to come to the United States, including nurses.¹¹⁸ By 1970, more Filipino nurses were registered in the United States and Canada than in the Philippines.¹¹⁹ Roughly 25,000 Filipino nurses arrived in the United States between 1966 and 1985.¹²⁰ Today, the Philippines continues to send nurses abroad. The country has 370 nursing programs and encourages its students to take foreign nursing examinations.¹²¹ Many Filipinos in other professions, including lawyers and engineers, routinely take the National Council Licensure Examination—Registered Nurse (NCLEX-RN) for the United States.¹²² Even doctors have switched professions; as many as 4,000 in 2004 were lured by

112. Romano, *supra* note 111, at 28, 30.

113. Am. Nurses Credentialing Ctr., Find a Magnet Organization, <http://www.nursecredentialing.org/Magnet/FindaMagnetFacility.aspx> (last visited Nov. 24, 2009).

114. See Romano, *supra* note 111, at 32, 34 (explaining how characteristics of the Magnet program itself have led to improvements in hospital quality in Magnet hospitals).

115. Barbara L. Brush et al., *Imported Care: Recruiting Foreign Nurses to U.S. Health Care Facilities*, HEALTH AFF., May–June 2004, at 78, 78–79.

116. KINGMA, *supra* note 83, at 23.

117. Jeanne LaMotte, *Nurses on the Two Way Street*, 53 AM. J. NURSING 683, 683 (1953).

118. See CATHERINE CENIZA CHOY, *EMPIRE OF CARE: NURSING AND MIGRATION IN FILIPINO HISTORY 97–98* (2003).

119. KINGMA, *supra* note 83, at 11.

120. *Id.* at 23.

121. *Id.* at 22–23.

122. *Id.* at 23.

international nurse recruitment.¹²³ Nearly nine out of ten Filipino nurses work around the world and send an estimated \$800 million back to the Philippines in remittances.¹²⁴

Today's globalized world has fewer trade and communication barriers, allowing for mobility of people, capital, and goods. One new creature of this paradigm is telehealth services, or the delivery of health services through telecommunications. A nurse halfway across the world can use video-based interactive technology and advanced medical equipment to examine wounds, monitor physiological data, and interact with other health practitioners.¹²⁵

Nurse migration is another example of an integrated world. Many countries with aging populations and a diminishing nurse supply are experiencing shortages.¹²⁶ At the same time, emerging nations such as India and China are becoming large suppliers of nurses.¹²⁷ Various *push* and *pull* factors influence the decision to migrate. *Push* factors force the nurses to leave their countries of origin, essentially *pushing* them out. Push factors include poor wages, inadequately funded health systems, the risk of contracting HIV, and economic instability.¹²⁸ *Pull* factors attract the nurses to the United States. Pull factors include better wages, standard of living, working conditions, and opportunity for advancement.¹²⁹

On the demand or *pull* side, many industrialized countries suffer from an aging baby-boom population requiring care, while having to contend with advances in health technology and a nurse work force which is older and seeking retirement.¹³⁰ For example, by 2015, the demand for nursing services in Canada will increase by more than half.¹³¹ These nations are increasingly turning to immigration to alleviate shortages. In Switzerland, nearly one third of registered nurses are educated outside of the country,¹³² with one hospital having almost three

123. *Id.*

124. Linda H. Aiken et al., *Trends in International Nurse Migration*, HEALTH AFF., May–June 2004, at 69, 75; see generally B. Lindquist, *Migration Networks: A Case Study in the Philippines*, 2 ASIAN & PAC. MIGRATION J. 75, 75–104 (1993).

125. KINGMA, *supra* note 83, at 147–48.

126. See STEVE SIMOENS ET AL., ORG. FOR ECON. CO-OPERATION & DEV., TACKLING NURSE SHORTAGES IN OECD COUNTRIES, at paras. 12, 31, 34, 92, 108 (2005), available at <http://www.oecd.org/dataoecd/11/10/34571365.pdf>.

127. Celia W. Dugger, *U.S. Plan to Lure Nurses May Hurt Poor Nations*, N.Y. TIMES, May 24, 2006, at Foreign Desk A1; Yu Xu, *Are Chinese Nurses a Viable Source to Relieve the US Nursing Shortage?*, 21 NURSING ECON. 269, 271–73 (2003).

128. Donna S. Kline, *Push and Pull Factors in International Nurse Migration*, 35 J. NURSING SCHOLARSHIP 107, 108 (2003).

129. *Id.*

130. See SIMOENS ET AL., ORG. FOR ECON. CO-OPERATION & DEV., *supra* note 126, at paras. 12, 31, 34, 92, 108; see also KINGMA, *supra* note 83, at 31–34.

131. KINGMA, *supra* note 83, at 35.

132. See SIMOENS ET AL., ORG. FOR ECON. CO-OPERATION & DEV., *supra* note 126, at paras. 64–65 & tbl.5 (citing statistics that 23.1% of Swiss nurses are foreign trained).

quarters of its recruits from outside Switzerland.¹³³ Between 1999 and 2002, the number of foreign nurses in the United Kingdom doubled.¹³⁴ This growth has been so dramatic that by 2002, more nurses entered the workforce from abroad than from domestic educational institutions.¹³⁵ In the United States, the use of foreign nurses has been less aggressive. Between 2000 and 2004, the number of foreign nurses entering the country changed little, despite the tripling of the number of nurses passing the licensing examination over the same period.¹³⁶

Nurses are also migrating abroad from the developing world. Some developing nations become reliant on loans from the International Monetary Fund and the World Bank. As a result, they have severely reduced their health budgets and nurse salaries to comply with financial restructuring requirements.¹³⁷ However, regardless of whether a developing nation is going through restructuring or is experiencing other economic instability, these countries pay nurses considerably less than nurses in developed nations. The 2006 median earnings for a nurse in the United States was \$57,280.¹³⁸ This is much higher than a Filipino nurse, who can make as little as \$2,000 in one year.¹³⁹ Migrants already in the host country also positively influence the decision to migrate.¹⁴⁰ Individuals make choices about where to work based on perceived opportunities.¹⁴¹ The presence of people from the developing nation in the host country facilitates the creation of support networks formed around kinship, ethnicity, and occupation.¹⁴² These networks are essential to the successful labor market integration within the host country. The combined effects of economic instability, migration networks, and pay gradients create a powerful pull away from the home country.

133. KINGMA, *supra* note 83, at 174–76 (describing the demographic of the nurses in the city of Geneva).

134. Aiken et al., *supra* note 124, at 69, 73.

135. *Id.*

136. Linda H. Aiken, *U.S. Nurse Labor Market Dynamics Are Key to Global Nurse Sufficiency*, 42 HEALTH SERVICES RES. 1299, 1305 (2007).

137. See KINGMA, *supra* note 83, at 122.

138. BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, OCCUPATIONAL OUTLOOK HANDBOOK: REGISTERED NURSES 5 (2009), available at <http://www.bls.gov/oco/pdf/ocos083.pdf>.

139. Brush et al., *supra* note 115, at 78, 81.

140. See Ranko Shiraki Oliver, *In the Twelve Years of NAFTA, the Treaty Gave to Me . . . What, Exactly?: An Assessment of Economic, Social, and Political Developments in Mexico Since 1994 and Their Impact on Mexican Immigration into the United States*, 10 HARV. LATINO L. REV. 53, 119–20 (2007).

141. *Id.* at 101–02.

142. *Id.* at 119–20.

B. Changes in Immigration Law as the Result of Nursing Shortages

A nursing shortage in the late 1980s prompted the use of immigration policy, with Congress enacting the Immigration Nursing Relief Act of 1989 (INRA).¹⁴³ At that time, nurse vacancy rates were as high as 10% in some areas, nearly three quarters of facilities had shortages, and nursing school enrollment was down 20%.¹⁴⁴

Many foreign nurses already in the United States at this time were on five-year visas set to expire.¹⁴⁵ INRA provided for new H-1A visas, making nurses eligible for permanent residency within a five-year period without any numerical limits or country backlogs, accelerating their permanent residence applications.¹⁴⁶ The new H-1A visas required a special employer attestation that nurses maintained active licensure.¹⁴⁷ The employer's attestation also certified that it had not experienced a strike or lockout, had not laid off nurses, and was not trying to influence a union election.¹⁴⁸ The employer also had to pay prevailing wages and guarantee that working conditions would not be adversely affected.¹⁴⁹ Further, eligible employers had to show that they were taking "timely and significant steps" to recruit and train nurses locally.¹⁵⁰

Despite these safeguards, fears arose that the increased number of noncitizen nurses would stop the rise of wages and would diminish working conditions.¹⁵¹ Based on these concerns, the H-1A program expired in 1996.¹⁵² Despite an official finding that the H-1A visas had little or no impact on wages and working conditions, proposals to revive the program were opposed by unions concerned about the program's effect on native nurses.¹⁵³

143. Trucios-Haynes, *supra* note 19, at 990–91 (explaining the catalysts for the passage of the Immigration Nursing Relief Act of 1989, Pub. L. No. 101-238, 103 Stat. 2099).

144. *Id.*

145. *Id.* at 991.

146. *Id.*

147. *Id.* at 992.

148. *Id.*

149. *Id.*

150. *Id.* at 992. Some of these steps included starting an RN training program, providing career development programs, and increasing nurse pay. *Id.* at 992–93.

151. *Id.* at 994.

152. OFFICE OF BUS. LIAISON, U.S. DEP'T OF HOMELAND SECURITY, EMPLOYER INFORMATION BULLETIN 19: GUIDE FOR HIRING FOREIGN NURSES (2005), available at <http://www.aile.com/services/employerinfo/EIB19.pdf>.

153. Trucios-Haynes, *supra* note 19, at 994–95. INRA established an Immigration Nursing Relief Advisory Committee to measure its impact. *Id.* at 994. The Committee's official report found that H-1As had little impact on wages and working conditions. *Id.* at 995. The AFL-CIO, ANA, and SEIU wrote a dissenting opinion to the Committee's report and claimed shortages were only transitory. *Id.* The Committee also recommended the expansion of the program because nursing shortages occurred sporadically and in certain locations. *Id.* The Committee also recognized that nursing shortages would

However, the opposition was not enough to defeat an attempt to use immigration to alleviate a nursing shortage in 1999. The Nursing Relief for Disadvantaged Areas Act (NRDAA) was passed with similar restrictions as its 1989 predecessor legislation, including the payment of prevailing wages and guarantees that working conditions would not be harmed.¹⁵⁴ The legislation created the H-1C visa, a nonimmigrant temporary employment visa.¹⁵⁵ In 2006, Congress extended the visa program for three years.¹⁵⁶ Since its inception, the program has been limited, with only 500 visas available annually and only fourteen hospitals nationwide with programs equipped to utilize them.¹⁵⁷ Only facilities in shortage areas are permitted to use H-1C nurses, and the nurses may comprise only up to 33% of their total registered nurse workforce.¹⁵⁸ No more than fifty visas may go to a state with nine million or more people, and no more than twenty-five are allowed for a state with fewer than nine million in population.¹⁵⁹ The participating nurses are also subject to professional certification requirements.¹⁶⁰ While the ANA officially took a neutral position on the creation of H-1C visas, it did not testify in favor of the legislation.¹⁶¹ The ANA stated that an increase in foreign-educated nurses serves only to postpone the solutions to the root causes of the problem.¹⁶²

grow in the twenty-first century. COMM. ON THE JUDICIARY, HEALTH PROF'L SHORTAGE AREA NURSING RELIEF ACT OF 1998, H.R. REP. NO. 105-668, at 7 (1998).

154. Nursing Relief for Disadvantaged Areas Act of 1999, Pub. L. No. 106-95, § 2, 113 Stat. 1312, 1313-16.

155. *Id.* § 2. Immigration law distinguishes between those individuals coming to the United States temporarily for work or education and those who wish to remain permanently. Those in the latter group are "immigrants." 8 U.S.C. § 1153 (2006). Those in the former are "nonimmigrants." *Id.* § 1101(a)(15). These visas are known as H-1C visas due to the subsection of the statute in which the visas are created. *See id.* § 1101(a)(15)(H)(i)(c).

156. Nursing Relief for Disadvantaged Areas Reauthorization Act of 2005, Pub. L. No. 109-423, 120 Stat. 2900 (2006).

157. Trucios-Haynes, *supra* note 19, at 997; Godinez, *supra* note 19, at 1H.

158. 8 U.S.C. § 1182(m)(2)(A)(vii), (m)(6)(A); Trucios-Haynes, *supra* note 19, at 997 n.127. The location of the hospitals in shortage areas may be viewed as a disadvantage by prospective foreign nurse applicants as some of the hospitals are located in unsafe neighborhoods and concern exists about their safety when working late night shifts. *See, e.g.*, Paul Merrion & Christine Ngeo, *Nursing Relief: In Answer to Hospital Shortages, Bill Would Allow Some Foreign Nurses to Work in U.S.*, MOD. HEALTHCARE, Nov. 10, 1997, at 56. In fact, U.S. nurses would not accept employment positions in those hospitals. *Id.*

159. 8 U.S.C. § 1182(m)(4)(A)-(B).

160. Trucios-Haynes, *supra* note 19, at 997.

161. Nursing Relief for Disadvantaged Areas Act of 1999, H. 441, 145 CONG. REC. H3477 (daily ed. May 24, 1999) (statement of Hon. Sheila Jackson Lee reading into record a letter from Beverly L. Malone, President, American Nurses Association).

162. *Id.*

Because the H-1C program is so small, it is ignored by most institutions. Only 170 of the 500 visas were used in 2008.¹⁶³ Attempts to expand the H-1C program have not been successful. Senator Brownback (R-KS) sponsored the Rural and Urban Health Center Act of 2001.¹⁶⁴ Rep. Sheila Jackson Lee (D-TX) introduced similar legislation in the House of Representatives three times.¹⁶⁵ This legislation would have lifted the H-1C cap and eased some of the restrictions on the program.¹⁶⁶ The ANA opposed the measure, claiming it would destroy the domestic market for nurses.¹⁶⁷ The organization stated “We’re disappointed that Congress, instead of providing appropriations for domestic nursing programs, is outsourcing the education of nurses.”¹⁶⁸ The Service Employees International Union (SEIU), the nation’s largest health care union, also opposed the legislation.¹⁶⁹

Recently, lawmakers have attempted to expand the H-1C visa program to 20,000 visas per year. The Emergency Nurse Supply Relief Act was introduced by Rep. Robert Wexler on May 20, 2009.¹⁷⁰ Unlike previous bills, the legislation aims to balance domestic nurse education investment and the use of visas to alleviate the shortage.¹⁷¹ Each nurse visa would carry a \$1500 fee.¹⁷² The revenue generated from the fee would be invested in capitation grants targeted at domestic nursing schools.¹⁷³ Moreover, not only does the proposed legislation seek common ground with those favoring a domestic approach to the problem, it also has the bipartisan support of cosponsor Rep. James Sensenbrenner, Jr. (R-WI). Rep. Carolyn McCarthy (D-NY), a nurse by profession,¹⁷⁴ had been a cosponsor of a previous version of this bill as well.¹⁷⁵ Despite these attempts to compromise, the ANA has expressed disappointment with the proposed law.¹⁷⁶ While the ANA’s official

163. OFFICE OF IMMIGRATION STATISTICS, DEP’T OF HOMELAND SECURITY, 2008 YEARBOOK OF IMMIGRATION STATISTICS 64 tbl.25 (2009), available at http://www.dhs.gov/xlibrary/assets/statistics/yearbook/2008/ois_yb_2008.pdf.

164. Rural and Urban Health Care Act of 2001, S. 1259, 107th Cong. (2001).

165. Rural and Urban Health Care Act of 2001, H.R. 2705, 107th Cong. (2001); Rural and Urban Health Care Act of 2003, H.R. 87, 108th Cong. (2003); Rural and Urban Health Care Act of 2005, H.R. 248, 109th Cong. (2005).

166. See bills cited *supra* note 165.

167. Dugger, *supra* note 127, at A1.

168. *Id.* (quoting Erin McKeon, Associate Director of Government Affairs for the American Nurses Association).

169. Godinez, *supra* note 19, at 1H.

170. Emergency Nursing Supply Relief Act, H.R. 2536, 111th Cong. (2009).

171. See *infra* text accompanying notes 172–173.

172. H.R. 2536.

173. *Id.*

174. Emergency Nursing Supply Relief Act, H.R. 5924, 110th Cong. (2008); see also Congresswoman Carolyn McCarthy: About Carolyn McCarthy, <http://carolynmccarthy.house.gov/?sectionid=4§iontree=4> (last visited Nov. 24, 2009).

175. 154 CONG. REC. H3886 (daily ed. May 14, 2008).

176. See *infra* text accompanying notes 177–178.

position on the legislation remains neutral, some members remain skeptical. ANA representatives have testified before the House Judiciary Subcommittee on Immigration that the ANA “supports the right of individual nurses to practice in the location of their choice, but opposes the use of immigration to solve domestic workforce shortages.”¹⁷⁷ Furthermore, the ANA contends that:

. . . it is inappropriate to look overseas for nursing workforce relief when the real problem is the fact that Congress does not provide sufficient funding for domestic schools of nursing, the U.S. health care industry has failed to maintain a work environment that retains experienced U.S. nurses in patient care, and the U.S. government does not engage in active health workforce planning to build a sustainable nursing and health professions workforce for the future.¹⁷⁸

The only successful efforts to expand nurse immigration came in 2006. The Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Tsunami Relief of 2005 allowed the State Department to release 50,000 employment-based (EB-3) visas for occupations such as nursing and physical therapy.¹⁷⁹ Fifty thousand unused visas from the previous four years were applied to eligible persons from India, China, and the Philippines.¹⁸⁰ EB-3 visas are for “skilled professionals” seeking to remain in the United States permanently.¹⁸¹ There are 140,000 EB visas plus any unused family-based immigration visas authorized each year.¹⁸² Of these, 28.6% plus any unused EB-1 and EB-2 visas are allotted to EB-3.¹⁸³ Nurses applying for EB-3 visas enjoy a shorter processing time because the law provides a special exemption from the lengthy process of labor certification for certain professions in shortage, known as Schedule A occupations.¹⁸⁴ While nurse EB-3 applications normally proceed faster than most

177. *Need for Green Cards for Highly Skilled Workers: Hearing Before the Subcomm. on Immigration, Citizenship, Refugees, Border Security, and International Law of the H. Comm. on the Judiciary*, 110th Cong. 61 (2008) (statement of Cheryl Peterson, Senior Policy Fellow, American Nurses Association).

178. *Id.*

179. Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Tsunami Relief, Pub. L. No. 109-13, § 502, 119 Stat. 231, 322–23 (2005).

180. Bureau of Consular Affairs, Dep’t of State, Visa Bulletin for February 2006, http://travel.state.gov/visa/frvi/bulletin/bulletin_2771.html (last visited Nov. 24, 2009).

181. 8 U.S.C. § 1153(b)(3)(A)(i)–(ii) (2006); *see also* STEPHEN H. LEGOMSKY, IMMIGRATION AND REFUGEE LAW AND POLICY 295–97 (4th ed. 2005).

182. Bureau of Consular Affairs, Dep’t of State, *supra* note 180.

183. *Id.*

184. *See* CHARLES GORDON ET AL., 3 IMMIGRATION LAW & PROCEDURE § 39.02 3[b] (Matthew Bender, Rev. ed. 1988 & Supp. 2007) (“The Department of Labor has effectively precertified certain occupations listed in its Schedule A. . . . An alien qualified in one of these categories need not and indeed may not seek an individual labor certification. Instead, the immigration agency decides whether to grant the Schedule A labor certification in making its determination on the employment-based (EB) second or third preference petition.”). The filing must still include proof that the nurse has passed the Examination of the Commission on Graduates of Foreign Nursing Schools (CGFNS) or holds a full and

other EB-3s,¹⁸⁵ they are not an efficient method of bringing foreign nurses to the United States because, like all EB-3s, there are numerical limits and lengthy backlogs for this category.¹⁸⁶ For this reason, in 2004, nurses only constituted 9.1% of all employment-based, principal legal permanent residents admitted to the United States.¹⁸⁷

C. Overview of the Foreign-Nurse Entry Process

Before being eligible for a visa, a foreign nurse must pass a battery of examinations. The Commission on Graduates of Foreign Nursing Schools (CGFNS) is a non-profit organization that certifies the credentials of 500,000 internationally educated nurses and other health care workers.¹⁸⁸ Before a foreign nurse enters the United States, the CGFNS reviews the applicant's credentials, English proficiency, and performance on the CGFNS examination or the NCLEX-RN licensing examination.¹⁸⁹ The review ensures that nurses have the minimum education required for RN licensure in the United States.¹⁹⁰ The CGFNS examination predicts passage of the NCLEX-RN.¹⁹¹ While most nurses take the CGFNS with the aim of completing the NCLEX-RN, some take the CGFNS merely to boost their credentials and never leave their home country.¹⁹²

All nurses must take the NCLEX-RN to be licensed in any state in the United States.¹⁹³ The NCLEX-RN is not available in many countries.¹⁹⁴ For this reason, it

unrestricted license to practice professional nursing in the state of intended employment. 20 C.F.R. § 656.15(c)(2) (2008).

185. See Memorandum from Michael Aytes, Acting Deputy Dir., U.S. Citizenship & Immigration Servs., U.S. Dep't of Homeland Security to Michael T. Dougherty, Citizenship & Immigration Servs. Ombudsman 3 (Mar. 13, 2009), available at http://www.uscis.gov/files/nativedocuments/Rec36_031309.pdf (explaining how nurses are "shortage occupations" and are exempt from filing requirements applying to other employment based visas as established in 8 C.F.R. § 204.5(a)(2) (2008)).

186. Bureau of Consular Affairs, Dep't of State, Visa Bulletin for December 2008, http://travel.state.gov/visa/frvi/bulletin/bulletin_4384.html# (last visited Nov. 24, 2009).

187. KELLY JEFFERYS, OFFICE OF IMMIGRATION STATISTICS, DEP'T OF HOMELAND SECURITY, CHARACTERISTICS OF EMPLOYMENT-BASED LEGAL PERMANENT RESIDENTS: 2004, at 2 (2005).

188. Comm'n on Graduates of Foreign Nursing Schs. Int'l, Who We Are/What We Do, <http://www.cgfns.org/sections/about/> (last visited Nov. 24, 2009); Comm'n on Graduates of Foreign Nursing Schs. Int'l, Mission and History, <http://www.cgfns.org/sections/about/mission.shtml> (last visited Nov. 24, 2009).

189. Tanya Bieski, *Foreign-Educated Nurses: An Overview of Migration and Credentialing Issues*, 25 NURSING ECON. 20, 21 (2007).

190. *Id.*

191. *Id.*

192. KINGMA, *supra* note 83, at 97.

193. Kathleen L. Sitzman, *Diversity and the NCLEX-RN: A Double-Loop Approach*, 18 J. TRANSCULTURAL NURSING 271, 272 (2007).

194. See NAT'L COUNCIL OF STATE BDS. OF NURSING, PUBLIC POLICY AGENDA 13 (2008), available at <https://www.ncsbn.org/PublicPolicyAgenda2008.pdf> (identifying the thirteen countries where the

was common for nurses to pass the CGFNS in order to gain entry to the United States. Then, once here, they complete the NCLEX-RN examination.¹⁹⁵ This practice is becoming less common, however, as the NCLEX-RN is increasingly available in foreign countries.¹⁹⁶

In addition to the nursing examinations, nurses must demonstrate English proficiency. An applicant must take one of the Test of English as a Foreign Language (TOEFL) examinations, or a combination of examinations approved by the Departments of Education and Health and Human Services.¹⁹⁷ English proficiency examination scores are valid for two years.¹⁹⁸ Students from Ireland, Australia, New Zealand, Canada, and the United Kingdom are exempt from the English requirements.¹⁹⁹

The application process for nonimmigrant visas, such as the H-1C, can take a year or longer.²⁰⁰ A hospital planning to file an H-1C petition for a foreign nurse must meet four criteria. First, the nurse must have a full and unrestricted license to practice nursing in his or her country of education, or must have been educated in the United States.²⁰¹ Second, the employer must show that the nurse has “passed an appropriate examination” or “has a full and unrestricted license under State law to practice professional nursing in the State of intended employment.”²⁰² Third, the nurse must be “fully qualified and eligible under the laws of the place where she will work” to practice “immediately upon admission to the United States and is

NCLEX-RN is available); Bieski, *supra* note 189, at 21 (commenting on how the NCLEX-RN is not available in all countries).

195. Bieski, *supra* note 189, at 21. Nurses may be granted an interim permit, even if it requires working under the supervision of a permanently licensed nurse, provided that the foreign nurse can still perform all the professional duties. *See* CHARLES GORDON ET AL., 2 IMMIGRATION LAW & PROCEDURE § 20.07 3[b][iv] & n.63 (Matthew Bender, rev. ed. 1988 & Supp. 2007). Nurses must pass their license examination within six months of entry. *See id.*

196. The NCLEX-RN is now available in London, England; Hong Kong, China; Sydney, Australia; Toronto, Montreal, and Vancouver, Canada; Frankfurt, Germany; New Delhi, Mumbai, Hyderabad, Bangalore, and Chennai, India; Mexico City, Mexico; Taipei, Taiwan; Chiyoda-ku and Yokohama, Japan; and Manila, Philippines. NAT'L COUNCIL OF STATE BDS. OF NURSING, *supra* note 194, at 13.

197. Bieski, *supra* note 189, at 21.

198. *Id.*

199. *Id.* Students from Quebec, Canada must take the English proficiency test since the official language of the province is French. *See id.*

200. *Id.* at 21–22.

201. 8 U.S.C. § 1182(m)(1)(A) (2006).

202. 8 U.S.C. § 1182(m)(1)(B). The legal requirement of an “appropriate examination” is satisfied by the Commission on Graduates of Foreign Nursing Schools examination. 8 C.F.R. § 214.2(h)(3)(D)(iii)(B) (2008) (describing the legal need for an “appropriate examination”). “Full and unrestricted (permanent) license” would require passage of the NCLEX-RN, which is the manner in which State Boards of Nursing authorize a registered nurse practicing in the United States. *See id.* § 214.2(h)(3)(A), (D)(iii); NAT'L COUNCIL OF STATE BDS. OF NURSING, 2009 NCLEX EXAMINATION CANDIDATE BULLETIN 2 (2009), available at https://www.ncsbn.org/2009_NCLEX_Candidate_Bulletin.pdf (describing the NCLEX-RN as the examination that State Boards of Nursing use to “make decisions about licensure”).

authorized under such laws to be employed by the employer.”²⁰³ Finally, the employer must have an attestation on file with the Department of Labor showing that it complies with the required employment conditions.²⁰⁴

In addition, Section 343 of the Illegal Immigration Reform and Responsibility Act of 1996 mandates a successful completion of the VisaScreen certificate prior to receiving a visa.²⁰⁵ CGFNS runs VisaScreen, a program that reviews nurse credentials to ensure they meet the government requirements.²⁰⁶ This includes review of educational background, English-proficiency, and assessment of the NCLEX-RN or CGFNS examination.²⁰⁷ Either the NCLEX-RN or CGFNS is required for the VisaScreen certificate.²⁰⁸ The H-1C is valid for three years and cannot be extended;²⁰⁹ however, nurses may attempt to adjust to a permanent resident status.²¹⁰

There are other employment-based immigration categories available to foreign nurses. A full discussion of these is outside the scope of this Article, but they are briefly mentioned here. Some nurses may be eligible for H-1B nonimmigrant visas.²¹¹ However, H-1B visas are rarely used in health care occupations.²¹² In 2005, only 6.6% of all H-1B beneficiaries were from “Occupations in Medicine and Health.”²¹³ H-1B visas are valid for six years,²¹⁴ and

203. 8 U.S.C. § 1182(m)(1)(C).

204. *See id.* § 1182(m)(2) (making attestation a statutory requirement); 20 C.F.R. § 655.1111 (2008) (setting forth the details of an attestation).

205. Illegal Immigration Reform and Responsibility Act of 1996, Pub. L. No. 104-208, § 343, 110 Stat. 3009, 3009-636 to -637 (codified as amended at 8 U.S.C. § 1182) (requiring aliens to provide a “certificate from the Commission on Graduates of Foreign Nursing Schools”); Comm’n on Graduates of Foreign Nursing Schs., VisaScreen Program, <http://www.cgfns.org/sections/programs/vs/> (explaining and naming the statutorily required certificate program) (last visited Nov. 24, 2009).

206. Marlene M. Rosenkoetter & Deena A. Nardi, *American Academy of Nursing Expert Panel on Global Nursing and Health: White Paper on Global Nursing and Health*, 18 J. TRANSCULTURAL NURSING 305, 309–10 (2007); Comm’n on Graduates of Foreign Nursing Schs., *supra* note 205.

207. Rosenkoetter & Nardi, *supra* note 206, at 309; Comm’n on Graduates of Foreign Nursing Schs., *supra* note 205.

208. Rosenkoetter & Nardi, *supra* note 206, at 309.

209. 8 U.S.C. § 1182(m)(3) (“The period of admission of an alien under section 101(a)(15)(H)(i)(c) shall be 3 years.”) (emphasis added).

210. 8 C.F.R. § 245.1(e)(2)(B) (2008).

211. *See* 8 U.S.C. § 1101(a)(15)(H)(i)(b) (allowing visas to nonimmigrant applicants who are in “specialty occupations,” such as nursing); *id.* § 1184(i)(1) (defining “specialty occupations” as “occupations that require theoretical and practical application of a body of highly specialized knowledge, and [] attainment of a bachelor’s or higher degree in the specific specialty (or its equivalent) as a minimum for entry into the occupation in the United States.”).

212. *See* U.S. CITIZENSHIP & IMMIGRATION SERVS., DEP’T OF HOMELAND SECURITY, CHARACTERISTICS OF SPECIALTY OCCUPATION WORKERS (H-1B): FISCAL YEAR 2005, at 13 tbl.8B (2006), available at http://www.uscis.gov/files/nativedocuments/H1B_FY05_Characteristics.pdf (comparing H-1B petitions from applicants in “Medicine and Health” to sixteen other occupational areas).

213. *Id.*

may not apply to some nurses.²¹⁵ The H-1B, like the H-1C visa, is a temporary work visa, in contrast with the EB-3 immigrant visa. EB-3 visas are for “skilled professionals” seeking to remain in the United States permanently and may lead to lawful permanent resident status, more commonly known as a having a green card.²¹⁶ Nurses seeking a green card intend to become permanent residents.²¹⁷ Finally, nurses coming from Mexico or Canada may be eligible for North American Free Trade Agreement (NAFTA)-enacted, temporary professional workers TN visa status for one year stays.²¹⁸

IV. THE NEED FOR INCREASED NURSE MIGRATION TO THE UNITED STATES

A. The H-1C Program Should Be Extended and Expanded as a Comprehensive Solution to the Nursing Shortage

The H-1C program should be expanded beyond the current 500 visas and fourteen U.S. hospitals. It should also be extended beyond its current expiration. A deficit forecast of one million nurses by the year 2020 demands a comprehensive approach.²¹⁹ While increased investment in nurse education, increased outreach to youth, better pay, mandatory staffing ratios, and *Magnet status* are all important parts of a solution, each line of attack has its limitations. These limitations are sometimes a function of economics. For example, in the case of pay, the factors that work to undercompensate nurses are unlikely to change in the near future.²²⁰ Other restrictions on reform may be political. As the Nurse Reinvestment Act debate illustrates, a Democratic Congress may fight cuts in nursing education.

214. 8 U.S.C § 1184(g)(4).

215. It is not clear whether a particular nurse would be eligible for an H-1B visa. Nurses with a baccalaureate degree would most likely be allowed; however, a nurse with an associate’s degree may have to demonstrate several years of additional work experience. *See id.* § 1184(i)(1) (defining “specialty occupations”).

216. *See id.* § 1153(b)(3); 8 C.F.R. § 204.5(l) (2008) (defining the statutory requirements of “skilled workers” and “professionals”); U.S. Citizenship & Immigration Servs., Dep’t of Homeland Security, EB-3 Eligibility and Filing, <http://www.uscis.gov/portal/site/uscis/menuitem.5af9bb95919f35e66f614176543f6d1a/?vgnextoid=b470194d3e88d010VgnVCM10000048f3d6a1RCRD&vgnextchannel=91919c7755cb9010VgnVCM10000045f3d6a1RCRD> (last visited Nov. 24, 2009) (naming the employment based visas of “skilled workers” and “professionals” as an “EB-3”).

217. *See* U.S. Citizenship & Immigration Servs., U.S. Dep’t of Homeland Security, Green Card (Permanent Residence), <http://www.uscis.gov/portal/site/uscis/menuitem.eb1d4c2a3e5b9ac89243c6a7543f6d1a/?vgnextoid=ae853ad15c673210VgnVCM100000082ca60aRCRD&vgnextchannel=ae853ad15c673210VgnVCM100000082ca60aRCRD> (last visited Nov. 24, 2009).

218. 8 C.F.R. § 214.6(a), (c)–(d) (citing North American Free Trade Agreement, Dec. 17, 1992, 32 I.L.M. 605 pt. 5, ch. 16, annex 1603, sec. D.1 & app. 1603.D.1 (entered into force Jan. 1, 1994)); *see also* GORDON ET AL., *supra* note 195, at § 20.07[4].

219. *See* Dohm & Shniper, *supra* note 12, at 112.

220. *See supra* Part II.B.

However, the minimal impact of restoring funding that was inadequate originally shows just how far legislators need to go in order to solve this problem.

Further, even with increased spending, the demand for nursing may be so great that reliance on homegrown nurses will not make up for the shortfall. Assuming that the 30,709 nurses turned away from nursing schools in 2007²²¹ were qualified to graduate, and this number remains the same each year, this would total 368,508 nurses over twelve years. However, even this increase would still be 631,492 nurses short of the one million needed. With the potential for further understaffing and adverse patient outcomes at stake, the U.S. can hardly afford to ignore the inclusion of foreign nurses as part of a comprehensive approach.

An expansion of the H-1C program would alleviate shortages expeditiously. For instance, an expansion of the program would have an immediate positive effect on retention by supplementing overworked, burned out nurses retiring early and dropping out. In addition, much of the infrastructure to increase the program is already in place. Established kinship networks and professional recruiting agencies are already in place in oversupplied nations such as India and China.²²² The Chinese Nurses Association (CNA) is a good example. The CNA has signed an agreement with a foreign recruiting agency to assist nurses with CGFNS examination preparation and immigration procedures.²²³ The CNA believes that if nurses receive foreign training, these nurses, upon return, will elevate standards of care, help reform government policies, and increase respect for the nursing profession.²²⁴

Other developed nations provide a useful model. The United Kingdom and Canada are already recruiting foreign nurses.²²⁵ They have adopted a more internationalist perspective, centered on the possibility of mutual gain.²²⁶ An internationalist perspective does not automatically assume a finite amount of resources.²²⁷ Instead, the focus is on cooperation, common benefit, and optimal use of resources.²²⁸ Such a philosophy is better suited for a world with fewer barriers and greater mobility. Unfortunately, the U.S. still has quite the opposite perspective. The treatment of undocumented migrants illustrates this perspective. Many persons in the U.S. still fear that illegal aliens deprive them of health care

221. AM. ASS'N OF COLL. OF NURSING, *supra* note 60.

222. *See, e.g.*, Xu, *supra* note 127, at 271–72 (discussing oversupply of nurses and recruiting agencies in China); Saritha Rai, *Indian Nurses Sought to Staff U.S. Hospitals*, N.Y. TIMES, Feb. 10, 2003, at A6; *see also* Nursing Relief Act of 2007, H.R. 1358, 110th Cong. § 2(a)(4) (2007) (discussing the oversupply of nurses in foreign countries).

223. Xu, *supra* note 127, at 271–72.

224. *Id.* at 272.

225. *Id.* at 269.

226. *Id.* at 270.

227. *See id.*

228. *Id.*

services.²²⁹ They fail to see the common benefits associated with reducing the risk of contracting communicable diseases among foreigners and rendering health care earlier to all persons regardless of immigration status.²³⁰ These measures result in savings for the entire health system.²³¹

A corollary of this perspective is that the ANA and other nurse trade groups do not realize the value of more foreign nurses.²³² The ANA's current *Health System Reform Agenda* does not even mention immigration.²³³ It is not clear why the ANA does not express more support for foreign nurses. Historically, many unions and trade associations have opposed immigration.²³⁴ Only recently has the labor movement embraced immigration and supported the latest efforts concerning reform.²³⁵ The ANA has expressed more positive attitudes towards immigration at some points in its past. For example, the organization developed a 1962 brochure for Filipino nurses called *Your Cap Is Your Passport*.²³⁶ At other times, the ANA has articulated the nativism common to other organizations. For instance, when it was uncovered that more than 500 nurses were smuggled into the United States with the fraudulent promise of H-1A visas in 1998, the ANA President said "While some areas . . . face labor shortages in the nursing field . . . the country as a whole

229. See Jyoti Thottam, *New Poll: Americans Favor Guest Worker Plan*, TIME.COM, Mar. 31, 2006, <http://www.time.com/time/nation/article/0,8599,1179117,00.html> (explaining that 75% of Americans do not want "illegal aliens" to have health care or food stamps).

230. See Brietta R. Clark, *The Immigrant Health Care Narrative and What It Tells Us About The U.S. Healthcare System*, 17 ANNALS HEALTH L. 229, 256–58 (2008) (stating that cost of prenatal care imposed on citizens and non-citizens, certain chronic diseases are cheaper to treat earlier rather than later, and that tuberculosis in the foreign born population can be spread to citizens).

231. *Id.*

232. See *Need for Green Cards for Highly Skilled Workers: Hearing Before the Subcomm. on Immigration, Citizenship, Refugees, Border Security, and International Law of the H. Comm. on the Judiciary*, 110th Cong. 61 (2008) (statement of Cheryl Peterson, Senior Policy Fellow, American Nurses Association). The ANA is a professional association. Am. Nurses Ass'n, About ANA, <http://www.nursingworld.org/FunctionalMenuCategories/AboutANA.aspx> (last visited Nov. 24, 2009). However, some state chapters engage in collective bargaining. See, e.g., Mass. Nurses Ass'n, MNA Bargaining Units, <http://www.massnurses.org/labor-action/bargaining-units> (last visited Nov. 24, 2009) (showing a list of over 100 organizations supported by the organization's collective bargaining services); Mich. Nurses Ass'n, MNA Local Bargaining Units, <http://www.minurses.org/Labor/lbu.shtml> (last visited Nov. 24, 2009) (providing links for collective bargaining services to nurses provided by the organization); Mo. Nurses Ass'n, Frequent Questions Collective Bargaining, http://www.missourinurses.org/resources/collective_bargaining.html (last visited Nov. 24, 2009) (stating that the "Missouri Nurses Association has long supported and encouraged the use of collective bargaining by nurses").

233. See AM. NURSE ASS'N, HEALTH SYSTEM REFORM AGENDA 11–13 (2008), available at <http://www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/HealthSystemReform/Agenda/ANAsHealthSystemReformAgenda.aspx> (explaining that the ANA relies solely on loan forgiveness, tax credits, and other domestic solutions).

234. VERNON M. BRIGGS JR., IMMIGRATION AND AMERICAN UNIONISM 74–78 (2001).

235. See AFL-CIO, THE AFL-CIO POLICY ON IMMIGRATION 1–2, available at <http://www.aflcio.org/issues/civilrights/immigration/upload/AFLCIOPO.pdf>.

236. KINGMA, *supra* note 83, at 23.

has enough nurses and does not need to import them in large numbers.”²³⁷ The ANA’s current fear that more foreign nurses will slow educational investment and other policy change is similar. However, the Emergency Nursing Supply Relief Act is a compromise.²³⁸ The group ignores a valuable part of the solution.

B. Expansion of Other Visa Programs

With the H-1C program set to expire, finding ways to further fast-track EB-3s, reduce backlogs, and otherwise expand their use will be important in years to come. One approach may be allowing nursing students already in the United States, who currently hold an F-1 visa, to more easily file for adjustment of status.

C. Increased Use of Foreign Nurses Would Enhance Health Care Access

Another important benefit of foreign nurses is an enhanced ability to bridge linguistic and cultural divides. The patient population within the United States is becoming increasingly multicultural and multilingual, often exhibiting limited English fluency. Data from the U. S. Census Bureau illustrates that, between 1990 to 2000, the percentage of Americans older than five years of age speaking a language other than English at home rose from 13.8% to 17.8%.²³⁹ The Limited English Proficiency population grew by one third, from 6.1% to 8.1%, with more than twenty-three million Americans speaking English less than very well.²⁴⁰ Language barriers impede health care access, compromise patient care, and increase adverse patient outcomes.²⁴¹ Further, language barriers create inefficiency because health care workers are unable to ascertain patient symptoms, leading to faulty diagnoses, and incorrect treatment regimens.²⁴²

In one case, a hospital failed to correctly interpret the statements of a Spanish-speaking boy.²⁴³ A paramedic interpreted a boy’s utterance of *intoxicado* as *intoxicated*, instead of its meaning *nauseated*.²⁴⁴ For the next few days, the boy was treated for substance abuse.²⁴⁵ He was then found to have a ruptured brain

237. Jodi Wilgoren, *5 Plead Guilty to Illegally Bringing Nurses into U.S.*, L.A. TIMES, Jan. 15, 1998, at Metro Desk A3.

238. See Emergency Nursing Supply Relief Act, H.R. 5924, 110th Cong. (2008) (proposing a fee of \$1500 for alien nurses to be used to fund grants for domestic nursing students).

239. U.S. CENSUS BUREAU, U.S. DEP’T OF COMMERCE, LANGUAGE USE AND ENGLISH-SPEAKING ABILITY: 2000, CENSUS 2000 BRIEF 5 tbl.2 (2003), available at <http://www.census.gov/prod/2003pubs/c2kbr-29.pdf>.

240. *Id.* at 3.

241. Leighton Ku & Glenn Flores, *Pay Now or Pay Later: Providing Interpreter Services in Health Care*, 24 HEALTH AFF. 435, 436 (2005).

242. *Id.*

243. *Id.* at 437.

244. *Id.* While Ku and Flores claim that “*intoxicado*” means *nauseated*, it can also mean *poisoned* or *drunk*.

245. *Id.*

aneurysm.²⁴⁶ As a result of the mistreatment, he became a quadriplegic and later was awarded \$71 million in damages for malpractice.²⁴⁷

Hospitals receiving federal funds must comply with Title VI of the Civil Rights Act of 1964, which ensures that federal funds do not support services that discriminate on the basis of race, color, or national origin.²⁴⁸ Thus, language interpretation is essential and required under the law.

Specialized training among diverse populations allows for better and safer communication and breaks down cultural and language barriers.²⁴⁹ Such education is quickly becoming a standard part of the health profession. New Jersey, California, and Washington have required that physicians and other health professionals complete language and cultural instruction.²⁵⁰ In New Jersey, each medical school must educate students on cultural competency, with an emphasis on language access.²⁵¹ Cultural competency education is also mandated for renewal of physicians' licenses in some locations.²⁵² For example, California requires all its clinically-oriented continuing medical education programs to include cultural and linguistic competency.²⁵³ Washington requires that all health care professionals receive multicultural health training.²⁵⁴ Eight other states are considering similar legislation.²⁵⁵ Current health care reform legislation under consideration includes funding for nursing diversity initiatives.²⁵⁶ Finally, many nursing scholars have called for internationalizing domestic education programs for native and foreign-

246. *Id.*

247. *Id.*

248. See Civil Rights Act of 1964, tit. VI, § 601, 42 U.S.C. § 2000d (2006) (making it illegal for any activity or program receiving public funds to discriminate). This applies to Limited English Proficiency persons. *Lau v. Nichols*, 414 U.S. 563, 566 (1974) (holding that a public school acted in violation of Title VI of the Civil Rights Act of 1964 by failing to provide linguistically appropriate accommodations).

249. See, e.g., AM. MED. ASS'N, AN ETHICAL FORCE PROGRAM CONSENSUS REPORT: IMPROVING COMMUNICATION—IMPROVING CARE 68 (2006), available at <http://www.mihealthandsafety.org/pdfs/06-improving-communication1.pdf> (stating the safety and quality improve with effective language assistance).

250. CAL. BUS. & PROF. CODE § 2190.1 (Deering 2004 & Supp. 2007); N.J. STAT. ANN. § 45:9-7.1 to -7.3 (West 2004 & Supp. 2008); WASH. REV. CODE § 40.70.615 (Supp. 2008).

251. N.J. STAT. ANN. § 45:9-7.2; Mara K. Youdelman, *The Medical Tongue: U.S. Laws and Policies on Language Access*, 27 HEALTH AFF. 424, 427 (2008).

252. Darci L. Graves et al., *A Survey of Cultural Competence Policy in Health Care*, 10 J. HEALTH CARE L. & POL'Y 339, 349 (2007).

253. CAL. BUS. & PROF. CODE § 2190.1(a)(1)–(2), (c)(1)(D); Graves et al., *supra* note 252, at 349.

254. WASH. REV. CODE § 40.70.615.

255. See Youdelman, *supra* note 251, at 427 & n.22 (listing Arizona, Colorado, Georgia, Illinois, Maryland, New Mexico, New York, and Ohio as states that have considered cultural competency requirements for health professionals).

256. H.R. 3200, 111th Cong. § 2242 (2009).

born students through the use of better mentoring and curriculum development.²⁵⁷ In light of these trends, a labor force with more foreign nurses would complement these efforts.

Countries that supply immigration to the United States should be targeted for nurse recruitment. Spanish-speaking countries are one example. Despite NAFTA measures that have allowed for easier immigration, many Mexican nurses have been unable to meet American standards.²⁵⁸ In 2006, only ninety-two Mexicans took the NCLEX-RN examination, and of those only twenty-one passed.²⁵⁹ Cuba has showed better results. In the same year, 521 Cubans sat for the NCLEX-RN examination, with 202 passing.²⁶⁰ One reason for the superior performance of Cuban nurses is the higher standards of Cuba's health care system.²⁶¹ With immigration from Latin and Central America changing the United States population and Fidel Castro no longer in power, increased cooperation with Cuba may present an opportunity to better both countries' health systems.

The presence of foreign nurses, however, presents the possibility for culture clash. For instance, China is said to have a collectivist culture, while the U.S. is considered an individualistic society.²⁶² Such distinctions could lead to communication problems and a greater potential for medical mistakes. Hence, many immigration policy experts recommend that foreign nurses be given cultural competency training.²⁶³ However, studies suggest that the values among nurses as a profession are equally as important as their ethnicity.²⁶⁴ For this reason, differences between collectivist and individualistic cultures are not as great as one would expect.

257. Mary E. Riner, *The Global Nursing Workforce*, in *ISSUES AND TRENDS IN NURSING: ESSENTIAL KNOWLEDGE FOR TODAY AND TOMORROW* 135 (Gayle Roux & Judith A. Halstead eds., 2008).

258. See 8 C.F.R. § 214.6(a), (c)–(d) (2008) (citing North American Free Trade Agreement, Dec. 17, 1992, 32 I.L.M. 605 pt. 5, ch. 16, annex 1603, sec. D.1 & app. 1603.D.1 (entered into force Jan. 1, 1994)); U.S. CITIZEN & IMMIGRATION SERVS., DEP'T OF HOMELAND SECURITY, FREQUENTLY ASKED QUESTIONS: USCIS ANNOUNCES INCREASED PERIOD OF STAY FOR TRADE NAFTA PROFESSIONAL WORKERS FROM CANADA AND MEXICO (2008), available at http://www.uscis.gov/files/article/tn_nonimmigrant_changes_faq.pdf; Aiken et al., *supra* note 124, at 72.

259. KEVIN KENWARD ET AL., NAT'L COUNCIL OF STATE BDS. OF NURSING, 2006 NURSE LICENSEE VOLUME AND NCLEX EXAMINATION STATISTICS 33 (2008), available at [https://www.ncsbn.org/08_2006_LicExamRB_Vol31_21208_MW\(1\).pdf](https://www.ncsbn.org/08_2006_LicExamRB_Vol31_21208_MW(1).pdf).

260. *Id.* at 32.

261. See PHILIP MUSGROVE ET AL., WORLD HEALTH ORG., THE WORLD HEALTH REPORT 2000: HEALTH SYSTEMS: IMPROVING PERFORMANCE 152 annex tbl.1 (2000), available at http://www.who.int/whr/2000/en/whr00_en.pdf (ranking the health systems of the United States, Cuba, and Mexico as 37, 39, and 61, respectively).

262. Xu, *supra* note 127, at 273.

263. See, e.g., Ashish Chandra & William K. Willis, *Importing Nurses: Combating the Nursing Shortage in America*, 83 HOSP. TOPICS 33, 35 (2005).

264. See Aiken, *supra* note 136, at 1310–11. See generally MADELEINE LEININGER, *TRANS-CULTURAL NURSING: CONCEPTS, THEORIES, RESEARCH & PRACTICES* (2d ed. 1995) (hypothesizing that nurses have a culture unique to the profession).

Finally, foreign nurses bring diversity in the U.S. nursing workforce. Currently, 90% of nurses nationally are Caucasian and only 8% to 10% are foreign-educated.²⁶⁵ According to the Census Bureau, by the year 2042, minorities will make up a majority of the U.S. population.²⁶⁶ A greater number of foreign nurses would ensure that the health care system changes with the demographics of the country and alleviate shortages within specific minority groups.

IV. CHALLENGES ASSOCIATED WITH INCREASED NURSE MIGRATION TO THE UNITED STATES

One of the most significant challenges resulting from nurse migration is the simultaneous erosion of human resources in developing nations, especially Africa. For example, a 2003 *World Health Report* concluded that Botswana's ability to provide AIDS drug therapy was undermined by a health care worker shortage, not finances.²⁶⁷ The migration of health personnel from developing countries has been called the *brain drain*.²⁶⁸ It is so significant that the South African Nursing Council called upon the government to impose a tariff on the exportation of nurses.²⁶⁹ Africa has an average of 76 nurses per 100,000 people, with some countries such as Uganda having as few as 6 nurses per 100,000 people.²⁷⁰ By contrast, the United States has 773 nurses per 100,000 people.²⁷¹ In total, the World Health Organization estimates that fifty-seven countries have critical shortages of 2.4 million doctors, nurses, and midwives.²⁷²

The attrition of nurses due to migration is only part of the story. AIDS/HIV is also responsible. Because health care workers have direct contact with AIDS/HIV patients, they risk contracting the virus.²⁷³ In Malawi, deaths from AIDS/HIV accounted for 43% of all nurse loss.²⁷⁴ Further, AIDS/HIV also increases the demand for nursing. It is estimated that the virus increased the need for nurses

265. Aiken, *supra* note 136, at 1300, 1310 & tbl.5.

266. Press Release, U.S. Census Bureau, U.S. Dep't of Commerce, An Older and More Diverse Nation by Midcentury (Aug. 14, 2008), available at <http://www.census.gov/Press-Release/www/releases/archives/population/012496.html>.

267. ROBERT BEAGLEHOLE ET AL., WORLD HEALTH ORG., THE WORLD HEALTH REPORT 2003: SHAPING THE FUTURE 110 (2003), available at http://www.who.int/whr/2003/en/whr03_en.pdf.

268. Chandra & Willis, *supra* note 263, at 35; Maria Merritt, *Bioethics, Philosophy, and Global Health*, 7 YALE J. HEALTH POL'Y L. & ETHICS 273, 299-300 (2007).

269. Brush et al., *supra* note 115, at 82.

270. JAMES BUCHAN & LYNN CALMAN, INT'L COUNCIL OF NURSES, THE GLOBAL SHORTAGE OF REGISTERED NURSES: AN OVERVIEW OF ISSUES AND ACTIONS 14 tbl.1 (2004), available at <http://www.icn.ch/global/shortage.pdf>.

271. *Id.* at 19.

272. LINCOLN CHEN ET AL., WORLD HEALTH ORG., THE WORLD HEALTH REPORT 2006: WORKING TOGETHER FOR HEALTH, at xvii (2006), available at http://www.who.int/whr/2006/whr06_en.pdf.

273. Martha Mondawi & Yvonne Hauck, *Malawian Midwives' Perceptions of Occupational Risk for HIV Infection*, 28 HEALTH CARE FOR WOMEN INT'L 209, 211 (2007).

274. BUCHAN & CALMAN, INT'L COUNCIL OF NURSES, *supra* note 270, at 24.

between 40% and 45% in South Africa between 2002 and 2007.²⁷⁵ With epidemics demanding more health care workers and losses due to increased migration, African countries are ill-equipped to provide proper care for their people.

Stemming from Nelson Mandela's pleas in 1997, the United Kingdom banned nurse recruitment from some countries.²⁷⁶ For example, the United Kingdom no longer receives nurses from Jamaica, a nation that has lost most of its nursing graduates to migration.²⁷⁷ Short of a ban, the United Kingdom and other European organizations have adopted ethical guidelines for nurse recruitment.²⁷⁸ Employers are voluntarily asked not to look to nurses from countries experiencing shortages.²⁷⁹ The World Health Organization has also convened a group—the Health Worker Migration Policy Initiative—that will adopt an International Code of Practice on Health Worker Migration with similar provisions.²⁸⁰

Global justice concerns require the creation of responsible policies that better regulate nurse migration.²⁸¹ If the United States were to expand the numbers of immigrant nurses yearly, it should be as equally responsible. Congress should require that hospitals adopt ethical rules for international nurse recruitment. The expansion of foreign nurses programs must be followed by the creation of community-specific strategies for ethical recruitment and retention of the foreign nurses. This would ensure the United States does not undermine efforts to combat AIDS/HIV and curb possible abuses associated with migration. However, it is unlikely that new recruits will be from African nations. India, the Philippines, and

275. *Id.*

276. KINGMA, *supra* note 83, at 126–27.

277. Shannon Peoples, *The Current Nursing Shortage: Will the Registered Nurse Safe Staffing Act Help?*, 72 UMKC L. REV. 809, 812 (2004); see Dagmare Scalise et al., *Global Health Report: A Snapshot of the Payer Systems, Major Diseases and Workforce Trends from Around the World*, 77 HOSP. & HEALTH NETWORKS 52, 63 (2003) (reporting that 95% of Jamaica's nurses who graduated between 1978 and 1985 left the country).

278. See U.K. DEP'T OF HEALTH, GUIDANCE ON INTERNATIONAL NURSING RECRUITMENT 11 (1999), available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4034794.pdf (“It is essential that all NHS employers ensure that they do not actively recruit from developing countries who are experiencing nursing shortages of their own.”); EUR. FED’N OF NURSES ASS’NS, EFN GOOD PRACTICE GUIDANCE FOR INTERNATIONAL NURSE RECRUITMENT, at 1, 4–5, <http://www.efnweb.org/version1/en/documents/EFNGoodPracticeGuidanceforRecruitment.doc> (last visited Nov. 24, 2009) (identifying a list of ethical guidelines for employers to use that recommend recruitment from EU nations first and only after consulting with local nurse organizations).

279. U.K. DEP'T OF HEALTH, *supra* note 278, at 11; EUR. FED’N OF NURSES ASS’NS, *supra* note 278, at 3; Tim Martineau & Annie Willetts, *The Health Workforce: Managing the Crisis Ethical International Recruitment of Health Professionals: Will Codes of Practice Protect Developing Country Health Systems?*, 75 HEALTH POL’Y 358, 359 (2006).

280. See generally Press Release, World Health Org., New Initiative Seeks Practical Solutions to Tackle Health Worker Migration (May 15, 2007), available at <http://www.who.int/mediacentre/news/notes/2007/np23/en/index.html> (describing the Health Worker Migration Policy Initiative priorities).

281. Lawrence O. Gostin, *The International Migration and Recruitment of Nurses: Human Rights and Global Justice*, 299 JAMA 1827, 1828–29 (2008).

South Korea have a higher number of nurses taking the NCLEX-RN examination.²⁸² Further, of the 267 U.S.-based recruitment firms, only forty have operations in shortage countries in Africa, Latin America, and the Caribbean.²⁸³ Consequently, India, the Philippines, and South Korea would be more likely to send nurses to the United States.

Furthermore, existing international outreach efforts should be expanded. The American International Health Alliance, a non-profit operating with funding from the U.S. Agency for International Development (USAID), created the Nursing Quality Improvement Initiative.²⁸⁴ This program pairs Magnet hospitals in the United States with hospitals in Russia and Armenia to replicate Magnet's best practices in these countries.²⁸⁵ During a three year period, nurse and manager exchanges have resulted in higher patient satisfaction and less adverse patient outcomes.²⁸⁶ In addition, international cooperation among nursing schools is already occurring. Johns Hopkins University has partnered with Peking Union Medical College School of Nursing on a joint program,²⁸⁷ graduating eight nurses with doctorate degrees.²⁸⁸ Vanderbilt University is also assisting in the creation of nurse education efforts in Katmandu, Nepal.²⁸⁹ The Nepalese benefit through receiving NCLEX-RN instruction and better professional standards in their country.²⁹⁰ Vanderbilt University gains by retaining some of these nurses.²⁹¹ Because efforts to improve health care worldwide are already underway, Congress should follow and appropriate additional funds, allowing for expansion.

282. Press Release, Nat'l Council of State Bds. of Nursing, Quarterly Examination Statistics: Volume, Pass Rates & First-Time Internationally Educated Candidates' Countries (2008), *available at* [https://www.ncsbn.org/NCLEX_Stats_2008_Q2\(1\).pdf](https://www.ncsbn.org/NCLEX_Stats_2008_Q2(1).pdf).

283. PATRICIA PITTMAN ET AL., U.S.-BASED INTERNATIONAL NURSE RECRUITMENT: STRUCTURE AND PRACTICES OF A BURGEONING INDUSTRY 4, 19 (2007), *available at* <http://www.fairinternationalrecruitment.org/AHReport.pdf>.

284. JUDITH T. FULLERTON, TECHNICAL REPORT: TECHNICAL ASSISTANCE FOR IMPROVING REPRODUCTIVE HEALTH/MATERNAL AND CHILD HEALTH EDUCATION IN RURAL MEDICAL COLLEGES 15 (2005), *available at* http://www.nova.am/Publications/Technical%20Assistance%20for%20Improving%20Reproductive%20Health,%20Maternal%20and%20Child%20Health%20Education%20in%20Rural%20Medical%20Colleges,%20October%202005_eng.pdf.

285. Am. Int'l Health Alliance, Nursing Quality Improvement Initiative, http://www.aiha.com/en/WhatWeDo/Nursing_NQII.asp (last visited Nov. 24, 2009).

286. Aiken, *supra* note 136, at 1317.

287. Chandra & Willis, *supra* note 263, at 35; Tom Waldron, *Global Positioning*, JOHNS HOPKINS NURSING, Spring 2004, at 28, 30.

288. *Doctoral Students Graduate from JHU/PUMC Nursing Program*, JHU GAZETTE, Aug. 18, 2008, at 2, *available at* <http://www.jhu.edu/~gazette/2008/18aug08/18briefs.html>.

289. Chandra & Willis, *supra* note 263, at 35.

290. *See id.*

291. *Id.*

CONCLUSION

While increasing pay, supplementing educational investment, and mandating better hospital staffing are all part of a solution, limitations on each approach require foreign nurse inclusion as part of a comprehensive plan. However, policies still reflect outdated needs and old immigrant stereotypes. Such thinking must give way to a new perspective, where highly mobile professionals are embraced, even if temporarily. The failure to create legal mechanisms to capture the world's most talented minds leaves the United States less healthy and financially worse off. Current data shows the H-1C program is not widely used. The Emergency Nurse Supply Relief Act is a good start toward its expansion. By utilizing finances from H-1C visas for domestic investment, the program provides a compromise for those reluctant to support an increased number of foreign nurses. This model may also be applied to the H-1B program, where schools seeking to encourage native students to become the next generation of teachers or engineers would benefit from more funding. However, even if the H-1C program expires, other approaches, including expanded use of EB-3 visas should be explored.

The movement of workers across the globe is a modern reality.²⁹² Today's foreign nurse grows up in Botswana, receives a Johns Hopkins University degree in the United States, and teleconferences with a doctor in the United Kingdom on a matter for a medical tourist from Canada. The story of this century will be characterized by interdependence and working cooperatively for mutual gain. Whether the challenge is solving the climate crisis or protecting people from terrorism, global problems require global solutions. Immigration and health care are no exception. The fate of millions of older Americans will be tied to our ability to train, recruit, and keep a skilled health care workforce. In 1893, nurse pioneer Florence Nightingale said, "health is not only to be well—but to use well—every power we have."²⁹³ Our strategy for international nurse recruitment should dare to do no less. And by joining with our global neighbors, we will prevent the tragedies like that of Kimberlyn Holt and the countless other American patients who have suffered the lethal, ill effects of the nursing crisis.

292. Lisa Leiman, *Should the Brain Drain Be Plugged? A Behavioral Economics Approach*, 39 TEX. INT'L L.J. 675, 675 (2004); Oliver, *supra* note 140, at 125; see, e.g., Karen E. Bravo, *Free Labor! A Labor Liberalization Solution to Modern Trafficking in Humans*, 18 TRANS. L & CONTEMP. PROBS. 545, 549–50 (2009).

293. Florence Nightingale, *Hospitals*, in 5 CHAMBERS'S ENCYCLOPAEDIA: A DICTIONARY OF UNIVERSAL KNOWLEDGE 805, 806 (1901).