Juanita Hunter, RN & NYSNA Papers [1973-1990]

1988

**RCT; Series I; File 179**

Juanita Hunter

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November 9, 1988

Karen O'Connor, Director
Nursing Practice Programs and Council Services
ANA
2420 Pershing Road
Kansas City, MO 64108

Dear Karen:

Enclosed is the information from Calvary Hospital. The professional nursing input is very clear in the Cancer Care Technician job description; it is less clear in the Procedure Checklist.

However, a follow-up telephone conversation with Ms. Fleming confirms the institution's non-support of the RCT movement. She informed me that the hospital's administration did not agree to be studied and that Dr. Chauvigny's visit should not be characterized as a study. Calvary Hospital has communicated its anger regarding the AMA news article to the American Medical Association. They are sending a letter to AMA stating that they will not support RCTs and requesting that their letter be printed in the "Letters to the Editor" section of the American Medical News.

In addition, Ms. Fleming stated that Calvary Hospital will be sending a copy of their AMA letter with a transmittal letter explaining Calvary's position to all major nursing organizations. She has promised to send me copies of these communications.

It would seem important to give Calvary's disavowal as much publicity as AMA's article. Ms. Fleming commented that she had met with Lucille Joel at the MARNA conference and that she personally felt very supported by organized nursing in responding to this situation.
I will keep you informed of any additional activities with regard to this situation.

Sincerely,

Karen A. Ballard, MA, RN
Director
Nursing Practice and Services Program

KAB/kac
Enclosures

cc: Juanita K. Hunter, President
    NYSNA

    Martha L. Orr, Executive Director
    NYSNA
Karen A. Ballard, MA, RN
Director
Nursing Practice and Services Program
New York State Nurses Association
2113 Western Avenue
Guilderland, New York 12084

Dear Ms. Ballard,

Enclosed is the information you requested about our Cancer Care Technician position and some additional information. I thought this might be helpful to you in understanding our utilization of paraprofessional staff. I appreciate your interest and support and will certainly keep you informed of any developments.

Please do not hesitate to call me with any questions or comments.

Sincerely,

Cornelia Fleming, RN
Assistant Administrator/
Director of Nursing Services

Enclosure

DEPARTMENT: Nursing Services

TITLE: CANCER CARE TECHNICIAN

OBJECTIVE: Assists the professional nursing staff by performing paraprofessional and technical nursing functions, which meet the physiological, safety, spiritual and psychosocial needs of the patients and their families; and meets the environmental needs of the unit.

PATIENT CARE RESPONSIBILITIES:

1. Gdves direct patient care and performs indirect patient care activities, under the direction of a professional nurse.

2. Communicates observations of patients' status to professional nurse.

3. Confers with members of the nursing staff regarding patient care plan.

4. Assists other staff members in providing patient care.

5. Explains paraprofessional procedures to patients and families, when appropriate.

6. Meets, or refers to a professional nurse, family needs, when appropriate.

7. Performs related duties, when assigned.

TEAM RESPONSIBILITIES:

1. Interacts, in a supportive manner, with co-workers for the welfare of the patient/unit/department/hospital.

2. Adheres to unit/department/hospital policies and procedures.

3. Participates in meetings of staff and department meetings.


5. Informs other team members of patients' progress.

6. Shares acquired knowledge and learning.

Approval of Department Head

Approval of Administration

Reviewed by Employment Manager
Support/Maintenance Responsibilities:

1. Takes appropriate action to maintain a safe and aesthetic
   patient care environment.
2. Participates in a program of continuous professional growth.
3. Maintains effective and efficient use of equipment and
   supplies.
4. Completes appropriate department forms, which monitor
   patient progress.

EDUCATION AND EXPERIENCE:

1. High school diploma or GED is required.
2. Successful completion of the Cancer Care Technician
   program.

REVISION DATE: 

1/77

PROGRESS:

1. Successful completion of the Cancer Care Technician
   program.
2. Takes appropriate action to maintain a safe and aesthetic
   patient care environment.
3. Participates in a program of continuous professional growth.
4. Completes appropriate department forms, which monitor
   patient progress.
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# PROCEDURE CHECKLIST

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Refers to assistance to X.

Assigned as per position & stage of pressure sore.
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Nursing Services

Title: Patient Assignments

1. Providing quality health care to every patient in the hospital is the concern and philosophy of the Nursing Services Department.

2. Patient care assignments are made out daily on each tour of duty, and assigned to the nursing personnel based on the following:

a. The patient's acuity level (Patient Classification).
   b. Census.
   c. Total staff available.
   d. Infection Control practices.
   e. The abilities, qualifications, and experience of the personnel on the unit:
      (1) Registered Nurse
      (2) Licensed Practical Nurse
      (3) Cancer Care Technician
      (4) Nurse Aide

3. Personnel Assignment
   a. Registered Nurse
      The Registered Professional Nurse is responsible for the total care of all categories of all patients based on the Nurse Practice Act. Her responsibilities include:
      (1) Assessment and nursing diagnosis of patient's health status.
      (2) Planning nursing care regime based on medical management and physical, psychological, social, spiritual, and educational needs of patient and family.
      (3) Implementing nursing actions and goals: coordinating activities of other health disciplines.
      (4) Evaluating and re-evaluating the patient's response to treatment, and makes adjustments, changes, and modifications to assist the patient in achieving the expected outcome.

   b. Licensed Practical Nurse
      The Licensed Practical Nurse works directly under the supervision of the Professional Nurse. Her assignment is based on her preparation, experience, abilities, and job description. He/she will follow the Nursing Care Plan implemented and contribute observations noted while caring for the patients.

Date: 5/80
Signed by: [Signature]
Amended: 7/81 - 5/85 - 1/88
Issued: 1/81 - 12/83 - 5/88
Primarily Affected: NURSING
c. Cancer Care Technician

The Cancer Care Technician works directly under the supervision of the Professional Nurse. He/she performs all skills defined in the job description and the inservice training program.

d. Nurse Aide

The Nurse Aide works directly under the supervision of the Professional Nurse. The Nurse Aide is assigned to perform basic nursing skills. These skills are based on the job description and the inservice training program.

4. The Assignment must be posted on the unit. Meal time, break time, and classes must be noted on the Assignment Sheet.
November 10, 1988

Karen A. Ballard, MA, RN
Director, Nursing Practice and Services Program
New York State Nurses Association
2133 Western Avenue
Guilderland, New York 12084

Dear Ms. Ballard,

Attached for your review is a copy of an article recently published in the American Medical Association Medical Newsletter and Calvary Hospital's response. I believe it is important that the misinformation be corrected. We are opposed to the RCT concept and do not wish to be associated with it in any way.

If you have any questions or comments about the article or our position, please do not hesitate to contact me. I can be reached at (212) 518-2269.

Sincerely,

Charles Fleming, RN
Cornelia Fleming, RN
Assistant Administrator/ Director of Nursing Services

CF: SKH
Attachment

AMA moves ahead with RCT pilot plans

AMA moves ahead with RCT pilot plans

AMA officials have warned that RCTs might eventually become 'gadgets for hospital patients,' they are prepared to ignore RCTs' declining interest in simple task-oriented care and to fund their research over RCTs.

The American Hospital Association, which represents more than 5,000 hospitals, has announced plans to fund RCTs that evaluate the effectiveness of new treatments and procedures. This move is in response to a growing interest in RCTs among hospital administrators and physicians.

AMA officials have said that RCTs will be required to evaluate new treatments and procedures in order to receive funding from the Association. The AMA believes that RCTs are the only way to accurately assess the effectiveness of new treatments and procedures, and that RCTs are the most effective way to evaluate new treatments and procedures.

AMA officials have also said that RCTs will be required to evaluate new treatments and procedures in order to receive funding from the Association. The AMA believes that RCTs are the only way to accurately assess the effectiveness of new treatments and procedures, and that RCTs are the most effective way to evaluate new treatments and procedures.

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M. Roy Schwartz, M.D.
Asst. Executive Vice President
Medical Education and Science
American Medical Association
525 North Dearborn
Chicago, Illinois 60610

Dear Dr. Schwartz:

This letter will serve as a restatement of Calvary Hospital's position on the RCT program along with a response to the article "AMA Moves Ahead with RCT Pilot Plans" by Leigh Page in the October 21, 1988 issue of the American Medical News.

As you recall, the administrative, nursing and medical leadership of Calvary Hospital disagree with the RCT plan developed by your organization. We feel that the patient care crisis in this country could be addressed in other ways. However, prior to your board making a policy decision, in a spirit of academic and professional responsibility, we invited you to look at an alternative to the RCT program that developed as part of the nursing program at Calvary Hospital. As you recall, Calvary Hospital employs modified primary nursing with a major Cancer Care Technician supplement. It is in that context we offered our input, not as a vehicle to help create RCT's.

In so far as your October 21, 1988 article, there are some inferences and items of mis-information which I would like to correct.

1. As stated above, we offered a review of our program as an alternative to RCT's not as a facilitator for their creation; also, we had not agreed to be a pilot project.

2. Despite the inference, no nursing, medical or administrative staff of Calvary Hospital would "welcome RCT's".

Continued...
M. Roy Schwartz, M.D.
November 4, 1988
Page 2

3. The article states "...an RN or LPN decides which procedures can be delegated to the hospital's basic caregiver called a technician..." In fact, the Cancer Care Technician has a specific job description. Nursing policies and procedures clearly define which procedures may be performed by a technician under the supervision of the nurse; also, LPN's do not assess care at Calvary. There is a JCAHO standard that states that only R.N.'s may assess care. The ratio of technicians to professional nurses is 2:1.

I hope this clarifies our position and the facts in this matter. I would appreciate it if you would publish this letter in your next newsletter.

Sincerely,

[Signature]

Frank A. Calamari
Executive Director

FAC:gh

cc: Katherine Chavigny, RN, MSN, Ph.D, FACE
    American Medical Association

    Dick Wall, Editor
    American Medical News
The New York State Nurses Association (NYSNA) recognizes that the current nursing shortage is serious, and concurs with its colleagues in medicine that this shortage of prepared bedside caregivers is jeopardizing the quality of health care.

Unfortunately, the American Medical Association's recent proposal to create a new category of health care worker, the Registered Care Technologist (RCT), will not solve the problem. It will only blur lines of responsibility, create unnecessary confusion and lead to a serious fragmentation of patient care.

Unfounded Assumptions

Underlying the AMA proposal is the assumption that professional nurses, particularly better-educated RNs, are leaving bedside care. That is a myth. Approximately 80% of all licensed RNs are currently in the labor force, a high percentage for a predominately female profession; and some 65% of hospital staff nurses hold community college, baccalaureate or more advanced degrees, the highest percentage in nursing's history.

The current shortage of RNs has not been caused by nurses fleeing the bedside, but by a dramatically increased demand for RNs who have proven to be skillful and versatile caregivers. Between 1972 and 1986, the number of RNs employed in hospitals per 100 patients rose from 50 to 95, and the full-time employment of nurses in hospitals is up more than 200,000 since 1977.

Improper Use of RNs

Since RNs are the ideal bedside caregivers, it is essential to make them available at the bedside by reducing the time RNs spend on tasks that could be performed by less expensive assistive personnel. For example, RN work measurement studies conducted by Ernst and Whinney found that between 10-40% of an individual RN's working hours are spent:

* answering telephones and delivering messages,
* arranging for housekeeping services and transportation of patients,
* filling out order forms for tests and supplies,
* assembling charts,
* arranging for supplies and completing patient charge forms.
To a large extent, misguided cost containment efforts have resulted in this wasteful substitution of versatile RNs for ancillary personnel.

Dangers of Unqualified Personnel

The RCT training outlined by the AMA will not prepare personnel to perform the tasks essential to bedside nursing, especially in this time of increasingly complex medical interventions and technology. An 18 month curriculum simply cannot develop the range of skills required for today’s intensive care nursing or the knowledge and judgment needed to make split-second decisions in life and death situations. There are also serious questions about the supervision of RCTs. The AMA claims they would be under physician supervision, but physicians are at the bedside only for brief periods of time. This would leave RCTs essentially unsupervised and in a questionable relationship with licensed registered nurses who are fully qualified to provide round the clock patient care.

A More Realistic Solution

The New York State Nurses Association is hopeful that our colleagues in medicine who share our commitment to quality patient care will reject the ill-advised RCT proposal and join the nursing profession in implementing more practical solutions to the current shortage, ones that will ensure the safety of patients entrusted to our care. For example:

* Increase the time that professional nurses spend with patients by expanding the use of ancillary personnel, and of technology to support patient care, e.g., computerized charting and data display.

* Promote the retention of experienced professional nurses by improving salaries and benefits, incentives for night, weekend, and full-time work, and for career commitment to clinical practice at the bedside.

* Provide nursing executives and administrators with the authority and resources needed to improve the work environment.

* Support funding for broad-based nursing education at the federal, state and local levels.

* Enhance nursing recruitment and retention by promoting the image of nurses as essential caregiving professionals.

The nursing profession's tradition of caring is historic and unique. Give nurses the tools to nurse and we will. Health care does not need a new provider, just the resources for the current bedside caregiver - the NURSE - to do what we do best.
An Open Letter

TO:
WILLIAM A. COOPER, M.D., Chairman, The Sub-Committee on Nursing Problems for the Medical Society of the County of New York

FROM:
R. LOUISE McMANUS, Head, Department of Nursing Education, Teachers College, Columbia University

SUBJECT:
The Sub-Committee’s Report on “Nursing Care for Patients—Dilemma 1959”
AN OPEN LETTER

The recent report on "Nursing Care for Patients—Dilemma 1959", prepared by the Sub-Committee on Nursing Problems of the Medical Society of the County of New York, is cause for concern among nurses.

It may well bring consternation to the public, which has increasing need for more and better health services, and to those physicians who weigh how seriously an acceptance of the Sub-Committee's recommendations—or even views—could hamper their own efforts to provide modern medical care to the American people.

The reason for dismay is that the Sub-Committee—in effect, whether or not by intent—would turn the nursing clock back a quarter of a century or more. They take no account of the changes which the march of medical science requires in nursing if patients are to be cared for safely. They make no effort to appraise the expanded roles of many nurses—and the additional education required to play them—that have resulted from the growth of hospitals and health services, and from the delegation by overworked physicians of more and more of their own responsibilities (and increasingly complex technical tasks they are) to the nursing staff.

The growing proportion of responsibility for modern patient care which nurses are carrying may be arresting suggested by the relative growth of the medical and nursing professions. Thus since 1930 the number of physicians for 100,000 people in the United States has increased only from 125 to 133.1 During the same period the number of active professional nurses per 100,000 population rose from 174 to 269.2 The relative growth of nurse totals before 1930 was even more striking, for in 1910—before the closing of many substandard medical schools—there were 149 physicians for every 100,000 people and only 89 nurses.3

The recent report of the Surgeon General's Consultant Group on Medical Education points out that "The growth of the allied health professions has had profound effects on the patterns and availability of medical care. In 1900, for every physician in practice there was one other professional health practitioner; today there are four such persons for every physician."

Two of these four are nurses, for the estimated 460,000 registered nurses active in 19584 were almost twice the estimated physicians. This it becomes clear that nurses have been carrying much of the expansion load as modern health care has developed. And the extension in kinds and quality of services nurses render has been more impressive than the dramatic quantity growth. This fact has profound implications for nursing education.

What lies ahead?

The Surgeon General's Consultant Group point out that a sharp rise in physician supply is required even to maintain today's ratio of physicians for a rapidly growing population. Even should this rise be realized—despite

3 Building America's Health, report of the President's Commission on the Health Needs of the Nation, pp. 115 and 164.
4 Physicians for a Growing America, op. cit., p. 65.
5 Facts About Nursing, op. cit., p. 2.
the history of recent decades—will not a better educated people, with higher incomes and more health insurance to meet the bills, continue to ask an increasing share of the greater benefits that an expanding medical science will presumably be able to offer? Who will take up the slack if not nurses?

When the physician prescribes a special medication or leaves a "prn" order for a surgery patient whose slightest reaction may be a danger signal, does not he want the watch kept by nurses best prepared to make discriminating observations and to exercise sound judgment?

Look at the situation from another angle. Demands for nursing care—the important minimums nurses plan and give quite independently of medical authority—will increase with population growth and increase in the complexity of medical care. In fact, present trends in health care, such as increasing stress upon the patient's participation in his own plan of therapy and on teaching for health preservation, suggest that we may see a greater proportional rise in demands for nursing care per se than for the purely medical measures that are the physician's province. Certainly the public clamor today is not for bigger and better operations, but for more handlings—more of the personal attention and more support for which people have turned, with the passing of the horse and buggy doctor, to nurses.

Yet if nurses go on indefinitely accepting responsibility for giving more and more of the time-consuming medical treatments that physicians—admittedly hand-pressed—are seeking to hand them, can nurses alone be held responsible for inadequacies in the services for which they are primarily responsible?

QUESTIONS OF NATIONAL IMPORT

The import for the well-being of the entire nation in such questions lends more than local significance to the report of the Medical Society's Sub-Committee. Nurses wholeheartedly agree with the Sub-Committee that, "The time for greater insight and understanding of the nursing problem among physicians and the public is overdue." It is gratifying, therefore, to find an important Medical Society seeking to inform its members about nursing.

Nurses also agree with the recommendation that all interested groups should work together toward helpful solutions of the nursing problem. Yet it is not clear how the Sub-Committee propose to win the desired cooperation.

Moreover, certain basic misapprehensions make the report's usefulness questionable. As the pioneer center of graduate education for nursing and the training ground for many of the nation's teachers and other leaders of nursing, the Department of Nursing Education of Teachers College, Columbia University, cannot shirk its responsibilities in the matter.

I have, therefore, asked comments on the report from the Department's teaching staff and certain advanced students who are also experienced nurses, and what is said here represents the thinking of a number of persons.

It is regrettable that the report does not explain why the Sub-Committee undertook to recommend a sweeping reorganization of another profession's educational system without consultation (at least none that has been credited to the title page) from either nursing or general education. How to meet the rapidly mounting demands for nursing services is a national problem of sufficient import to justify seeking the best possible first-hand information, step that might surely have been expected in a foundation-supported effort such as the Medical Society's report.

Unless the Sub-Committee can cite nursing and education consultants, such phrases in the report as, "Everyone who has thought about this problem agrees..." may well elevate eyebrows. For it would seem that the thinking of those who have done the most of it on these complex problems—nurses themselves—is not reflected at all.

The lack of either specific documentation creates great difficulty in differentiating between parts, to which anyone is entitled, and purported fact, and makes dealing with the report not unlike trolling for minnows. A line-by-line analysis of the errors in fact and the fallacies upon which statements are based would become tedious, but a few major misapprehensions reflected in the brief of the report should be indicated before the Sub-Committee's recommendations are considered.

MUCH HAS BEEN DONE

First, the Sub-Committee's view that in nursing "so much has been said and so little accomplished" (italics ours) "that the doctors were discouraged and resigned to let come what may" calls for examination.

Though nursing as it is known today is a relatively new field, the estimated 460,000 registered nurses now active in the United States are more than nine times the number available half a century ago. Besides being about twice the total of physicians, as noted earlier, nurses are nearly five times as numerous as dentists, and many, many more than are found in any of the growing lists of health therapist and technician specialty groups.

This increase in numbers of nurses has been achieved during years when drastic and continuing changes in medical treatment of patients, the extension of health services of all types, growth of hospitals, and increase in numbers of auxiliaries whom professional nurses must supervise, have expanded the functions of some nurses almost beyond recognition.

Alice Blake, M.D., director of the Grace-New Haven Hospital and past president of the American Hospital Association, has stated the dilemma of nursing thus: "Doctors have complained that nurses are doing too much paper work and are being educated too highly for their jobs. Doctors and other scientists have made the nurses' job more complex by decreasing patient stay, increasing patient turnover, developing new and complicated procedures, and then expecting the nurses to absorb them and take them in their stride. Doctors and hospitals have made hospital care more active and complex, and are requiring nurses to be skilled technicians and expert team leaders, not only as bedside angels..."

It is, therefore, no longer adequate to say—that the Sub-Committee do—that the nursing situation can be summed up in a word—shortage.

Nursing is deeply concerned with improving its services to keep pace with advances in the social, natural, and medical sciences upon which both nursing practice and medical practice are based. Inevitably, therefore, nursing is concerned with the growing encroachments upon time available for the nursing care functions that are independent of medical authority by the one dependent function—the giving of treatments prescribed by the physician that he himself once gave. Too frequently pressure to perform medical tasks has forced nurses to turn over to inadequately prepared auxiliaries the ministrations that are the heart of nursing care—to the dissatisfaction, too frequently, of doctors as well as patients and nurses.

Too seldom do nurses question the doctors' orders as did the director of nursing in a well-known Boston hospital recently. Next morning after a..."
meeting of the hospital's medical staff (no nurses were present) she was
told (not asked—told) that it had been decided nurses were to serve as
surgeon's assistants in the operating room to permit interns more freedom
to secure the varied experience they sought. "But the nursing service is
already short-staffed," this director said. "We can spare no nurse capable of
filling that post. Why not train a medical technician for it?" Her sugges-
tion was followed, with satisfactory results.
Nurses sincerely hoped that—so the Sub-Committee say—"the public will
not indefinitely tolerate policies that deny it needed nursing care" but surely
we must consider all policies that may be culpable.
It is time now for physicians and public—and more nurses themselves—to
examine dispassionately the evidence that until there is better management
of medical as well as nursing services, more effective utilization and assimila-
tion of available nursing skills, better teaching and assimilation of new ma-
terials into current medical and clearer differentiation among kinds of nurses and the
services each type is prepared to give safely and well, the mere multiplication
of hands and feet can go on indefinitely without assuring good present-day
nursing of patients. The meanings for nursing education of such evidence
should be clear.

THAT "FINEST NURSING" OF THE 1930'S

Though the Sub-Committee take brief note of the problems that have
"been the result of social and economic changes quite beyond the control
of nursing, of indeed any segment of society," too often they seem oblivious to
those changes.
This attitude is aptly illustrated by the nostalgia, expressed twice, for
the "finest nursing care" of the 1930's.

One is tempted to ask, "Finest for whom?" As America sank into the
depths of depression, few of the ill could afford to pay for the private
duty nursing in which some 75 per cent of all registered nurses had been
employed.4 Students had, up to those years, provided most of the nursing
services in the hospitals with schools.

4 Brown, Esther Lucile, Nursing As a Profession, Russell Sage Foundation, New York,
1940, pp. 89-94, describes the situation thus:
"Although the number of graduate nurses increased with great rapidity after 1880
such an expansion of hospital building began with the second decade of the twentieth
century that it created an urgent demand for more nursing service. Inasmuch as the
new hospitals wished to operate as inexpensively as possible, they continued the custom
of opening schools of nursing in order to benefit from the assistance of students. . . .
Few of them weighed the advisability of utilizing graduate nurses or paid attendants;
instead the precedent of admitting to training vast numbers of unqual-
ified women was maintained.

Between 1914 and 1919 the only field which was reasonably well supplied was that
of private duty, which probably contained some 75 per cent of the graduate nurses.
In addition to Red Cross detachments that had already been sent to Europe, the
United States Army and Navy called in 1917 for 10,000 and later for 30,000 graduate
nurses. In the meantime the volume of work in hospitals and public health organiza-
tions at home increased rather than diminished. As a result of these demands, the number
of young women entering nursing schools was increased in 1917-18 and 1918 by about
4 per cent over the immediately preceding years.

With the conclusion of the war and the passing of the epidemic of influenza, there
was no longer an inadequate supply of nurses. Nevertheless, until about 1930, great
numbers of women continued to pour into the schools, and went out after the completion
of training to attempt to find work. Numbers increased with such rapidity that the
federal census in 1930 showed over 294,000 graduate and student nurses, or nearly
twice the number in 1920. In 1928, 361 nursing registers filed returns with the
Committee on the Grading of Nursing Schools. The majority stated very definitely
there were too many nurses. Three hundred and twenty-five did not want any more

With increasing numbers of nurses facing starvation, these hospitals made
places for as many of their graduates as they could, not because of a recog-
nized need for the services of registered nurses but for charitable reasons,
to keep them out of the breadlines.

A hospital in a nearby state where the writer was doing university extension
training teaching in the 30's, was among those that, during the great depression,
"employed" its first graduate nurses. Except for room and board, at first
these registered nurses received no payment whatever or at best the small
stipend paid to students. This practice probably typified what went on all
over the country.

Was nursing fine in the 1930's for the thousands of patients who, unable
longer to afford it, had to forego nursing entirely? Would the Medical
Society's Sub-Committee, who in another chapter concede that "most agree"
recent nurse salary increases were necessary, seriously suggest returning
nurses to the subsistence levels and consequent insecurity and self-deprecation
of the 1930's?—Might not the whole economy suffer?—to say nothing of
discouraging recruitment and diverting a much higher percentage of nurses
than now are diverted into other fields?
Economics aside, would the nursing of the 1930's be thought "fine" today?
The nurse of the '30's, who typically gave all care to perhaps four patients
receiving relatively few treatments, would be completely at a loss in today's
ward where one professional nurse, with several auxiliaries to aid her, must
care for 20 or 30 patients, each requiring many more treatments and medica-
tions than a typical patient received two or three decades ago.

For again let me point out that professional nurses now are expected to do
and understand many things that their counterparts of 25 years ago either never
heard of (because nobody had) or considered the physician's prerogative.

Yet the new technical skills are easy to acquire compared with the ability
to exercise the judgments incident to use of these skills. A nurse must have
psychological and physiological insights of considerable depth to observe and
report patient reactions adequately to the doctor who so seldom now can
stay long by the bedside, or to take emergency action as required.

Recognition that the patient's mental and emotional attitudes may do as
much as medications to cure or kill: the "positive health" component in
all patient care and the lack of a firm dividing line between physician and
nurse responsibility for the teaching of health practices; the new difficulties
in "ambulatory" patient care—all these and many more factors would con-
found those "finest" nurses of the dear, dead '30's and, whether or not doc-
tors (or even nurses) are aware of it or like it, are forcing a revolution in
nursing education comparable in sweep to the changes that took place in
medical education after publication of the now famous Flexner report in
1910.5

The Sub-Committee concede that teachers of nursing need something
more than a three-year basic hospital training (though more about that when
recommendations are discussed). They fail to note the administrative impli-
cations for nurses in the great growth of hospitals and other health organiza-
tions, and the fact that the very march of medicine makes constant teaching and
nurses to move to their cities. . . . Although the number of nurses completing training
decreased appreciably throughout the country between 1930 and 1935, the ability
of patients to pay for nursing service declined even more rapidly, as the result of the
economic situation. Consequently many nurses continued to find themselves unable
to earn a living and some were obliged to resort to work relief.

5 Flexner, Abraham, Medical Education in the United States and Canada, a Report
to the Carnegie Foundation for the Advancement of Teaching, 1910.
retraining of all nursing personnel, regardless of original preparation, a necessity if patients are to be cared for safely.

THE TWO-YEAR NURSING SCHOOL AND NEW YORK STATE

Because the Medical Society's report was occasioned by the recent New York State study, which among many other things recommends encouraging two-year community colleges to develop and offer nursing education programs, it will be well to look with some care at several misapprehensions in the Sub-Committee's document about both the state study and the new two-year "associate degree" program.

Among multiple errors in their second paragraph the Sub-Committee implies direct, drastic action that is impossible by saying: "Briefly, it" (the state nursing study) "recommends that the State of New York establish two-year academic nursing schools in state junior colleges, and scholarships of $500 per year per student in such schools." The University of the State of New York, which sponsored the study, has power "to promote and encourage" (italics ours) "the extension and improvement of educational facilities and techniques throughout the state." The Nurse Resources study, therefore, merely recommends -- as one of a series of recommendations about different types of nursing schools -- that "every competent, degree-granting, two-year postservice institution in the State should be encouraged to explore the desirability and possibility of offering a two-year, associate degree, professional nurse program."

The nursing study does not recommend establishing preservice nursing scholarships, but rather increasing to 500 the 300 already being offered.

There is no thought of limiting these scholarships to the students in the two-year community college programs. They have been available to students in any state-approved basic professional nursing program, including the hospital schools, and the nursing study visualizes provision of the larger number on the same basis.

The state study makes no specific recommendation about the financial value of the scholarships. Those that have been granted range from $200 to $500 per student per year, depending upon financial need.

2. The Medical Sub-Committee states that the community college program "was developed as an alternative to collegiate nursing." The two-year program has been developed as an additional, different, and speedier way to help meet the needs of society for more nurses, not as an alternative to either the four-year college program or the three-year hospital school. It is not "a compromise between the ideology of collegiate education for all nurses and the impracticalities of that ideal," as the Sub-Committee states, because no such ideal exists.

Dr. Mildred Montag, director of the five-year Cooperative Research Project in Junior and Community College Education for Nursing, states: "The inclusion of a nursing program within the community college was a natural development, since one of the basic functions of the community college is to meet the needs of its community for essential services. Nursing is an essential service." And again: "The purpose of the project was to prepare

3. The Sub-Committee states that graduates of the two-year programs can qualify for State Board examinations in two years "but need six to twelve months of hospital experience before they become qualified bedside nurses." The statement is not documented. Dr. Montag found that: "The estimates of the amount of practical experience required by the pilot-program graduate to develop into a fully competent practitioner varied from two weeks to six months." Few graduates of any type of nursing school but would need a period of orientation to a new work situation.

At the beginning of the research an added internship was planned to meet the legal requirements in some states for a three-year period of nurse-training. Since then, on the basis of evidence that two years are sufficient, the laws in several states offering the two-year college course for nurses have been changed.

Dr. Montag reports that: "Hospital administrators have expressed considerable interest in the internship. This is understandable since an internship would assure them of the services of a given number of nurses for a year, and then an easy replacement with succeeding groups of interns. Findings of this study show that students in the practicum were functioning as graduate nurses, and they were so considered in the evaluation. That the internship is a period ripe for exploitation is all too evident."

The New York Nurse Resources study says in a note on page 40: "A report from the New York University-Bellevue Medical Center, which has employed more than 40 associate degree program nurses, indicates that a six-week orientation is all that is necessary. In fact, the six-week orientation program has proved so successful that it is now provided for all newly employed nurses, whether two- or three-year graduates."

4. The final paragraph of this section on community colleges in the report's Chapter VII reflects additional misapprehensions. For one thing, there is no "State Department of Nursing Education" to arrange for a community college to provide courses to a hospital school. The State Education Department has, in fact, encouraged such arrangements, and more than one third of the hospital schools in New York State operate with college cooperation.

COSTS OF NURSING EDUCATION

In their Chapter VII the Sub-Committee present undocumented figures on the costs of nursing education. Some of these apparently come from Appendix B of the New York State study. The source of others is less clear. Actually, there is a vast dearth of generally accepted information in this area. The National League for Nursing is engaged in a three-year study of the costs of nursing education with financial aid from the Public Health Service. Recently the Institute of Research and Service in Nursing Education of Teachers College supervised a brief study of the costs to the institution of a masters degree program in nursing, made under a grant from the Sealantic Fund. Estimates arrived at in this study will soon be published, but are not directly pertinent to these comments.

It may be noted that the Sub-Committee, in the figures they cite, fail to
differentiate clearly between instructional costs and living costs; between costs to hospital or college and costs to the student. There is no evidence that they take into account the value of services provided by the student in the hospital school, or are aware of a rising aversion to asking sick patients to pay the costs of nursing education not met by those services.15

The curious logic of this chapter is illustrated by the statement that the nursing shortage "adds greatly to the cost of medical care ... in dollars!" Those patients who "have to wait for beds and operating rooms" may be paying dearly in comfort and health—perhaps in lives. Yet surely non-existent nursing services do not cost dollars! Nor is it fair to blame nursing for all the needed health services that cannot be provided when shortages exist in nearly all kinds of health personnel, including physicians.16

The "fluid picture" the Sub-Committee drew from an (unnamed) "large New York City metropolitan hospital" also is vividly in need of comment. In 1946 this hospital, then with a "three-year R.N. school", believed the cost of nursing (including education) to be $1.93 per patient day. When this same hospital was operating a "collegiate school" (italics ours) "11 years later in 1958", this same figure was $2.72 per patient day; an increase of 295 per cent. Whereupon the Sub-Committee conclude that collegiate education costs at least twice as much as hospital nursing education!17

In the first place, if the hospital is still operating the school, can it be really a collegiate program? But the basic question is, should we not know more, before reaching conclusions, about all the factors that contributed to the recent nursing service cost?—cost of living increases, changes from student labor to the services of graduate nurses, added nursing functions, a reduction in working hours per week, perhaps a new system of bookkeeping? After all, the nation's total medical care bill is said to double what it was in 1950.18 Let's let cost accountants analyze that metropolitan hospital's records.

MARY M. ROBERTS AND NURSING EDUCATION

It seems an extraordinary travesty on logic to try to twist the facts of Mary M. Roberts' delayed acquisition of a college degree into an argument for postponing the collegiate and higher education of any nurses.

Before patients for the education of health personnel, including nurses, is discussed by Dean A. Clark, M.D., General Director, Massachusetts General Hospital, in Resident Physicians, September, 1947, as follows:

... it seems likely that hospital costs will rise about five per cent per year indefinitely...

As for the problem of meeting the special educational costs of voluntary teaching hospitals, it too has arisen in part from tradition—the tradition that interns, residents, and student nurses, among others, pay for their education by the services they give to the patients. This may once have been true in the days when hospital care and education in these fields was much simpler than it is now, but it is certainly not true any more. It would be fair to estimate that from 5 to 10 per cent of a teaching hospital's operating budget (excluding research) is for the direct expense of education.

These are not true costs of hospital care at all. Yet, traditionally, they have been met either by philanthropy or by the sick person in a hospital bed. Why should an unfortunate person, who certainly has enough of a problem to pay for the true cost of his care alone, also be obliged to pay for the education of the country's future doctors, nurses, social workers, dietitians and the rest? This is all the more unfair in that these educational activities, which are designed to benefit the whole country, are confined to about one-sixth of the country's almost 10,000 general hospitals.

Provisions for a Growing America, op. cit., estimates shortages of dentists as well as physicians.


Miss Roberts was in the vanguard of nurses seeking better preparation for their service to humanity. In 1899 when she became a registered nurse, there were no colleges offering degrees in nursing. In 1921 when she secured her B.S. degree, fewer nurses were undertaking baccalaureate study than are in the doctoral programs today. And when she retired after 28 years as editor of the American Journal of Nursing, she returned to Teachers College, Columbia University, for graduate study to assist her in the research for and writing of her history of American nursing.15

What more might Miss Roberts have done with her splendidly directed life of achievement if she had had opportunity earlier to acquire more educational tools with which to work? Perhaps she had in mind the handicaps she herself was forced to overcome when she wrote in her history,16 "Two-thirds of all graduate nurses who were working toward graduate degrees in 1954 were studying on a part-time basis. The courage and persistence of such nurses reveal one of the glories of the profession, but it is a socially wasteful process. Too often the degrees represent little more than an aggregation of credits instead of a balanced program leading toward a planned professional objective. If scholarship aid and professional counsel were more generally available nurses could more quickly achieve the higher competency which is so greatly needed."

Throughout her long editorship of the American Journal of Nursing, Miss Roberts conducted a creative campaign for the improvement of nursing education in order that nursing services might be bettered which members of the Medical Society's Sub-Committee seem to have misunderstood completely.

It is true that exceptional persons rise above the handicaps they may face in any field. Thus Abraham Flexner said of the teachers in the proprietary medical schools of some decades ago:17

"A minority successfully wrung a measure of good from the vicious system which they were powerless to destroy. They contrived to reach and to inspire the most capable of their hearer. The best products of the system are thus hard to reconcile with the system itself. Competent and humane physicians the country came to have—at whose and what cost, one shudders to reflect; for the early patients of the rapidly made doctors must have played an unduly large part in their practical training."

Similarly nursing has had not only an occasional Mary M. Roberts but also thousands of rank and file workers who gave and continue to give splendid service in spite of the limitations of nursing education. That fact is, however, a spurious argument for purposefully perpetuating the limitations.

The most curious part of the report's Chapter VIII, which discusses Miss Roberts' magnificent leadership of the nursing profession, is the assumption—echoed again and again throughout the report—that "a policy of college degrees for all nurses" prevails.

Nurse leaders seek a system of nursing education oriented to education of the student rather than to getting service out of her while she is a student because only thus can nurses be prepared for good patient care. And unless if good education is offered our nursing schools—in a world of increasing opportunities for women and interest in educational self-development—
Tract a sufficient number and requisite quality of persons into nursing and prepare them for the different roles that nursing must play in the actual health services of today and tomorrow. The number of hospital schools that are meeting good educational standards are increasing, thanks to self-improvement stimulated by the accreditation program of the National League for Nursing, and more must be encouraged to achieve good standards.

Nevertheless, since preparation for professional nursing is professional education beyond the high school, gearing it into our college and university educational system as rapidly as feasible is surely indicated. That such gearing-in constitutes "a campaign to separate nursing education and nursing services", "taking off into the area of theoretical intellectual pursuits", or means that all nursing personnel seek degrees, may be categorically denied.

Instead, even though offered by an educational institution, the art of nursing is learned through practice. A sound education for nursing (like medical education) stays close to clinical experience, while at the same time providing some of the general and scientific background so essential to modern nursing. (Yet the type and amount of clinical experience should be determined by the needs of the student rather than by the service needs of the institution offering the experience.) Did patients suffer because medical education, early in this century, sloughed off the proprietary schools and sought, through university affiliations, sounder principles of preparation? And where would medicine be today without the advantages of university libraries and laboratories, the assistance of related disciplines, and opportunities under theegis of the university medical schools for advanced study and research on the part of some physicians?

Do not the growing responsibilities of nursing indicate that—for the public good alone—comparable advantages should be available to at least some nurses?

THE SUB-COMMITTEE'S RECOMMENDATIONS

Although the general observations above have bearing upon most of the specific recommendations offered by the Medical Society's Sub-Committee, comment may be offered on each of the seven.

"Comprehensive Nursing Education"

The first recommendation, for a "flexible" plan that would force each person wishing to enter nursing first to prepare (and hopefully to serve) as a practical nurse, may be approached from a number of viewpoints.

Interests of the public, genuinely in need of more nursing services, should come first, and it is probable that no surer means to reduce the number of strainers to nursing careers at all levels, and to increase attrition among students, practical, professional, and advanced, could be found than adoption of this recommendation.

Practical nurses, who assist and work under supervision of the professional nurse and physician, are filling a real need in the provision of health care to the American people. Their ranks have been built up by reducing requirements and extending age limitations. Most state approved schools or practical nurses now ask only two years of high school preparation, as compared with four required by all types of schools preparing for R.N. license, and admit students from 17 to 50 years of age instead of the 17 or 18 to 35 range observed by the professional schools.

A field supervisor in the Department of Nursing Education at Teachers College, a registered nurse, spent ten years teaching in schools of practical nursing. Her experienced opinion is that trying to make the practical nurse course the first rung on a ladder would lose many practical nurses. Those seeking to enter this circumscribed service area do so because their abilities indicate a natural interest in an early and limited goal, because they must earn quickly, or for both reasons. They are satisfied with course content they can grasp and goals they can hope to achieve. If thrown in with students impatient to gain wider understanding, the group who are making good practical nurses would become discouraged.

How such lumping together would hamper building up the professional nursing ranks is also indicated by this same field supervisor's experience. She found that the drop-out rate during the first three months of the practical nurse program was highest among students with the intellectual capacity for deeper study than the courses called for. They were dissatisfied, bored, what possible hope would there be of holding in such a situation the high school graduates who aspire to professional nursing?

A major problem faced by nursing today (though not touched upon by the Medical Sub-Committee) is attracting into the present programs the caliber of young person who can go on to secure the preparation needed to provide the nurse leadership—administrators, nursing specialists, consultants, and researchers, as well as teachers—required to cope with the problems involved in filling the mounting bedside nursing demands. Are we to increase the handicap? If the Medical Sub-Committee's recommendation is educationally sound, why not seek more physicians by giving medical technicians credit toward an M.D. degree?

Let me press as emphatically as I can that, under today's conditions, bedside nursing ranks can neither be filled nor will bedside nurses serve satisfactorily unless or until we can provide a much greater number of capable administrators, teachers, and specialists than we now have.

That fact requires a careful look at the "comprehensive nursing education"—or progression—recommended by the Sub-Committee as it applies to the student beginning preparation for R.N. license.

Let me say, first, that one nursing program is experimenting with a "ladder plan". Did the Medical Sub-Committee study the integrated "8-year-plan" now in operation at Rutgers University under which the student begins with the two-year associate degree program and can continue through doctoral studies?

While watching this program carefully, many nurse educators think it violates important principles which I may state briefly thus:

1. The widely varied functions of vocational, technical, and professional nursing today make steeply ascending demands upon learning capacity and therefore require educational preparation that is sharply differentiated in scope and length.

2. It is important to the student but even more important to the society to be served that, insofar as possible, each student be placed from the beginning in the program best suited to that individual's capacity for learning.

31 An article entitled "Education for Professional Nursing—1959" in Nursing Outlook, August 1959, published by the National League for Nursing, says, "While more graduates are needed from every type of educational program in nursing, the situation in graduate education is the most critical one. Against an estimated need, by 1970, for 78,000 to 91,000 nurses prepared as administrators, supervisors, teachers, consultants, research workers, and expert practitioners, there were, in 1956, only 6,400 active nurses who had completed graduate programs."
Any other procedure is inexcusably wasteful of time, money, and the leadership potential that—again for the sake of society—must be nurtured in nursing perhaps more carefully than in many other fields.

3. When a student, in spite of best guidance efforts, proves to be misplaced in a program below individual capacity, a way should be found for that person to advance educationally, even at the price of extra time expenditure.

4. A few senior colleges—by no means all—have an open door policy and will enroll the exceptional graduate of the two-year program in the junior year of a four-year program in nursing without a great amount of backtracking. Arranging for the exceptional student (and practitioner of nursing) to progress to the more complex and more seriously needed types of service does not, however, mean that it is wise to make wholesale progress a cornerstone of the nursing education system. Two years of technical education plus two years of professional education cannot be equated with four years of professional education.

It is worth noting that, while a few professional engineering schools are willing to admit the occasional experienced technical engineer, they do so only if the individual has great promise and can face considerable time loss. The reason is that the applied science and mathematics of the technical programs fail to meet the requirements for work in the third and fourth year professional courses.

It seems probable that educational economy and social values will be best served if, in nursing, as in other fields, we do our utmost to guide the student into the program that has an objective most nearly consistent with the individual’s capacity and goals, and a curriculum adjusted to the program objective.

The 21 separate items in this first Sub-Committee recommendation suggest too many violations of sound educational procedure to permit comment on all of them. It should be pointed out, however, that citation of “West Point, etc.,” as proof that scholarship aid should be tied to “periods of nursing service” seems to indicate that the Sub-Committee is thinking of a military regime that could scarcely be imposed upon nursing in peacetime unless by a totalitarian state. In nursing as in medicine, some scholarships are service-connected, yet wholesale application of the principle might well defeat its purpose.

2. “A Master Plan for Nursing Education”

Good in general intent is the recommendation that, “The Board of Regents of the State of New York should evaluate the nursing educational facilities of the State to determine which schools should be closed, consolidated, or expanded, or when and where new schools should be established. To accomplish this it should develop a Master Plan for Nursing Education comparable to the Master Plan for High Schools.”

That the State is already exercising the “vigorous leadership” urged by the Sub-Committee is attested by the new study that occasioned the Medical group’s concern. “Needs and Facilities in Professional Nursing Education in New York State.” This report of a study group whose work was authorized by the Regents of the University of the State of New York is, in fact, a blueprint for action and perhaps the best “Master Plan” that could be formulated at this time.

It is certainly “debatable” whether or not the more pre-emptory pattern of procedure that the Medical Sub-Committee apparently visualizes could or should be developed. Nevertheless, any effort that can be made by any group or individual, in any state, to focus public attention upon the public’s stake in nursing education should be welcomed, provided it is based upon full and accurate information about nurse experience and thinking to date.

3. “Relaxation of Rules and Regulations”

By recommending that teachers of nursing should not be required to have a B.S. be tied “until the supply of nurses more closely approximates demand” the Medical Sub-Committee not only proposes to set the clock back but—if the recommendation were adopted and standards “relaxed” more than they now are—recruitment and attrition problems would double.

It is the considered judgment of persons who have been doing yeoman service on nurse recruitment committees—leading citizens in many walks of life as well as nurse tribunes—that the comparative quality of teaching in schools of nursing is a major deterrent to recruiting adequate numbers into schools of nursing today and keeping them there.

Schools of nursing, including those conducted by hospitals, provide education beyond the high school, and thus compete for students with college training of all sorts. Most fields require at least a masters degree for teaching at this level, and some states require it of high school teachers. Yet 23 per cent of all nursing faculty members in hospital and other noncollegiate nursing schools in the United States hold no degree whatever and 55 per cent have only a baccalaureate degree. Only 17 per cent of the teachers in hospital schools hold the recommended masters degrees. It is not a question of prestige for either the faculty members or the schools. It is a matter of providing teachers who can prepare students adequately for the complexities of today’s nursing, teachers who can offer course content that will challenge the student able to deal with those complexities.

Even in the collegiate schools, while a mere fraction of one per cent of the faculty are without any degree, only 64 per cent have the masters degree.

The proportion of nursing teachers in New York State and in the country as a whole without the needed preparation suggests that rules are being “relaxed” operationally as expediency seems to demand far more than they should be, without recommendations for relaxation from Medical Societies.

The proportion of nursing teachers who are qualified is, fortunately, rising but it is still too low to permit nursing to compete on an equal basis with other fields seeking to enlist young people of ability.

4. “Recruitment of Nurses”

It is probably not appropriate for the college group offering these comments to attempt to judge the fourth recommendation, that all New York State nursing recruitment activities center in a State office. Presumably it would be a matter to be decided between the Recruitment Committee of the State League for Nursing (since the National League heads up recruitment activities) and other interested groups in the State. Again presumably any intensified cooperation that proves feasible would be a step in the right direction.

The fact that the extensive recruitment carried on by the Committee on Careers of the National League for Nursing, to which the Sub-Committee themselves pay tribute, has thus far failed to bring an adequate number of students into schools of nursing, suggests that successful “recruitment” must go deeper than publicity and information can.
For example, better quality teaching in schools of nursing, as suggested in discussion of Recommendation 3 above, might do more to build up enrolment in schools of nursing than hundreds of thousands of dollars worth of persuasive recruitment literature. A similar spur to recruitment could come from focusing more school programs more closely upon students' education rather than upon the work they do.

Still greater help might come from more understanding, on the part of physicians and hospital administrators, of the realities of nursing today. The changes taking place are requiring an increasing proportion of nurses to be persons of exceptional knowledge, judgment, and social-human perceptions and skills. In an era when many fields of opportunity are opening wide to young women, the ability among them would inevitably think twice before entering a field involving extensive cooperation with and from a profession that recommends tying their education to indented or not military service.

5. The Utilization of Nurses

While reorganization of many hospital nursing services for better utilization of personnel and increase of actual bedside service, as item 5 recommends, is certainly in order, the methods the Sub-Committee seem to suggest scarcely promise to be effective.

Good administrators, in nursing as elsewhere, can be and have been self-taught. Yet if they must be born and cannot be made, a great deal of time and money are now being wasted in efforts to prepare young people for business administration.21 Since the Sub-Committee observed that utilization of personnel is better the smaller the hospital, they might also have noted that the smaller units require the least administration. The number of large hospitals, however, and their rapid growth are creating needs for capable nurse administrators so real and so pressing that the nation cannot wait for their spontaneous emergence from the ranks.

While there is no statement that will be entirely true for every separate hospital, the seeming to the Sub-Committee, "that Parkinson's Law has worked overtime in the nursing field" would in most cases mean—not that nurses are striving for administrative posts—but that they are ill-prepared for the administrative duties they must try to handle if patient care is not to fall into chaos. The nurse who does unnecessary paper work while patients go unattended is not a good administrator.

We do not think the courses in administration our graduate programs are offering nurses now are as good as they should be. They are new, and we are constantly striving to fit them more closely to needs.

Yet hospitals themselves have cast their votes for exposure to the advanced education we now can give, in a sampling study made by the Division of Nursing Resources of the Public Health Service.22 In different categories of service, employing hospital administrators reported that they wanted up to 50 per cent more nurses with baccalaureate degrees, and up to 44 per cent more with masters degrees. Presumably these felt needs grow out of relatively

21 Russell, Charles H., in Liberal Education and Nursing. Institute of Higher Education, 1939, p. 2, says: "Many of the present schools, such as those in business administration and journalism, were inconspicuous, if not completely missing, in the total enterprise of higher education at the turn of the century. There were, for example, only three schools of business before 1900 enrolling a mere handful of students. Now tens of thousands of students attend several hundred such institutions."

22 Professional Nurse Traineeships, Part I, Public Health Service Publication No. 675, p. 29.

satisfactory experience with employees who do have the indicated college preparation.

6. "Nursing Salaries"

The recommendation that hospital administrators explore and evaluate the principles of incentive wages and bonuses as applied to the nursing shortage is commendable in spirit but practical only in part.

The concept of "bonuses" is a bit far-fetched in the context of hospitals, which generally operate on a deficit basis. Profit-making businesses, on the other hand, can and sometimes do at year's end divide their profits with employees. Hospitals would seldom have such happy a distribution of money to distribute to nursing staff members no matter how great their "diligence."

Again is "diligence" enough to assure good nursing care? The American Nurses Association which, through its Economic Security Program, has given thought to the matter of incentive pay, has not yet found a satisfactory tool for measuring merit. One per cent recommends automatic salary increases over a period of years on the assumption that the nurse becomes more valuable to the employing institution the longer she stays—would not, in fact, be permitted to stay if she were not giving satisfactory service. If the hospital wishes to reward merit over and above the recommended range of increase, the ANA definitely approves, but finds that in practice such rewards are seldom forthcoming.

The largest single employer of nurses, the United States Veterans Administration, recognizes as do school systems that salaries should be based upon educational and professional qualifications and that educational advancement deserves a salary increment because of increased competence.

The problems created by salary rewards for superior teaching are described in a recent study23 made by the National Education Association which concludes that "In spite of the recent resurgence of interest in quality-of-service provisions, the obstacle of evaluation still stands as a formidable barrier to the acceptance and use of them."

7. "The Cooperation of All Interested Groups"

A bit of editing will make acceptable to all nurses the seventh recommendation which the Sub-Committee made to read: "It is evident that there is no single or simple remedy for the nursing shortage; that regardless of policies, plans and attitudes, hospitals, doctors and the public will have to adjust to a type of nursing care that falls far short of the standards of the 1930's. But it is also evident that the public will not indefinitely tolerate policies that deny it needed nursing care. In the light of these facts, it is incumbent upon all groups to work together toward helpful solutions, or any reasonable plan that will tend to relieve the shortage. This unity of purpose is paramount and has not been evident up to the present time."

Italics are ours. We recommend omitting the italicized words and inserting in their place "that the American people are demanding and should receive few patients today would tolerate on profit from the nursing care of the 1930's that the Sub-Committee choose to vaunt, as an earlier discussion endeavors to make clear. As for the rest of the deletion, together with the Sub-Committee, nurses hope that the public will not indefinitely tolerate policies that deny it needed nursing care," but have had to face the fact that adequate interest in and understanding of nursing problems is slow in coming.

In discussion of this seventh recommendation, however, the Sub-Committee are standing over more of those misapprehensions. The picture of "the national nursing societies and their followers" locked in mortal combat with the three-year hospital schools is an exaggeration at best.

As for the statement about elimination of the hospital schools, the New York State Resources study which occasioned the Sub-Committee's report offers this as its first general conclusion:

"The hospital schools of nursing have carried the load in preparing the nation's supply of professional nurses, and nothing should be done to damage the quality and prestige of such programs."

In a later recommendation for regional cooperation among two-year and four-year collegiate and hospital schools for most efficient use of instructional personnel, libraries, etc., the report says:

"The training hospital schools, which must continue to educate a large share of New York State's supply of nurses, should be strengthened and made more economical."

These passages indicate the tenor of the report.

Any system that, under the guise of education, too often sacrifices the student's interests to the service needs of the institution is what nurses leaders seek to discard, not the hospital school that does a good job of teaching. The primary purpose of any school worthy of the name undoubtedly should be the education of the student.

In conclusion

Edited as indicated above, the Sub-Committee's seventh recommendation approximates the plea with which these comments should end.

The seeming "nursing shortage" grows out of many shortages and out of vast changes in health services, the course of which may need to be shifted somewhat if good patient care is to be realized. Interdisciplinary cooperation in seeking solutions to nursing problems is certainly indicated, for nurses play a part in nearly every type of health service, carrying a heavy share of the direct patient contacts.

Since the overhauling of medical education is comparatively recent history, the medical profession should be particularly able to counsel nurses in steering a wise course through the massive transition in which nursing education has been plunged by the rapid growth of both quality and quantity demands for nursing services. Medicine, in its own and society's interests, has an obligation to uphold and promote nursing standards.

We have grave need for more effective means to honest, earnest interdisciplinary consideration of the problems of patient care, consideration that rises above the "grape sessions on nursing" alone, that such efforts too often become. The Medical Society's plan of action to enable "all groups to work together toward helpful solutions" is eagerly awaited by nurses, and no doubt will be welcomed by the public as well.

Whether or not the present doctor-nurse ratio is here to stay, the fact remains that most physicians today are so engrossed with the scientific aspects of their work as to wish to turn over to nurses a very large share of the socialistic aspects of medical care. To what extent such transfer of duties is in the best interests of patient and society and how the consequences of such transfer may be met are questions which can be answered only if doctors, nurses, perhaps other health professionals, and public face them together.

Excellency and compromise are not the answer to the dilemma of nursing in 1959, or in 1960 and the years to come.

January, 1960
Nursing Care for Patients—Dilemma 1959

A Report by

The Sub-Committee on Nursing Problems

for

The Medical Society of the County of New York

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The support of the Wrock Fund for Postgraduate Medical Education for assistance in publishing this material is gratefully acknowledged by The Medical Society of the County of New York.
CHAPTER I

Introduction

Everyone concerned with the care of patients in the past 10 years has become aware of problems that exist in the field of nursing. Some nurses, most hospital administrators, and a few doctors directly involved with the demand, supply and cost of nursing care in their hospitals have become adequately informed about the problem. But the medical profession as a whole, and the public which serves, remain ignorant of its many facets. The time for greater insight and understanding of the nursing problem among physicians and the public is overdue. The first purpose of this study is to consolidate our thinking and bring it up to date.

Another more immediate reason for concern about the nursing problem is a study by the New York State Board of Regents completed in 1939, which is oriented toward solutions to the nursing shortage on a state level.

Briefly, it recommends that the State of New York establish two year academic nursing schools in state junior colleges, and scholarships of $500 per year for student in such schools. It is incumbent upon each physician to know whether he should support these recommendations, and why. Further, it offers an occasion for physicians, as members of the profession most directly concerned with the health of people, to become informed on this matter of public interest.

In approaching this subject the committee encountered almost universal agreement that nursing was a major problem about which something should be done, and equally unanimous opinion that little could be done about it. As physicians we could not escape the view that so much had been said and so little accomplished that the doctors were discouraged and resigned to let come what may; that there were forces at work beyond our means to influence or modify. So it was that we approached the subject with skepticism, little optimism and even less hope. It was only after some months on nursing that it became clear that we had a story to tell. There are no new facts in this tale; rather it is a compilation of well known information from many sources. The interpretations and recommendations that lead up to are our own.

To understand nursing better, its historical development is traced, leading up to a picture of nursing education in New York State today. This is followed by chapters on the supply, the demand, and distribution of nurses, and one on the state of nursing education. Up to this point the information is largely factual; beyond this we branch out into the area of opinion. Three chapters appraising the various educational methods, the shortage, the outlook for the future, and comments on the State Nurses Resources Study. These give the background and lead to the focusing point, which is found in the recommendations. While these recommendations concern everyone, the first four are necessarily directed primarily at state level, and the last three at local hospitals.

CHAPTER II

The Origin and Development of Nursing Education—A Brief Historical Sketch

The seed of the nursing profession here and abroad is found in the charitable practices of many religious and military orders. Starting with a tentative past. But it was not until after the Civil War that Louisa Lee Shuler, great-granddaughter of Alexander Hamilton and prominent New York matron, zealously applied her visionary organizational talents to the care of the sick at Bellevue Hospital—an effort which culminated in the founding of the first American nursing school in New York City in 1873. That same year, two similar schools, the Connecticut Training School at New Haven and the Boston Training School at Massachusetts General Hospital, were founded, and American nursing was on the way.

Hospital Schools

By 1880 there were fifteen nursing schools: by 1900 four hundred and thirty-two, most of them under the control of hospitals. A peak of 2,286 schools was reached in 1927. In 1936 there were 1,115 schools; 118, or about 10% of them, in the State of New York. This rapid growth paralleled that of hospital and other medical facilities throughout the land. The services of the professional nurse soon became an essential part of the expanding medical care of the sick.

These early schools closely followed the precepts and teachings of Florence Nightingale, who was the recognized authority. In a letter of instruction to Bellevue she said in part: "... unless there is, so to speak, a hierarchy of women, as thus. Matron or Superintendent, Sisters or Head Nurses, Ward Mails or scrub-nurses or whatever other grades are, locally, considered most appropriate" discipline becomes impossible.

"In this hierarchy, the higher grades ought always to know the duties of the lower better than the lower grade does itself, and so on in the scale. Otherwise, how will they be able to train?"

In her concepts were three strong elements: (1) the execution of medical orders and nursing care for the benefit of the sick; (2) teaching, supervisory and disciplinary duties carried out through the "hierarchy," and (3) an extraordinary and dedicated sense of duty and devotion to mankind.

Though the sound philosophy of the Nightingale schools fortunately dominated the expanding picture, many schools failed to live up to these exacting standards. Starting with a concrete training period, which was gradually extended to three years, the nursing profession itself defined and established higher nursing educational standards and practices during the formative years. Some concept of the scope of education in 1905 is conveyed by the following quote from Miss Nightingale: "If, therefore, we claim to receive the appearances, privileges, and standing of a profession, we must recognize professional responsibilities and obligations which we are in honor bound to respect and uphold."

In the headlong development of more and more nursing schools designed primarily to produce bedside nurses, it was inevitable that more emphasis be placed upon the training of nursing educators and specialists. Nursing leaders were aware of this problem as early as 1903, and since that time we have exerted constant pressure toward more formal education for the professional nurse. This was realized in two ways: the development of (1) collegiate schools, and (2) post-graduate nursing education.

Collegiate Schools

The first collegiate school of nursing was founded in Minneapolis in 1889 at the University of Minnesota, and in 1910 (1919) developed to the point where it offered a four-year degree in nursing. There, for the first time, the student studied nursing on a campus rather than in a hospital, and the school was controlled by the university. In 1916 the University of Cincinnati organized a collegiate school, and by 1917 twenty-five of these or universities were offering preliminary courses.

In 1926 the Connecticut training School, one of the three original Nightingale schools, became the Yale School of Nursing, granting the degree of Bachelor of Nursing. A similar school was founded at Vanderbilt University, and a third at Western Reserve in Cleveland. By 1928 eighteen colleges and universities were offering the combined academic and professional course of four or five years. In 1921, 1922, 1923 there were 104 such schools, 22 of them in the State of New York.

Post-graduate education for the nurse had its start at Teacher's College, Columbia University in 1900, with a course in Hospital Economics. By 1910 this had expanded into the Department of Nursing and Health, offering a variety of courses, particularly for Public Health Nurses. Many of the better known and staffed schools were, as far as we are aware, to give the post-graduate courses in the nursing specialties, a practice which is widely continued to the present.

Community College Schools

The third and newest approach to nursing education is through two-year courses given in vocational or junior colleges. This method was developed as an alternative to collegiate nursing, in the hope that it would attract better students and at the same time be an economical means of training for the State of New York. State the first such school was organized in 1905 at McChesney, which gave three year courses for licensed nurses. It is hoped to give two year courses for nurses. It is hoped that these students

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who receive the Associate in Arts degree at the end of two years, can qualify for their State Board examinations, but need an additional twelve months of hospital experience before they become qualified bedside nurses. It is this type of nursing education that is being promoted as the best solution to our nursing shortage and educational problem by the Nurses Resources Study Group in New York State, in a report which was published in 1959. Further comment will be made on this later.

Practical Nursing Schools

Nurses aides, practical nurses, or some type of sub-maltese, have long been considered an important part of nursing services as a whole. This idea was pushed in the special Goldmark report as early as 1931, and has been used in some extent since. The greatest progress in this direction started in 1943 when, under the acute shortage in civilian nursing caused by World War II, nurses aides, many of them volunteers, filled some of the void left when 70,000 nurses entered the Armed Services. These aides were trained on the job for short informal courses during the war years, but the shortage of R.N.'s continued, the volunteers decreased and the training was reorganized into schools for practical nurses. In New York State there were 96 such programs operating in 1959.

CHAPTER III

Nursing Today in New York State

The types of nursing schools available in New York State in 1957 are shown in Table I.

<table>
<thead>
<tr>
<th>TYPE</th>
<th>DEGREE</th>
<th>NUMBER OF SCHOOLS</th>
<th>PERCENT OF SCHOOLS</th>
<th>ENROLMENT</th>
<th>% OF 1957 ENROLMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hospital Schools</td>
<td>R.N.</td>
<td>60</td>
<td>100%</td>
<td>10,659</td>
<td>78%</td>
</tr>
<tr>
<td>2. Colleget Schools</td>
<td>B.S.</td>
<td>21</td>
<td>18%</td>
<td>2,780</td>
<td>25%</td>
</tr>
<tr>
<td>3. N.Y. Community Colleges</td>
<td>A.A.</td>
<td>11</td>
<td>3%</td>
<td>295</td>
<td>1%</td>
</tr>
<tr>
<td>4. Practical Nurses</td>
<td>Diploma</td>
<td>35</td>
<td>100%</td>
<td>1,606</td>
<td>1%</td>
</tr>
</tbody>
</table>

CHAPTER IV

The Supply of Nurses

From the educational facilities described in the last chapter, New York State in the year 1956-57 graduated 3,922 nurses and about 1,100 practical nurses. Most of the graduates registered, and in 1958 there were 112,376 registered nurses in the State of New York. Of these, about 52% and possibly nearer 50% are inactive. The availability for nursing of those who register is less than one might think. About 55,000 are known to be actively employed in the State, about 23,000 are known to be inactive, and about 21,000 have no addresses outside of the State. Some confusion is caused by reciprocities and multiple registrations.

In the hospitals, about 1/3 of those admitted last year to graduate programs meet the hospital nursing, that the practical nurse will have an increasingly important part in the overall picture of nursing care. The training of nurses in Community Colleges of N.Y. State is a compromise between the ideology of collegiate education for all nurses and the practicalities of that ideal. A complete study of this experiment in nursing education titled "Community College Education for Nursing" has recently been published by Mildred Montag, who is the prime mover of this project at Teachers College, Columbia University. Though this approach is much too new to have much impact on filling the need for bedside nurses, it is not without virtue, particularly if used as an insurance potential. This will be discussed later.

CHAPTER V

The Demand for Nursing

The demand for nurses is not as easily defined as is the supply picture considered in the foregoing chapter. The conventional method, formerly used, was to number and percent of vacancies in each hospital or employing agency. So measured, the national vacancies are between 15% and 25%, mostly of them in general duty nurses. The deficit is most acute in psychiatric and TB hospitals. But demand has outranked the supply for so long that the patterns and standards of nursing care have changed. What was considered essential in the 1930's is now thought superfluous. Practical nurses have filled some of the void and can potentially fill more. So staff vacancies have come to mean less as a measure of nursing demand. More significant is the overall ability of the hospital to provide nursing care to patient, and this is more difficult to control in a firm figure. For practical purposes, attempts to project the demands for nurses are somewhat academic. Everyone who has thought about the problem agrees that demand far exceeds the supply. Estimates are that the public need is 25% to 50% more professional nurses. Of the vacancies, about 75% are for general duty positions, head nurses, superintendents and instructors follow in that order.

CHAPTER VI

The Distribution of Practicing Nurses in Field of Science

Nursing service is widely distributed in the health field. An idea of the various activities...
of the estimated 30,000 active registered nurses in the nation in 1956 is shown in Table 2. It should be noted that 62% are employed by hospitals, and another 17% are doing private duty. About 4.5% of the nurses employed by hospitals are general duty nurses. It would thus appear that about 80% of the active professional nurses are engaged in direct patient care, the area where nurses are most needed.

<table>
<thead>
<tr>
<th>TABLE 2 DISTRIBUTION BY FIELD OF NURSING—1956</th>
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</thead>
<tbody>
<tr>
<td>(National figure—1958 Facts About Nursing)</td>
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<tr>
<td></td>
</tr>
<tr>
<td>100%</td>
</tr>
<tr>
<td>Hospital Nurses</td>
</tr>
<tr>
<td>Private Duty</td>
</tr>
<tr>
<td>Office Nurses</td>
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<tr>
<td>Public Health</td>
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<td>Indwter</td>
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<tr>
<td>Nursing Education</td>
</tr>
<tr>
<td>Others</td>
</tr>
</tbody>
</table>

CHAPTER VII
The Cost of Nursing Education

The cost of nursing education in the three-year R.N. schools is about $100 per year per nurse, this cost being borne by the hospital. It costs the nurse herself about $1000 for the three years in tuition and other charges, or $100 in all for the three-year course.

The educational costs in the collegiate schools are at least $3000 per year. This has to be borne by either the college or the nurse, the four-year bill running to a minimum of $3000.

In the two-year A.A. schools, the cost is comparable to that in colleges, a minimum of $2000 a year, but because less time is involved, it approaches the cost of the hospital schools. It is evident that the hospital school is the least costly method for producing a bedside nurse with an R.N.

Since the practical nurse has less didactic and more on-the-job training, the costs are proportionately lower. Depending on the size of the school and whether the students get board and room in or out of the hospital, the cost of the 1-year program is less than $300, about half of which is borne by the student.

Though the least expensive bedside care is obviously that given by the practical nurse, it must be remembered that the least costly and least expensively trained practical nurse has to be supervised by the more expensive R.N. as B.S. The least expensive combination, both "salary wise" and "cost of education wise," is practical nurse and Registered Nurse working as teams.

A more lucid picture of nursing educational costs is given in the following illustration: In one large New York City metropolitan hospital, with a three-year R.N. school, the cost of nursing (including nursing education) in 1956 was $1.93 per patient day. When this same hospital was operating a collegiate school 11 years later in 1957, this same figure was $7.82 per patient day, an increase of 295%. During this 11 year period nursing salaries doubled, but nursing service to patient actually decreased. It is difficult to escape the conclusion that collegiate nursing education is at least twice as costly, a cost that goes directly back to the public in higher hospital bills, taxes, increased gifts, or a combination of these factors.

Increased nursing salaries (which must agree were necessary), and increased educational costs reflect directly on the increased cost of medical care. As shown above these effects are measurable and are large. But the nursing shortage itself has had another effect on the cost of medical care that can only be estimated and must be enormous. Everyone connected with hospital practice knows that hospital functions are limited by the shortage of nursing service. Hospital rooms or even floors are closed, operating schedules are curtailed, patients have to wait for beds and operating room time, the use of clinical facilities is limited—because of the nursing shortage. What these costs in dollars can only be estimated. But this we know, unequivocally: It adds greatly to the cost of medical care, and it is a non-productive addition.

Whether the public is willing or able, or would be wise, to pay the higher costs entailed in more collegiate education for all nurses is a pertinent question. Can society afford elaborate and costly education that is only 1/3 used, or are there things more important? If medical education was as poorly utilized as nursing education the medical school facilities would have to be increased 4 or 5 fold at a cost of to the public that would be staggering. Unless education of nursing can be kept within reason, few people will come to be by the uneducated. A sense of balance is clearly needed.

CHAPTER VIII
Approval of Nursing Educational Programs

It is not possible in this state categorically that one type of nursing education is better than another. Each approach has its strengths and weaknesses. We strongly support the view that in the period of shortage, all methods should be used wherever and however best fit the local facilities and needs. A brief review of the points for and against each system follows:

I. The 3-Year Hospital Schools

The present day hospital schools as they have developed over the years account for the basic training of most nurses today. In hospitals they account for well over 80% of such nurses. The advantages of this system are many: It is the least expensive method of training a practical nurse; the attrition is least; it is specifically oriented toward training the bedside nurse and most likely to produce one; the R.N. is well qualified for the performance of general hospital nursing duties today; it affords the soundest background for further formal education if so desired. Perhaps the best that can be said for hospital schools is that during the 1930's they produced the finest nursing care the public has known in the past 20 years.

The liabilities of the three-year, hospital R.N. course are: It has failed to produce enough nurses to fill the need; in itself, it does not give the prestige of a college education or degree; it is subject to objectionable abuses by local hospitals; postgraduate training is rarely available to hospital nurses.

II. Collegiate Schools

The liabilities of the collegiate method of training a nurse are briefly: It is the most costly method, the attrition is greatest; it is wasteful of educational facilities because bedside nurses do not need full collegiate education to nurse well; and (most important) it is the method least likely to produce a bedside nurse.

Its attributes are: It produces a more soundly educated nurse; it attracts some who might otherwise go into other fields; and (most important) it belongs to nursing the group it needs for teaching. What percentage of all nurses should be quality, is impossible to say, but the present ratio in N.Y. State of 15% would now seem adequate.

Perhaps the most serious indictment of collegiate nursing is that it fails to emphasize the fundamental of nursing care which is at the bedside. In this approach the R.N. nurse often becomes an executive or teacher, heavy on theory and light on practice, who knows less about fundamental nursing jobs than those she directs or teaches. This defect in the collegiate system is difficult to rectify, and may be found inadequate for the present day standards for bedside nurses. This defect becomes even more serious when one considers that collegiate education has long been available to the bedside nurse through post-R.N. training, a system that has motivated the Nursing Department at Teachers College since its origin in 1910. Post graduate training is a good and reflexive system. It emphasizes the basic concepts expressed by Miss Nightingale in her letter to Bellamy in 1873; it is responsible for most of our leaders in nursing today. To discontinue such as the other hardly seems justified, but we cannot escape the conclusion that the soundest approach to modern and administrative nursing is through the ranks rather than through the collegiate classrooms.

It has been said that the great emphasis on collegiate education today tends to dishearten potential bedside nurses. While nursing requires the intellect of a college education or degree; it is subject to objectionable abuses by local hospitals; postgraduate training is rarely available to hospital nurses.

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is accepted there will be much turned not only in nursing circles, but in related areas concerned with the care of the sick.

This is not to say there is no need for intellectual disciplines or higher education in the nursing field. Nothing could be less true. As in almost every field of endeavor, educated, intelligent, analytical, and often intellectual leadership is needed and necessary, particularly in nursing education. But this leadership should always be oriented toward the job to be done, which is primarily the care of sick patients.

There is much to suggest that some of the nursing problems of today are closely related to a lack of proper orientation. Some of the teachers of nursing today have strayed away from the fundamental problem of care for the patient and have taken off into the area of theoretical intellectual pursuits. It is disheartening to observe the distracting influence on nursing as a whole of this relatively small group, most of whom are not nurses, who are now concerned with the abstract or theoretical aspects of nursing problems than with the fundamentals. It is hoped, however, that in the end, the sound thinking and stable influences within the nursing profession will prevail. There are many fine minds with great experience among the nurses, many without college degrees and it is believed they have a vital influence on some of those who are trying to revolutionize the whole field of nursing education.

It is probably of some significance that the late Mary Roberts, R.N. and B.S., author of "American Nursing," one of the true scholars and leaders in nursing, for over a quarter of a century, who had a profound influence on nursing during her time, earned her R.N. in 1899 and her B.S. 22 years later in 1921. As an outstanding example of scholarly leadership, her career in nursing illustrates one of the great truths sometimes lost sight of in our quest for formal education. It is not the degrees but the person; not the formal education, but the mind which are important. Though nursing, and indeed, all of the professions, need every Mary Roberts they can find, will the policy of college degrees for all nurses be most likely to produce them? Further, if all nurses conformed to the mold of Mary Roberts, would the sick patients receive care? These fundamental questions are pertinent to immediate problems.

III. The Community College Schools

This system, with its degree as Associate in Arts, is too new to evaluate clearly. The cost between that of the collegiate and the hospital schools, the attrition seems reasonable, with suitable applications and 8 to 12 months of hospital training following the 2 year course, is shown in 1960. The prospective nurse in helping the hospital schools expand their teaching facilities and in appealing to a group of students that want formal education short of a 4 year college degree. It appears reasonable and wise to use this approach similar to it proves useful and effective in training nurses. The fact that it is an experimental system and may be at the beginning of a group of new and objectively interesting, speaks well for its eventual place in nursing education.

As organized and practiced at present the Community College approach is a single position, starting with the AA degree and leading to the R.N. We would like to suggest another and perhaps broader use of Community College facilities in the training of an R.N. If a hospital school were to find it advantageous to have all or part of the academic portion of its curriculum given in a Community College in the area, it should be possible to arrange this through the State Department of Nursing Education. This possibility would give maximum potential utilization of Community College facilities for the overall public good, and would also fit into the basic purpose of the Community College, which is community service.

IV. The Practical Nursing Schools

The schools of practical nursing with their 8 to 12 months course, leading to the Practical Nurses diploma, have become an important part of the nursing educational system since the shortage, for they have provided the finger in the dike that has prevented a complete collapse of hospital nursing service. It is perfectly clear that to the extent the professional schools fail to provide nurses, the practical nurses will become the nurses of tomorrow; for the hospitals must have nursing service to serve the public and if it is not to be had under one name it will be had under another. The public is still R.N. minded, and will go far to try to get them, but if, in the next 10 years, professional nurses become increasingly difficult to obtain, another group will take their place.

We do not feel that this is either necessary or desirable, by the upgrading of one group will start the upgrading of those that replace them and the cycle will repeat itself. However, we must accept the practical nurses as an increasingly important factor in nursing service.

It would be in the public interest that the rules and regulations of nursing practice be consistent with this group prevailing whatever it can in the way of nursing service in this period of shortage.

CHAPTER IX

The Problem

Nursing, like the other facets of the ever expanding health services, has always had its problems, great and small, external and internal. The most pressing of these problems we have seen the result of social and economic changes quite beyond the control of science, or indeed any segment of society. Through its highly developed and integrated organizations, the local and national, for which we like to call the Miss Nightingale's "battalions," nursing has always met these problems square in the face and has handled them with a forthright energy that is a marvel to behold. Even the severest critics, if informed, must give them full credit for doing a job in meeting their obligations during our national crises. From the time of the first school at Bellevue, they have demonstrated over the years a fine sense of public responsibility.

The most recent area in which nursing is deeply involved can be summed up in one word—shortage—on national, state and local levels. Just how short we are today it is difficult to measure; the need is already beyond the point where it can be measured in terms of open staff positions as it was in the first postwar years. But the shortage is so profound and so prolonged that it can be called both chronic and acute degeneration. It is so marked that it is not only not threatening but actually changing the fundamental policies and practices of hospital care that are known to be good and sound. Though nursing policy is not the primary cause of this shortage, there is no question that it aggravates the shortage. On all sides can be found evidence that (1) the strong push for formal education for all nurses, (2) the campaign to separate nursing education and nursing service, and (3) the radicals' attacks on standards, are, in fact, restrictive. These goals of nursing which time may prove to be in the public interest, are today limiting over all hospital services to the public, and aggravating the nursing shortage.

It is not suggested that nursing abandon these objectives; the passage of decades may find these policies fruitful. It is suggested that the nursing profession as a whole, instead of every effort toward a general plan for more and better bedide nursing in our hospitals, that all nursing groups rally their most inconsiderable talents behind a solution to the current problem of shortage. If in the problems of today's demonstration of national and local, we must set as our ultimate goal.
facilities in New York State. It is doubtful if this can be accomplished without vigorous direction and leadership at state level.

CHAPTER XI
The Recent New York State Study

The most recent effort to do something about nursing in New York State is a study conducted under the Board of Regents by the Nurses Resources Study Group. Among many good and sound recommendations are two which are promoted as most likely to be helpful: (1) that the state establish nursing schools in two-year community or junior colleges, and (2) that the state expand its scholarship and endowment funds to encourage high school graduates to study nursing in these and other colleges.

While the first recommendation has merit, we cannot endorse it without qualifications which follow: (1) new schools of nursing should be established only in geographical areas where there are needed to expand or consolidate teaching facilities; (2) the nursing teaching facilities that may be created in junior colleges should be used to augment, expand, or strengthen existing or new hospital nursing schools and (3) control and coordination of the nursing school should be in the hospital or college, whatever is mutually advantageous in the local situation.

The recommendations regarding scholarships might be useful, but should be tested in service in the affiliated hospital. We must keep in mind that the first year of these scholarships is to produce hospital nurses. The production of nurses who can teach is secondary.

We felt that the use of community college facilities in this way would permit existing or new hospital schools to make maximum use of these teaching clinical facilities and at the same time make whatever help was needed available to the academic facilities at an overall minimum cost to both the hospital and state, i.e., the people. This plan will not permit rapid expansion of nursing teaching facilities but is the limit of the clinical facilities available.

While the final recommendations of the nursing facilities study deserve much with which we can agree that are disappointing in that they fail to define a specific plan for action. The fact that the public needs must be met and should be met, and that the problem of nursing shortage is one which variety is clear. The entire subject has been studied, conferences, recommended, resolutely, and "workshopped" to death. Has the time not come for the Regents to come out with a comprehensive plan that can receive the support of all interested groups and the public? We believe that they can, and should, and must.

CHAPTER XII
Recommendations

1. Comprehensive Nursing Education

All teaching and organizational facilities of nursing should unite behind a program of comprehensive nursing education, or a highly integrated system offering the high school graduate a flexible plan in which the student could divide from year to year how far she wished to advance.

a. The first year of training, or the initial educational package, should qualify the nurse for the practical nurse's diploma. If the student wished to go further in the R.N. credit to be given for this first year of work.

b. The high school graduates could proceed to the R.N. through the practical nurse system, in flexible steps (intensive) with financial aid in the form of scholarships, if such were needed. If scholarships were given by or to a nursing school, the financial aid should stop at the end of periods of nursing service possible mechanisms.

c. The R.N. may proceed to an academic (collegiate) degree by further intensive steps within the system, again with scholarship aid if this would require another two years of full-time work, but should be flexible enough to suit the needs of the student.

2. Wherever possible, this integrated program should be given in the same institution or group of institutions, through systems of affiliation that suit the needs of the particular comprehensive nursing school and the geographic area.

3. The integrated program should not be specifically tied to other colleges, hospitals or facilities, but wherever combination of these facilities best for the local situation.

4. The plan and clinical methods of the nursing school are important, but the curriculum should be integrated primarily toward both nurses. Beyond that it should be directed toward nursing administration and education.

5. The R.N. study should be possible for any nurse who has graduated from an efficient, well-organized nursing school and is interested in the profession. It is not for every nurse.
categorically, what effect this trend is having on the supply of nurses in the State of New York. But it is certain that the prerequisite and duty of the State to study and advise on this matter, for vigorous leadership at State level is necessary to promote logical local action.

Though the recent report of the Nurses Resources Study Group stresses the consolidation and expansion of schools, the scope of the recommendations does not suggest that a realistic broad plan exists. What is needed is logically doable. The plan should encompass all nursing education: Practical, 3 year hospital, collegiate and community college. The State must be prepared to show each local region what it can do to improve the supply of nurses on all levels, using all educational media. Thus a few facts or long-term studies are necessary to produce such a plan—then the fundamental information should be available.

As Dr. Gantt has brought out in his recent study of high school education, the New York State Master Plan for High Schools does not have legislative force, but acts as a guide. The Board of Regents has the power to initiate and recommend specific projects, but ultimate action lies with the voters of each district. The legislature has offered certain financial inducements to encourage the activation of its High School Master Plan. Similar plans and inducements might profitably be applied to nursing education.

Recommendation 3—Relaxation of Rules and Regulations

The Nursing Practice Act of the State of New York defines the terms under which a nurse may practice. It is worded and applied to an extent that it does not often have to be amended. The Administrative Policy and Guide for each Practical and Professional Nursing School has the spirit, and can be adapted without any provision in the State Law, by the Board of Regents. The present policy is that all practical nurses should be able to take their state and make their living in the state. The Board of Regents has the power to change the provision in the State Law to that extent.

The recommended policy is to relax the rules and regulations so that they are more flexible and adapted to the needs of the state. The scope of the regulation should be extended to cover all areas of the state and to cover all schools of nursing, both private and public.

Recommendation 4—Recruitment of Nurses

In spite of all that has been done in the recruitment of student nurses, it is believed that more can be accomplished by making certain that the various agencies are put to work to the best advantage. The practical nurses should take it upon themselves to gather information, by committee work, as to what they can do to help in the recruitment of nurses. The state and local nursing associations should be encouraged to aid in the recruitment of nurses.

The National League for Nursing through its Committee on Careers has done a truly comprehensive job in recruitment on the national level. This work has been broadened and professionalized by the formation of the National League for Nursing, the state and local associations of nurses, and the various state and national nursing organizations.

It is long past time to consider the development of a national nursing school. This school should be established in the state where the graduate nurse is most needed. The school should be open to students of all levels of education and should offer a course of study that is adapted to the needs of the state. The school should be state-supported and should be under the direction of the state board of nursing education. The school should be located in the city where the graduate nurse is most needed. The school should be open to students of all levels of education and should offer a course of study that is adapted to the needs of the state. The school should be state-supported and should be under the direction of the state board of nursing education.

Recommendation 5—The Utilization of Nurses

The professional and practical nurses available in hospitals are not always utilized to give patients optimum nursing service. This is an entirely local problem, and the regulations apply only to the hospitals. It is recommended that hospital nursing administrators carefully appraise the utilization of nursing personnel in their organizations, with the objective of more and better bedside care for patients.

Professional people would like to believe that their dedication and idealism render them immune to the pitfalls of an era, yet this is far from true. Nursing service has been the victim of the same forces that have changed the pattern of personal services throughout society. Though quite aware that "hating the tide is unwise, we retain sufficient idealism to point out trends that clearly seem wrong. Among these are administrative defects on the local level which fail to get the best nursing service out of those available to give it.

There are suggestions that Parkinson's law has worked overtime in the nursing field. The larger hospitals where administration is simpler, the utilization of nurses is better. But in the larger hospitals the various divisions of administrative nurses suggest that some staff could be taken up by better utilization. The grade of nursing staff is often the group in which experienced nurses, hospital nurses and those in military service are found. Less administrative talent is in a factor. Others are the difficulties of bringing up standards under conditions of high turnover, the increasing lack of staff and the other problems of providing care for patients in hospitals and schools. These problems are not new, but they have been renewed and intensified by the current economic situation.
but a few of the problems, which are easier to define than solve. To meet them requires not only imaginative and dynamic leadership but objective appraisal of the utilization of nurses by each administrative group.

Recommendation 6—Nursing Salaries

It is recommended that hospital administrators explore and evaluate the principles of incentive wages and bonuses as applied to the nursing shortage.

An unfortunate by-product of total employment and standard wages in any field is that the less willing and able get the same monetary reward as others. The nursing profession is no exception and this factor is a source of many problems on the local level. Both nursing and hospital administrators are quite aware of this but in the mad scramble for bedside nurses have done little about it. Since random sampling of the opinions of general duty nurses often brought this factor out, it is mentioned here.

While it is beyond the scope or judgment of this report to make specific recommendations on this problem, we would urge hospital and nursing administrators on local levels to consider the plan that some plans might be worked out to reward diligence. If diligence is not rewarded, over-all performance tends to decrease. Incentive plans are fruitful in many fields.

Another related problem is the nurseless shift who drifts from one job to another. Year-end bonuses tied to length of service or parable units after delivery of the service might tend to reduce this wasteful practice. Again, this committee is not qualified to make specific recom-

Recommendation 7—The Cooperation of All Interested Groups

It is evident that there is no single or simple remedy for the nursing shortage; that regardless of policies, plans and attitudes, hospitals, doctors and the public will have to adjust to a type of nursing care that falls far short of the standards of the 1930's. That it is also evident the public will not indefinitely tolerate policies that deny needed nursing care. In the light of these facts, it is incumbent upon all groups to work together toward helpful solutions, or any reasonable plan that will tend to relieve the shortage. This unity of purpose is paramount and has not been evident up to the present time.

Most of the controversy has arisen over methods. There are two main adversaries: The national nursing societies and their followers, and the three-year hospital schools and their advocates. All profess to pursue the same goal: the difference lies in how these goals should be achieved. The hierarchy, in vigorously pur-

CHAPTER XIII
Summary of Recommendations:

1. All teaching and organizational facilities of nursing should unite behind a program of comprehensive nursing education, or a three-year hospital schools to determine which nursing schools should be closed, consolidated, or expanded, and when and where new schools should be established. To accomplish this, it should develop a Master Plan for Nursing Education comparable to the Master Plan for High Schools.

2. The Board of Regents of the State of New York should evaluate the nursing educational facilities of the State and determine which nursing schools should be closed, consolidated, or expanded, or when and where new schools should be established. To accomplish this, it should develop a Master Plan for Nursing Education comparable to the Master Plan for High Schools.

3. The administrative policy and guide that requires practical and professional nurses to be taught by those with B.S. degrees should be relaxed until the supply of nurses more closely approaches demand.

4. The New York State Nursing Department should take more active leadership and responsibility for the recruitment program on the local high school level.

5. Hospital nursing administrators should carefully appraise the utilization of nurses in their respective organizations with the objective of more and better bedside care for patients.

6. Hospital administrators should explore and evaluate the principles of incentive wages and sources as applied to the nursing shortage.

It is evident that there is not one single or simple remedy for the nursing shortage; that regardless of policies, plans and attitudes, hospitals, doctors and the public will have to adjust to a type of nursing care that falls far short of what we have accustomed to in the 1930's. That it is also evident the public will not indefinitely tolerate policies that deny needed nursing care. In the light of these facts, it is incumbent upon all groups to work toward helping solutions, or any reasonable plan that will tend to relieve the shortage.

There is much more that might be said and many more suggestions that might be made about nursing. These administrators and doctors on the frontier of the problem are aware of all of them, for they are widely discussed. It is hoped that they, and the Board of Regents who are in a position to either help or hinder, will do the very best that can be done in the public interest.

References:


5. COMMUNITY COLLEGE EDUCATION FOR NURSING: By: A. L. Weinberger, Ed.D.


TO: Presidents and Executive Directors
State Nurses' Associations

FROM: Betty J. Thomas, M.N.Sc., R.N.
Director Betty Thomas
Center for Governance

DATE: July 15, 1988

RE: President Styles' Report to the Constituent Forum Meeting, June 10, 1988 in Louisville, Kentucky

In response to many requests we are sending you a copy of President Styles' report to the Constituent Forum held June 10, 1988 in Louisville, Kentucky.

BJT:jg:026
Good morning and welcome to Louisville. It is a pleasure to be here with you. Our topic for discussion this morning is "Encroachment on Nursing Practice and AMA's proposal for Registered Care Technologists (RCT)." I know that each of you is working very hard at the state level over the past few years to advance nursing's cause and could probably recite chapter and verse the reasons for many of our current dilemmas in nursing. Increased patient acuity -- serious salary compression in the workplace -- increasing career options for women -- the reality of demographics, that is, a declining pool of young people from which to recruit and the greying of America. And there is also the underlying struggle to define our health care environment.

A few months ago, in February, I made a presentation before the Virginia Nurses' Association and remarked about the revolution within the health care system as described by Joseph Califano, former Secretary of the Department of Health, Education and Welfare under the Carter administration. I quoted Mr. Califano from his recent book: This Revolution Promises to be Bruising and Bloody. "At stake are who gets how much money out of one of America's top three industries, who suffers how much pain how long, and who gets the next available kidney, liver or heart; in short, who lives and who dies -- and who decides." ... I added, "and who cares." It now looks as though this statement may apply to health professions, as well as patients.

Nurses care for the health of the people of this nation. Nurses are proud to care. Nursing has been in the forefront fighting for change in the American health care system for decades. This struggle has been motivated by centuries of inequity in the delivery of quality health care -- access to care -- for women, children and the poor and other vulnerable populations. Nursing has come a great distance and we can be proud to acknowledge that nursing has been very influential in bringing the health care system from an institution -- to a system that attempts to serve every citizen regardless of ability to pay. We have come this far through carefully considered actions, counteractions -- through practical involvement in politics. As nurses we should be proud that our unity and our actions have enhanced life for all Americans. As nurses we must continue to exercise our political power and be alert to opportunities to impact the health care policy-making process. Indeed, we must become, in ever greater numbers, policy makers.

All of you are aware that we face a new challenge. I am now speaking of the American Medical Association's solution to the nursing shortage -- the creation of a new category of care giver which AMA has titled "Registered Care Technologist," or the RCT. According to the AMA Board of Trustees, which adopted a plan for implementing initiatives to prepare RCTs for employment in the nation's hospitals and long-term care facilities, medicine has determined that such action is necessary because, and I quote, "nursing has abandoned its commitment to the provision of nursing services at the bedside, and is devoting its resources primarily toward the development of the nurse in advanced practice in a variety of settings external to the hospital."
In response, AMA has announced its intent to educate, employ and supervise the RCT to execute "medical protocols at the bedside with special emphasis on technical skills."

Medicine's licensing and supervision of the RCT, whose primary functions would be nursing-related tasks, would be impinging on the nursing profession. The proposed scope of practice of the RCT is a clear duplication of the functions of the technical nurse and the professional nurse, as currently defined in law. RCTs would however, according to AMA, have much more limited training. And if RCTs are used, as AMA proposes, as a substitute for nurses, then quality of care will be compromised. In addition, another level of health care personnel would be added to an already poorly defined system, and would complicate safe, effective care in acute and long-term care facilities. To the public and policy-makers, it might sound quite simple. Boiled down to its most common denominator, medicine is saying that if nursing cannot solve the nursing shortage, then for the sake of the nation, medicine will. However, things are never as simple as they might seem.

First of all, nursing has not abandoned nursing at the bedside. There are great and difficult problems ahead, but to blame nursing for an increasingly complex health care system, highly dependent upon technology; to blame nursing for increased patient acuity in hospitals and long-term care facilities; to blame nursing for a decade of decreasing federal support for nursing education; to blame nursing for serious pay equity and salary compression problems within hospital settings is, sum it up, either deceptive or unknowing. But before describing what I believe are the other motivations behind the AMA proposal, let me bring you up to date on nursing's response to this proposal as it has unfolded.

A representative of the ANA Board of Directors was present at the AMA report in Reference Committee in December 1987 held at the same time as our board meeting when the AMA Governing Body first discussed solutions to the nursing shortage. ANA set forth nursing's concern about the critical shortage of nurses and reaffirmed our position about educational preparation for professional and technical nursing.

The ANA Board of Directors received AMA's implementation plan related to solving the nursing shortage on March 29, 1988; the RCT was the solution. One week later, the ANA Executive Committee discussed this report with the AMA Executive Committee during a regularly-scheduled joint-meeting on Monday, April 4, 1988. Nursing's opposition to AMA's proposal for registered care technicians was made clear and a follow-up meeting was immediately scheduled for April 20, 1988. On that date, representatives of the American Medical Association, members of the ANA Board of Directors and the Executive Director of ANA met in Chicago. The President of AONE joined us for that meeting since ANA is a pivotal player in the game. AMA indicated that the proposal would remain intact and that it would serve as the foundation for discussions related to the nursing shortage.
Following this meeting, the Tri-Council, composed of the American Nurses' Association, the National League for Nursing, the American Organization of Nurse Executives and the American Association of Colleges of Nursing, planned a meeting in ANA's Washington, D.C. office on May 5, 1988—the nursing summit. Representatives from SNA regions and from all national nursing organizations were invited. The focus of this meeting was twofold: first, to consider the implications of proposals to introduce new categories of care givers in response to the nursing shortage; and second, to mount a unified strategic offensive to resolve the nation's continuing nursing shortage.

During this historic meeting, participants representing 25 separate groups focused on immediate solutions and affirmed that nursing is committed to resolving this problem through both short-term and long-range strategies. It was the overwhelming consensus of the group that the creation of new categories of health care providers is unnecessary, duplicative, costly, and further fragments patient care. A position paper entitled "short-term strategies to resolve the nursing shortage" was developed. These short-term strategies, which have now been endorsed by 44 organizations, are:

1. Immediately increase the time that registered and licensed practical nurses spend with patients by reallocating resources and designing new staffing systems to: a) expand utilization and employment of ancillary personnel responsible to nurses to assist in the clinical and nonclinical support tasks essential to nursing care; b) increase the retention of experienced nurses by improving salary and benefit structures; and c) increase the use of informational and systems technology to support patient care.

2. Quickly expand the overall pool of nurses who work in hospitals and long-term care facilities by: a) helping nurses who work part-time to return to full-time employment; b) developing nursing educational outreach programs to corpsmen, paramedics, technicians and others with health care training; c) facilitating educational mobility; d) increasing financial aid to career changers to complete accelerated nursing programs; e) increasing financial aid to students; f) increasing the number of minority students; and g) increasing the number of work study programs.

This position paper, distributed to all the SNAs, was sent with a cover letter to William S. Hotchkiss, M.D., President of ANA, May 13. In this letter, signed by 33 representatives of national organizations, we state, "nursing's major occupation has always been and will continue to be providing nursing care at the bedside."

If we examine ANA's proposal and their arguments for the creation for the BCT we find that medicine purports to be concerned about the critical shortage of bedside care givers to monitor medical procedures in acute and long-term care facilities. AMA suggests that the movement of nursing toward R.N.-prepared professional nurses and A.D.N.-prepared technical nurses is eliminating those nurses who traditionally have functioned as bedside care givers. The AMA
states that RCT-educated personnel will "supplement and eventually replace those hospital-based programs that are being phased out by organized nursing." AMA further contends that the availability of RCTs "will assist business and administration to access interchangeable pools of bedside technologists and nurses for acute and long-term facilities."

However, the facts don't support the argument. Numerous studies, including one completed by the Hawaii task force on nursing education and service, find that hospitals and skilled nursing facilities prefer to hire BSN-prepared nurses when they can. The majority of providers report the need for greater numbers of BSN-prepared nurses to manage increased patient acuity and dependence on complex technology. Providers agree that the BSN-prepared nurse is more competent in areas of patient teaching, case management, coordination of services, health guidance and counseling, and overall assessment and evaluation, because of a more comprehensive theoretical background. Clearly, it seems to me, personnel given the "basic training" described by AMA for licensing as an RCT will not adequately meet the need for quality nursing care services in this country. All citizens will suffer, especially the frail elderly, and the chronically and critically ill.

AMA proposes to prepare RCTs to reflect three levels of preparation. The first level requires two months of training. The basic training, described by AMA requires seven months of training and is similar to LPN programs and would prepare individuals to provide care of all patients requiring custodial care and/or relatively low technology bedside care in homes, hospitals, and long-term care facilities. An additional nine months of training would qualify RCTs to specialize. According to AMA, these advanced RCTs would provide the type of high technology care in acute care facilities that has been provided in the past mainly by nurses prepared in hospital-based diploma programs. It is AMA's intention that status as an advanced RCT be made available to "current" RNs who wish to remain at the bedside.

Nursing has held, for some time now, that nurses devote too much time to non-nursing tasks. This country can no longer afford the down substitution of professional nurses to tasks best performed by auxiliary personnel. Health care providers must accept the responsibility of assisting nurses in their efforts to provide the quality services nurses are prepared to deliver. Nurses make up the largest percentage of the nurse workforce and there is no question that they are carrying a greater share of the burden with the erosion of support systems. Professional nurses transport patients, devote hours to clerical work, and other duties that could be assumed by other personnel. This should not be. The infrastructure is in place to supply nursing care and the support systems that will free nursing from non-nursing functions. And so I suggest, the creation of the RCT is unnecessary, duplicative, costly, and will further fragment patient care.
We recognize that the trend in hospitals to use more professional nurses in comparison to other personnel is motivated by cost containment. But it has been, is, and will continue to be a very short-sighted solution to the underlying and very long-range reasons for the current shortage of nurses. A much more efficient short-range solution would be, again, to increase the time nurses spend in direct patient care.

For example, if it is assumed that support systems to nursing can free up 20 percent of a nurse's time for patient care, then we potentially can eliminate the shortage. The use of nursing assistants could begin almost immediately. Minor budget and personnel systems adjustments will be required, and nurse administrators may be able to direct implementation without undue administrative approval time in major institutions.

Nursing's second major strategy to address the shortage—expand the pool of available nurses—can be accomplished through better benefits and compensation—this too can be implemented quickly. Improved compensation is seemingly an expensive strategy. But if one considers that increasing the compensation of all 1.2 million fully employed nurses by 10 percent would cost between $3.0 and $3.5 billion per year, this represents only about two-thirds of 1 percent of the nation's annual health care expenditure. Given the serious consequences of the nursing shortage, this expense seems justifiable. This is particularly true when the long-run nature of the nursing shortage is considered. Improved compensation is a long term as well as a short range strategy and will improve nursing as a desirable career choice for young people.

It has become clear that the AMA is prepared to move forward to conduct prototype training programs for the RCT and that the AMA plans to establish national coalitions of providers and interested groups in support of the proposal. The RCT will not solve the nursing shortage. If implemented, this proposal will have a detrimental impact on the delivery of care in acute and long-term care facilities.

States, as well as the AMA, have pointed out the weaknesses in the AMA proposal. The first major weakness in AMA's proposal of the creation of the RCT is the false assumption that standardization of nursing education will lead to the elimination of nurses prepared to deliver bedside care. To cite a rebuttal in this state, the Kentucky Board of Nursing's response to the AMA proposal dated May 4, 1988 states in part... "A cursory analysis of this proposal demands that it be noted at the outset that the decline in the number of diploma programs in the United States was well underway long before the current shortage of licensed nurses. The Kentucky Board of Nursing has no plan to phase out LPNs or LPN education programs in the Commonwealth. The AMA proposal does not provide any basis in fact for either the conclusion that academic nursing education inadequately prepares bedside care givers or that licensure of yet another health care worker will attract additional persons to a career centered around the delivery of bedside care... Rather than attempting
to add a new category of health care worker to purportedly resolve the current nursing shortage, diligent efforts and maximum resources should be expended to appropriately educate, recruit, utilize, and retain nurses in the health care delivery system.”

The second major weakness of this proposal is the failure of medicine to acknowledge the current use of nursing assistants. Rather than addressing resolution of the nursing shortage, AMA’s proposal is designed to strengthen medicine’s control over bedside care givers and to weaken nursing’s control of nursing personnel and undermine nursing’s efforts to standardize nursing education.

I believe that these weaknesses in AMA’s argument direct us to the truer motivations for their proposal. Some years ago medicine lost control over nursing education, more recently the medical profession has lost some control over health care workers, over the hospital environment, and aspects of medical practice that are now determined by cost containment measures, such as length of patient stay. More physicians are now employees of hospitals and other major institutions, and are thus competing for a greater percentage of the hospital salary share. In addition, general medicine has expressed its view that nursing roles such as those of nurse practitioners and clinical nurse specialists are encroaching on medical practice. However, it is likely that specialized medicine supports nursing’s expanded roles and would see elimination of such roles as a loss to their income and loss of effectiveness of the medical-specialist/nursing-specialist team. Some of the most negative feedback on the AMA proposal is coming from the medical specialty groups. We should not make the assumption that individual physicians or other sectors of organized medicine are supportive of the RCT proposal.

Nursing has raised questions about the appropriateness and feasibility of the AMA proposal to answer the nursing shortage. Nursing has asked AMA to modify or withdraw the proposal and work with us on the real causes of this shortage and specifically to refocus on support systems to nurses. During all discussions with AMA on this issue, organized medicine has adhered to its original proposal, as well as to several inaccurate statements about nursing practice and the goals of organized nursing. Nursing can only conclude that quality of care is not the central aim of AMA. It is power.

Again, I would like to quote from the analysis provided by the Kentucky Board of Nursing...”In addition to diluting the quality of care rendered at the bedside, one of the primary effects of the AMA proposal will be to enhance the monopoly power of physicians in the health care marketplace while simultaneously undermining the hard won professional identity of nurses, a competitive occupational group. Further, the proposal calls on other significant players in the health care arena to join in a conspiracy to those ends. Simply stated, the AMA proposal is a blueprint for the re-subjugation of the nursing profession or, failing that, its displacement and destruction as a viable competitor in the delivery of health care services...Predatory conduct of that nature raises substantial questions under both Kentucky and Federal Anti-Trust Law.”
Since the AMA is determined to move forward on the proposal, we have promised to wage an all-out offensive to prevent its implementation and to gain support for nursing’s solutions to this shortage. The ANA board is determined to work with the SNAs to stop this movement and will be bringing forth a strategy document to the house. The board is authorizing that $120,000 from reserves be allocated to this effort. Moreover, on a national level we have been meeting with AMA’s designated allies to align them with nursing on this issue.

In closing, nursing will meet this challenge and it will be our finest hour. The panel discussion which will now begin will surely raise other questions. I know that many of you are aware of activities of groups within your states proposing the use of new categories of bedside care-givers.
The Wrong Prescription
For Hospital Care

Why no shortage of doctors to worry about, the American Medical Association is now directing its fire to the undersupply of nurses. At its convention in Chicago in late June, the association's House of Delegates proposed a solution: Create a new type of worker, the "registered care technologist."

The scheme, at best, is a sugar pill that creates the illusion that help is on the way for hospitals desperate for nurses. A current federal report says that as many as 300,000 vacancies exist.

The AMA forecasts its registered care technologists as executing "the medical protocols at the bedside with special emphasis on technical skills." They would be trained for 2 to 18 months, ranging from "low-tech" bedside care to the "high-tech" work of renal dialysis and emergency-room medicine. In the vision of Dr. James H. Sammons, an AMA vice president, "the registered care technologist is a nonleadership, technical role, in contrast to professional nursing care that is labeled as autonomous, managerial and holistic."

Sammons said last week that his "profession is not going to tolerate not having people at the bedside to take care of the patients."

Such high-toned chatter belies the reality of current hospital care.

Orderlies, nurses' aides, LPNs (licensed practical nurses), nurses, nurse practitioners, physicians' assistants and physicians are already meant to be tending patients. Why add a new worker? If Sammons is alarmed about untended bedside, why doesn't he be bold and remind doctors that nothing is keeping them from that kind of care? Do their high salaries exclude them from the human touch of spending time on a personal basis with the sick? With an oversupply of doctors, bedside care should be one of the daily ministries for which physicians now have time.

Hospitals, like governments and churches, have hierarchies. Everyone lower down, it is decreed, is to perform lesser work that allows higher-ups to do greater work. Orderlies take care of bed sores and bedpans to free up nurses' aides. Nurses' aides take temperatures, bathe patients and check IVs. In free LPNs, LPNs do some meditating, change dressings and monitor diets to free nurses.

But who watches the doctors? How do they become more sensitive to bedside care? How do hospital administrators treat them as cheap labor? The American Nurses Association reports that nurses can expect only a 36 percent lifetime salary increase, compared with a 231 percent increase for chemists, 192 percent for accountants and 106 percent for computer programmers.

The AMA fears nurses as rivals. Its record of opposing reforms proposed by nurses is almost as black as its long opposition to progressive health care legislation, independent-thinking doctors, sure in their skills and sure that compassion is the essence of their craft, welcome nurses as partners, not threats. Many of these doctors reject the AMA's "registered care technologist" solution as little more than another grab for power. The technologists would be registered through state medical boards. Nurses, as if they haven't enough harassment, are now organizing to defeat the AMA's plan. They have logic and facts on their side. If the supply of 1.3 million nurses now at work is far short of the demand, then the solution is not to bring in low-past workers but to strengthen nursing by increasing salaries, autonomy and power. Nurses have earned all three.

The idea of placing "care technologists" at the bedside is an insult to nurses. That's exactly where they prefer to be. Care needs to be humanized, not technologized.

Along with other noted humanitarian groups—the Teamsters and the National Association of Realtors—the AMA ranks among the nation's seven richest political action committees. It spends lavishly to advance its self—its self-interests. As well as anyone, nurses know that when the AMA comes around offering a cure—as it does on this issue—watch out. It's probably spreading the disease.
REPORT OF THE BOARD OF TRUSTEES

Subject: Registered Care Technologists

Presented by: Alan R. Nelson, M.D., Chairman

Referred to: Reference Committee C
(John J. Gaughan, M.D., Chairman)

At its February 1988 meeting the Board of Trustees approved a proposal to develop a non-nurse, bedside care technician, to be called a Registered Care Technologist. The goal of the proposed Registered Care Technologists (RCT) program is to contribute an innovative solution to the shortage of bedside personnel that will be timely, cost effective, and efficient. The purpose of the plan is to provide a dependable supply of technically oriented bedside caregivers that will improve access of patients to needed medical care in hospitals. It is also the intention of the proposal to:

1) provide support services for nurses at the bedside and a recruitment pool for higher education in the health professions,
2) coordinate the fragmented education of certain hospital based technicians, and 3) organize and implement accredited hospital based apprenticeship programs and hospital based inservice programs to teach technical skills to nurses.

Background

At the Interim meeting 1987, Report CC, "Nursing Education and the Supply of Nursing Personnel in the United States," was adopted by the House of Delegates. The recommendations supported the efforts of nursing to facilitate the recruitment, retention, and education of nurses to provide care at the bedside. In response to the growing shortage of bedside caregivers, the report also recommended support for hospital based programs to promote the education of non-nurse caregivers for acute and long term facilities. The report recommended that the AMA cooperate with other organizations to develop and accredit programs to increase the availability of caregivers at the bedside in order to meet the medical needs of the public.

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1. Initiatives of Organized Nursing to Solve the Shortage of Nurses at the Bedside

Organized nursing has promoted several initiatives to solve the problems of bedside nursing shortage. These include the solicitation of funds from Congress to support higher education of nurses. Funds have been acquired for demonstration projects to differentiate practice between the two levels of entry into practice, the two-year Associate Degree (ADN) for the "technical" nurse, and the four-year Bachelor of Science in Nursing degree (BSN) for the "professional" nurse. It is the goal of nursing to promote the technical nurse as the bedside caregiver in long term care facilities, to replace LPNs, and to place professional nurses in hospitals as case managers and providers of comprehensive care at the bedside. This strategy is consistent with the goals of the nursing profession to upgrade education for nurses. Organized nursing has also convened several conferences on the nursing shortage and has been the major influence in promoting Secretary Bowen's Commission on the Nursing Shortage. The Commission is charged to offer solutions for the registered nurse shortage by the end of 1988. An ANA representative sits on the Commission.

In response to the shortage of nurses, the nation's hospitals have adopted various measures to maintain access to medical care. Substantial increases in nursing salaries have occurred. Nurse registries have provided bedside care on a temporary basis in places where the need is urgent. On-the-job training of technicians in various hospital units is taking place. Many hospitals have engaged recruitment firms to sponsor nurses to come to the United States from the Far East and Europe. The House of Delegates adopted Resolution 121 (T-87) supporting efforts of members of the health care field to extend H-1 visas for nurses actively practicing clinical nursing. While all these are necessary responses, a new approach is required to provide safe, effective, quality care for the basic and technical needs of patients at the bedside in the immediate and long term future.

The Proposal for a Program to Prepare Registered Care Technologists (RCTs)

The RCT program is designed to meet the variable needs of patients for bedside care during the current shortage and beyond. The RCTs would work with nursing personnel and assist with bedside care at non-managerial levels. These technologists, however, will be oriented to the highly technical environment of modern medicine. The RCTs would be part of a medical support system that will be of assistance to nursing in hospitals.
1. There are several kinds of technicians who already deliver
2. direct patient care in hospitals and provide a safe environment and
3. support for physicians and the health care team. Surgical
4. Technologists, Respiratory Therapy Technicians, and Emergency
5. Medical Technicians, among others, have programs that are accredited
6. by the Committee on Allied Health Education Accreditation (CAHENA).
7. Many technician roles at the bedside are not accredited by CAHENA
8. such as cardio-pulmonary and dialysis technicians. In some
9. hospitals where bed closures impede access to medical care,
10. physicians report the training and supervision of technicians to
11. monitor medical services in critical care and other highly technical
12. units. The RCT program will offer a mechanism to coordinate and
13. extend the current training of technicians delivering direct patient
14. services and assure consistent standards of education necessary for
15. quality care.

16. RCTs will form a recruitment pool of experienced, skillful
17. bedside care technologists who may consider advancement in the
18. health field through higher education as part of their future career
19. plans. At the same time RCT training could provide a potential
20. source of revenue for technologists seeking to defray the costs of
21. higher education in the health disciplines of their choice. The RCT
22. will maintain a special role, oriented to bedside care and assure
23. access to needed medical care in an increasingly technological
24. environment that requires highly personalized services.

25. Scope of Practice of RCT's
26. The RCT's scope of practice would be to continuously monitor and
27. implement physicians orders at the bedside in order to support and
28. promote the welfare of patients in institutions. Three levels of
29. competence would be included in the program: 1) assistant, 2) basic,
30. and 3) advanced levels. The RCT is a resource for nurses but not a
31. direct substitute for nurses in long term care institutions and in
32. acute care hospitals.

33. Functions of the Three Levels of Competence of RCTs
34. The assistant to the RCT would be able to function as a bedside
35. aide equal to assistants now required by the new federal law (PL
36. 100-203 Omnibus Reconciliation Act, 1987) for long term care
37. facilities. The basic RCT would substitute work now performed at the
38. level of licensed practical nurses. Licensure as an RCT would be
39. available to LPNs who desire to monitor and implement bedside
40. medical care, administer routine, non intravenous medications, with
41. supervision. Advanced RCTs would require an additional nine months
42. of experience in several hospital intensive care units. RNs and
hospital technicians already experienced in the delivery of direct
patient care would be eligible to complete this course which will be
sufficiently rigorous to serve as a practical-orientation program
for new graduates from schools of nursing.

Structure of Educational Program for RCTs

Education for Registered Care Technologists would be offered at
a post high school level and provide instruction for three
contiguous levels of competence: assistant, basic, and advanced
Registered Care Technologist. An assistant RCT would require two
months of training; the basic level would be completed after an
additional seven months, after which the RCT would be eligible for
licensure. An additional nine months of highly technical education
would provide certification as an advanced RCT. The total program
could be completed in eighteen months. The program is stringent but
flexible and can be accessed at any level at the discretion of the
student, or the RCT could be recruited for service by the hospital
on completion of any stage of preparation.

Accountability

The Registered Care Technologist would require licensure to
assure minimal standards of practice and protect the public good.
To avoid a multiplicity of licensure boards, the RCT would be
licensed under an arm of the State Medical Boards. To assure
quality of education, accreditation through a national body such as
the Committee on Allied Health Education Accreditation (CAHEA) would
be essential. Liability insurance would be under the auspices of
the hospital employer which would also be responsible for assigning
technicians and relevant resources to the appropriate department.
The RCT would be accountable for physician orders for patient care
in accordance with the scope of practice and would report to the
head of the unit where they are assigned.

Recruitment

The program would be marketed to high school students, with
emphasis on low income groups. The program may also attract male
and female students who are uncertain about their choice of health
care career. LPNs and many kinds of technicians with experience in
the delivery of direct patient care may also be recruited for
advanced training as RCTs. The program would be offered in
hospitals in cooperation with local vocational schools or community
colleges. Apprenticeship programs ordinarily pay partial salaries
during the period of education. Current costs of hospital inservice
education might be appropriately applied against salaries.
Interorganizational Coordination

A meeting between the executive directors of Associations concerned with providing safe bedside care in long term and acute care settings and the ANA is planned in the near future. The following organizations have been invited to help plan this initiative: the American Hospital Association, the American Academy of Physician Assistants, the American Association of Community and Junior Colleges, the American Association of Retired Persons, the American Health Care Association, the Federation of American Health Systems, the Joint Commission on Accreditation of Healthcare Organizations, and the National Association of Practical Nurse Education and Service. The purpose of the meeting is to coordinate the concerns of non-physician associations regarding the bedside care shortage and to focus their efforts on a possible long term solution.

Plan of Action

- The Federation will be consulted to identify states where the shortage of bedside personnel is crucial and where there is a willingness to participate in a demonstration project for educating RCTs.
- A grant proposal will be completed to further develop and implement the RCT demonstration projects through the selected Federation members.
- The cooperation of non-physician associations to improve and market the proposal will be sought.
- Cooperation with nursing will continue to be sought to assure that the RCT project provides a recruitment base for nursing.
- Support for nursing in its efforts to recruit and educate nurses for the bedside will continue as an important aspect of this initiative.
FROM THE EDITOR

An alarming proposal

Picture yourself at the bedside of the future: You assess patients. You monitor medications. You chart. You attend to skin care, ambulation, nutrition. You know anatomy, physiology, psychology. You’re licensed by the state. You look like a nurse. You act like a nurse. But are you a nurse?

Not if the American Medical Association has its way. AMA’s trustees would turn the bedside over to a new breed: Registered Care Technologists. They see this as the answer to an acute shortage of nurses. Instead, it may be the most serious challenge ever to the autonomy of nursing.

The AMA argues that organized nursing’s emphasis on “autonomous professional status”—specifically, phasing out LPN and diploma programs in favor of the BSN—takes nurses away from the bedside. Basic care requires “relatively low levels of technology,” so RCTs would be adequately prepared by the equivalent of current LPN programs. More complicated care would be given by Advanced Registered Care Technologists, roughly equal to diploma nurses. In short, the AMA thinks that nurses can be professionals only if they become “hands-off” managers.

Exceptions might be made. Nurses with “sufficient experience at the bedside” could get RCT licenses. And advanced certification—which AMA suggests be supervised by its own Committee on Allied Health Education and Accreditation—“will be available for current RNs who wish to remain at the bedside.” The result: Staff could be hired from “interchangeable pools of bedside technologists and nurses.”

Interchangeability implies equality, but you can bet the last latex glove in the ER that salaries won’t be equal for nurses and “care technologists.” Rather than pay nurses what they’re worth, the AMA would create a new class of caregivers—and control the standards of that second class.

Who’ll support this move? The AMA notes that the American Hospital Association and the Federation of American Health Systems are concerned about the shortage of nurses. The American Association of Community Junior Colleges—who could use an influx of RCT students—is mentioned as an interested party, as are specialty medical organizations, particularly surgeons and ER physicians. See any nurses in that group?

In fact, where were nurses while the AMA was thinking up RCTs? Too many were arguing with each other. The American Nursing Association proposed two levels of practice some 22 years ago, but the distinction between technical and professional has yet to be implemented in a way that properly respects both academic credentials and hands-on experience.

It’s been said time and again that if nurses don’t get their own house in order, someone else will do it for them. This ill-conceived and ill-concealed grab for control cannot be met with dissension and indecision. The ANA has argued lucidly against the RCT concept from the start, and now there is no choice but to present united opposition. Do it with your voting power—new state laws and federal money will be needed to implement the RCT proposal. Do it through your national, state, and specialty nursing organizations. Do it anywhere you can, but do not fail to maintain control over your own profession. The lives of too many patients are at stake.

Rick Lavin
On the Silly Season . . .

In spring, the old Life magazine used to catalog goldfish swimming and phone booths stuffed with undergraduates. It was the "silly season."

This particular spring we have a new example of how the return to nice weather makes silliness sprout, in the form of a proposal by the American Medical Association (AMA) to create a new category of personnel for hospitals, the "Registered Care Technologist."

We did not make this up.

The Registered Care Technologist (RCT) will "execute the medical protocols at the bedside with special emphasis on technical skills." The basic RCT (there is an advanced one proposed too) would deliver "low-tech" care. High-tech care, as we read it, is medical care. We did think that one of these days it would become clear that modern medicine is, increasingly, the exercise of technology.

But "at the bedside?"

The AMA says "consistent with the goal of nursing to achieve autonomous professional status, hospital-based programs preparing bedside care nurses are being phased out." (They refer to LPN programs as well as diploma schools.)

The solution, therefore, is this new category of people, who would be licensed by the states, as graduates of programs accredited by the Committee on Allied Health Education and Accreditation, run by, guess who?

Registered nurses could "challenge [the new licensing examination] if comparable experience at the bedside can be validated."

Honest, we didn't make this up.

The RCT "is a non-leadership, technical role in contrast to professional nursing care that is labeled (emphasis added) as autonomous, managerial and holistic."

There are lots of ways of thinking about this proposal and most of them make our blood pressure spray out our ears. The easiest way to think about it, however, is that it is just part of the silly season.

The RCT is proposed as an answer to the nursing shortage. We are rather more impressed with some of the things we are hearing about all over the country, ways in which nursing is acting to relieve the pressures on our scarce resource. We heard, for example, of a hospital in the mid-Atlantic area that has created essentially two nursing staffs. Nurses who wish to go to school are hired full time in the summer months and work one or two shifts a week during the academic year. Nurses who wish to be at home with their families during their children's summer vacation are hired to work full time during the academic year and a couple of shifts a week in the summer. Nice idea.

The Today show recently had a whole series of programs about nursing. On one of them, a vice president for nursing from Florida talked about how he had deal with shortages in his institution. First, salaries were raised and that made recruitment for the day shift easy. Then, he experimented with salary increments for the evening, night, weekend and holiday times that are more difficult. Over a series of moves, he found out what the "price" should be for an unpopular shift, and paid it. Problem solved.

In another hospital, the management decided to ask nurses what would make their jobs better. The management was astonished to find a number of problems they didn't know about. Among them was the impossibility of parking and the unavailability of linen and other stock floor supplies. Solution? Restrict one floor of the parking garage for the evening shift (since those nurses had the most trouble finding a place to park) and tell the purchasing department to stop trying to save pennies by ordering less than needed. It costs the hospital a lot more to be short of nurses than a truckload of diapers or Chux.

On that same Today show, Joyce Clifford, Vice President for Nursing at Boston's Beth Israel Hospital, put the whole thing into perspective. "We expect nurses to make serious decisions involving people's lives," she said. "So why not let nurses make serious decisions involving institutional policy too?"

Spring may bring out silliness, and crises such as the nursing shortage do provoke odd proposals. To nursing's credit, our professional organizations have avoided hysterical reaction to some of the sillier notions about the work. For us, this spring is the sensible season.

Donna Diets
Editor
OF TASKS, TECHS, AND CONTROL

What do you do when you hear someone give an opinion about your work that’s so ignorant it’s outrageous?

What if that person is a highly placed colleague? Like those in the American Medical Association who suggest the creation of Registered Care Technologists to be trained to give hands-on care and medicines in hospitals?

Or the American Hospital Association’s personnel directors, who say that nurses should become delegates of tasks, not performers of care?

See their suggestions on p. 894.

Why is it so difficult for these physicians and personnel directors to get beyond the antiquated notion that patient care is only a series of mechanical tasks?

And what do their opinions about to patients about the patient’s place in the hospital hierarchy?

Maybe they don’t know hospital history. When historian Susan Revery was told of AMA’s “new” idea, she laughed. “Every time there’s been a nursing shortage or when nurses have pushed for further education, AMA has recycled the same solution. It says nurses are overtrained and suggests a quick fix with technicians.

In 1921 during the influenza epidemic, for example, Dr. Charles Mayo suggested recruiting 100,000 farm girls as sub-nurses” to relieve the shortage.”

Most of us latter-day farm girls have strong feelings about handing care of patients to technicians. Think back, for instance, to the recesses of state mental hospitals where patients were warehoused, controlled, “managed.” Where patients were viewed as rows of diapers to be changed and where urine was constantly being mopped off floors.

Custodial care. What techs (and many had good intentions) had any concept of behavior modification, of bowel and bladder training, of watching for tiny sparks of change that could be fanned into embers of hope?

Some of the techs also had an overblown sense of fairness. Why should one patient receive more attention than another? This misguided application of the democratic ideal ignored the whole concept of timing, of seizing the opportune opening. And hope was there by neatly flattened, along with the pillowcases.

Then my brain fast-forwards to a hemodialysis unit where the attitude toward patients was dominated by technicians who relieved their boredom with speed games: how fast could the “techs (and the nurses they bullied) get ’em-on and get ’em-off dialysis? Never mind that patients were terrorized in the process. And again, that same perversion of democracy: Don’t give one especially terrified patient control of his IV flow rate, because not all patients could handle such judgments. Don’t allow new patients to relax into deference for a few days to get over their fear. That would be “babying” them. Don’t prevent hypovolemia by taking vital signs more often; instead, stick to the schedule, then pride yourself on how fast you can rush to treat shock.

Sure, you can teach most people sets of manual skills. Look at the complex tasks families perform at home. But a family cares desperately and deeply about its patient, who to them is one of a kind.

Physicians often don’t understand the “tech take-over” phenomenon, even when it occurs under their noses. They see only the tasks, they’re relieved the tasks are getting done, they hear few complaints from critically ill or fearful patients, and they blow up at the head nurse when patients go sour. They weren’t around to see the missed warning signs. Maybe they can’t imagine how exquisite care could be in skilled professional hands. Maybe they’re afraid to think of such possibilities. Or maybe they’ve gone sour themselves and have resolved to treat their own work like a set of tasks to be completed, instead of outcomes to agonize over.

Of course, there are wonderful technicians who transcend both their limited education and their job descriptions. No doubt some of our own discomfort with the terms technical and professional stems from our awareness that job descriptions and degrees are boxes that human beings don’t always fit neatly into.

The “professional” MD, for example, may be mired in a tech mentality, while the “tech” may wince at the MD’s callousness.

We do, AMA, have a system for flushing out the inscrutable ones, the careless, the sadists. It’s called nursing education. And for all its warty faults, it works amazingly well, turning out graduates who know how to protect the vulnerable and nurture hopes. Already, our soundings are telling us more people are entering LPN and ADN programs (see May A&N News). Why not help us by cosponsoring tuition fund-raisers and state scholarships for a system we already have in place?

Or is this whole brouhaha not about the shortage of nurses, but about the shortage of medical control?

Mary B. Mailson, RN, Editor
Answer to Nursing Shortage Is More Nurses

To the Editor:  

The American Medical Association's proposal to create "registered care technologists" to alleviate the shortage of nurses is unrealistic and dangerous ("A.M.A. Bucks New Category of Hospital Workers," Health Pages, June 30). Statistics show that hospital patients are sicker than ever before because of the increased age of patients, Medicare requirements for medication and therapy, and the stress of major surgery. As a result, increased levels of skilled care are needed.

Since the early '70s, nursing has been concerned about the shortage. Across the country, nurses educators, nurse administrators, and practicing nurses have been working to recruit talented, bright people to nursing. Antithetical to this included meeting with guidance counselors, attending high school career days, giving talks, developing funds sources for scholarships and devoting programs to make going to nursing school easier. Nurse administrators work assiduously to keep nurses in the profession with such programs as career ladders and flexible time. Nurses have worked in professional associations and on their own to recruit and retain nurses.

Nursing is difficult when salaries are low, and the work, while rewarding, is hard. Nurses suffer from its image. You quote Dr. Marian Craigfill asking, "Does it really require four years of college to change bedpans and replace bedpans?" This reflects nursing's image problem. You can be sure that the patient whose bed is to be made by a nurse is in the bed and too sick to get up.

Empty beds are made by aides or housekeeping personnel. While making the bed and talking to the patient, the nurse makes an assessment of the patient's physical and mental status. Is the skin intact? How is the circulation, range of motion, respiration, mood? Checks are made on any tubes, drains and dressings. Emotional support is given, and teaching may be done.

The physicians who put forth this proposal suffer from the misconception that anyone can do nursing, and if no one wants to be a nurse, no one will be missed. A nurse graduate with a few hours of training can replace a new graduate. What would make people take a job like this? The pay would be low, and there would be little or no possibility of advancement. This position is a dead-end job. Since this "registered care technician" would be certified and registered under an am of the state medical boards to assure minimal standards of practice and protect the public, good, it could be presumed that physicians would train and em- ploy these new workers, or are they committing nurses to train them? Educators know it is not possible to train individuals in such a short time to work at the required level. Institutions employing student nurse interns insist they have at least two reme- ters of clinical courses. This is true of associates degree and bachelor students. Who will supervise the new workers? Will the physicians do it, or do they expect nurses to do it? Will they also propose a new "registered care technologist supervisor"?

The proposal is a sad commentary on nurse-physician relations. Even though the American Nurses Association has consistently stated that one is not a viable solution to the nursing shortage, the A.M.A. has put forth this ill-conceived, selly flaunted pro- posal. Because of added costs with no control of quality, it is not in the interest of patients, taxpayers, or third-party payers.

As with teaching, our society has undermined nursing. The public must demand that registered nurses be patients would suffer.

To the Editor:

The American Medical Association is gravely mistaken if it believes that another category of hospital workers will relieve the nursing shortage (news story, June 30). This will not only devalue the public but also, and more important, jeopardize the care given to ill and frail patients in hospitals.

Who will train the new health-care workers? Who will supervise the administration of these medications? If nurses train and supervise, aren't we removing them from the bedside, where they are most needed? What medications will be administered by these technologists? A seemingly harmless medication such as aspirin may impair vision and hearing, and cause confusion and gastrointestinal bleeding. Are head nurses, who are responsible for their staffs, willing to risk liability and patient safety?

There is more to nursing than changing bedpans and replacing bedpans. While changing bedpans, the nurse examines the patient's skin for potential bedsores which, if not treated, lead to infection and ultimately death. The urine and feces are examined for the presence of a uri- nary tract infection, a garden- angular disturbance and occult blood (a sign of malignancy). The patient is also assessed for subtle changes in mental functioning, for depression and agitated behavior. The nursing student learns this in such courses as microbiology, medical-surgical nurs- ing and physical and psychosocial as- sessment. It takes four years of col- lege to recognize potential problems and intervene appropriately.

The solution to the nursing shortage is competitive salaries and benef- its, and education. The nurse Educa- tion bill proposed by Senator Edward M. Kennedy has received bipartisan support in the Senate. It will increase authorization from $89 million to $194 million, offer scholarships and establish nurse recruitment centers throughout the country for Geriatric Nursing Newsweekly, July-August 1981. Dr. Catherina Mallard, administra- tors, educators and recruiters should seek the best and the brightest for their institutions. Let's help the nursing profession benefit, but also red to those particular the scarcity.

The writers are registered nurses.

The writer is a registered nurse.
The Wrong Prescription
For Hospital Care

With no shortage of doctors to worry about, the American Medical Association is now
directing its fire to the understaffing of
nurses. At its convention in Chicago in
late June, the association's House of
Delegates proposed a solution: Create a
new type of worker, the "registered care
technologist." The scheme, at first, is a
step up in the mind that helps to:

- The nurses, at least, in a way sell
that removes the illness that helps to:

- A current report from says
that as many as 300,000 vacancies
exist.

- The AMA sees its registered care
technologist as executing "the medical
permits at the bedside with special
emphasis on technical skills." They
would be trained in 18 months, ranging
from "low-tech" bedside care in the
"high-tech" era of heart bypass and
emergency-room medicine. In the
words of Dr. James H. Sammons, an
AMA vice president, "The registered
care technologist is a necessity, a
technical role, in contrast to pro-
gessional nursing care that is labeled
as autonomous, managerial, and holistic.
Sammons said last week that the
"professions is not about to tolerate not
having people in the bedside to take
care of the patients."

- Such high-priced charter helps the
availability of current hospital care.

- Nurses, nurses aid, LPNs plus
practical nurses, nurse's aides, prac-
tical nurses, physicians assistant and
physicians are already meant to be
"tending patients. Why add a new
worker?" If Sammons is alarmed about
limited liability, why doesn't he be
bad and made doctors that nothing is
severing them from that kind of care? Do
their high salaries include them from
the human touch of spending time on a
personal basis with the work? With an
oversupply of nurses, bedside care
could be one of the daily missions for
- computerize charts, watch life support
machines and work the floor to free
doctors. Doctors can then turn to this
mountain of high-technology care
cross the rising costs of malpractice
insurance and descend to patient
illness at the grand moments of
life-and-death decision-making.

- Everyone is freeing someone else, but
the health care system as it is more
and more a system of itself. The biggest
time are around nurses. Too many
nurses, even in small hospitals,
report that they have had to make
patient care decisions because of
cheap labor. The American Nurses
Association reports that nurses can
expect only a 26 percent lifetime salary
increase, compared with 231 percent
increase for chemists, 182 percent for
accountants and 106 percent for
corporate programmers.

- The AMA fears nurses as rivals. Its
record of opposing reforms proposed by
nurses is almost as bleak in its long
opposition to progressive health-care
care. Legislation, independent thinking
in their skills and aware that
same as its long
-"the exercise of their
craft, welcome nurses as partners, not
- Many of these doctors reject
the AMA's "registered care
technologist solution as little more than
another grab for power. The
- technologies would be registered
through state medical boards.

- Nurses, as if they haven't enough
hassle, are now organizing to
organize for the AMA. They have
- and facts on their side. If the supply of
1.5 million nurses now work is far
- A new dream, the solution is not to
be brought low and yet worthy titles
- substituting but to strengthen nursing by
- increasing salaries, autonomy and
- power, Nurses have more than three
The idea of placing "care technologists"
the bedside is as much to nurses.
That's exactly where they prefer to be.
Caretaking needs to be humanized, not
technologized.

- Along with other noted humanization
- groups—the Teachers and the
National Association of Realtors—the
AMA ranks among the nation's seven-
most political action committees. It
deems legislative to advance its self—as in
self-aggrandizement. As well as sources

- Nurses who know that when the AMA
comes around offering a cure—as it does in
this—will see its probably spreading the disease.
RCT Proposal

AMA

AMA Rationale and Facts

American Nurses' Association

AMA Retract

Nurses are leaving the bedside for positions with insurance, HMOs, managed care, hospitals. Quality as nurses are better educated and choosing to practice bedside nursing positions will exacerbate the situation by creating fewer nurses who will be likely to practice bedside nursing in the future.

High rates of recent budgeted nursing personnel, including RNs and RNs, are increasingly leaving hospitals. Popular press accounts of the shortage of nurses and particular RNs for hospitals have increased the higher and higher RNs to patients ratios. The number of RNs employed in hospitals continued to grow. In 1986, an 8% increase. The number of RNs employed in hospitals grew up to 50 RNs to 100 patients in 1972 to 91 nurses per 100 patients in 1986. It is a myth that nurses are leaving bedside care or uneducated. Some 62% of hospital staff nurses hold college or graduate degrees. The highest proportion in history. It is not true that better-educated nurses are abandoning bedside care.
b. Nurses and RCTs would be interchangeable now. (In future, nurses could obtain RCT to remain at bedside.)

ANA

b. ANA's solution is the four year nurse and current education programs do not prepare graduates to function (quickly or well) in acute care. RCTs will be trained to provide care that BSN graduates are not taught to provide.

ANA Rationale and Facts

b. The shortage is in nursing. Patients need nursing care. Nurses are cost-effective and versatile. Nursing education is and will continue to be focused on preparation to provide care across all settings. No other provider can substitute for nursing care.

Studies have documented that nursing care is the element in patient satisfaction. Better-educated consumers consider the quality of nursing care a prime factor in selecting a hospital.

No amount of education can totally prepare professionals so that upon graduation they are prepared to function autonomously immediately in every situation. This is an argument for more, rather than less, education as is called for in the RCT proposal.

ANA Robust Nature
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<td>c. Lack of bedside care-givers is jeopardizing the quality of patient care now.</td>
<td>c. Red closings, delays affecting physicians' efficient use of time which affect patient care, and under-staffing of open units are prima facie evidence of the adverse quality effects associated with the lack of bedside care-givers.</td>
<td>c. <em>Agree.</em> Immediate implementation of nursing's short term solutions, particularly the reduction of nursing time spent on non-nursing functions and the return of ancillary staff, will immediately ensure that quality patient care is delivered.</td>
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| d. RCT more cost-effective. | d. Salary and education costs will be lower than nurses. RCTs will spend more time directly at the bedside providing needed care. | d. Nurses are more versatile and cost-effective (industry movement to increasingly higher ratio of RN to pt. populations during an era of rapidly expanding technology and extensive cost-containment). Nursing education programs for both levels of nursing are already in place. The addition of RCTs will drive up cost substantially, particularly, when this proposal is compared to the expense of immediately implementing nursing's solution to decrease nursing time spent on non-nursing functions. 

RCT salary and education costs will be lower than nurses, but because RCTs will not substitute for nurses on a one-to-one basis, their pay must be much below that of RNs for them to be cost-effective. 

AMA states that RCTs will be under the direction of MDs. It will be necessary for MDs to carry additional liability insurance to provide coverage for claims incurred by RCTs. MDs have traditionally passed along the cost of increased insurance.
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<th>AMA Rationale and Facts</th>
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<td>e. RCT will expand the recruiting pool for bedside caregivers. Will also attract men to the field.</td>
<td>e. The terms &quot;nurse&quot; and &quot;nursing&quot; have negative stereotyped connotations for many men. A &quot;technician&quot; title will therefore be more appealing. The opportunity to work with physicians will also be an attractive feature of RCT practice.</td>
<td>Because RCTs will be under the direction of MDs, more physician time will be required in hospitals. This will increase the cost of physician services and will also increase physician incomes because of charges for more MD time. While this may be desirable to MDs, whose hospital-based incomes have suffered due to reduced lengths-of-stay, it is contrary to the AMA assertion that RCTs will be cost-effective.</td>
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| e. The reality of RCT work, whatever the personnel are titled, is in nursing. To the extent that "nurse" or "nursing" have negative connotations for men, educational efforts to remove these perceived stigmas are needed. More clarity may also be promoted about male nursing opportunities. |
WHEREAS the American Medical Association (AMA) is proposing the creation of a new category of licensed health care worker, to be called a basic or advanced "registered care technologist"; and

WHEREAS the stated objective for the creation of the RCT role is to increase the availability of bedside care givers; and

WHEREAS the role description for the RCT is "execution of medical protocols at the bedside with special emphasis on...

WHEREAS the AMA proposal calls for RCTs to substitute for nurses at the bedside even though it acknowledges that the scope of nursing practice is much broader than that envisioned for RCTs; and

WHEREAS the lack of clarity in roles would create public confusion about what caregivers are responsible for; and

WHEREAS the recruitment of persons for the proposed RCT role would be pulled from the same recruitment pool for nurses and

WHEREAS the use of the same person pool to recruit bedside care givers would diminish available numbers for nursing,

BE IT THEREFORE RESOLVED that the National Council of State Boards of Nursing strongly oppose the AMA Registered Care Technologist Proposal; and

BE IT FURTHER RESOLVED that the National Council support all efforts in concert with its Member Boards and the nursing community to prevent its implementations and

BE IT FURTHER RESOLVED that the National Council send the message of strong opposition to the RCT Proposal to the American Medical Association's Board of Directors and

BE IT FURTHER RESOLVED that National Council's Delegate Assembly support working cooperatively with AMA's Advisor on the critical issues of the nursing shortage; and

BE IT FURTHER RESOLVED that a copy of this resolution be widely disseminated by Member Boards.

[Image of a TV show with the text: "TV show can't sully nurses' image"]
TV show sullies nurses' image

By Lucille A. Joel
Guest columnist

KANSAS CITY, Mo. — The American Nurses' Association objects to the image of nursing conveyed in the NBC program Nightingales and challenges its producer, Aaron Spelling, to work with us to improve the accuracy of this show about nursing students.

The ANA, nursing's professional organization, is concerned that the image projected on Nightingales hampers our efforts to resolve the nation's severe shortage of nurses. In recent years, our profession has been competing with many other lucrative careers to attract men and women into nursing. Patients deserve and require the best and brightest nurses caring for them. We believe the Nightingales portrayal of nursing's future professionals undermines our efforts to bring qualified people into health care.

Much can be done to enhance the accuracy and the dramatic story line of Nightingales. Nursing students can honestly be portrayed as intelligent, motivated and caring. Their education can realistically be depicted as challenging, stimulating and intellectually demanding. Nurses are part of daily drama that includes life-and-death situations and ethical decisions that test skills and judgment in complex, high-technology environments.

The nursing student at Nightingales can discover their role as effective patient advocates in settings that include but are not limited to hospitals, their Internal care units, emergency and operating rooms, and nurseries.

Nurses are vital to the quality of life of patients in nursing homes, clinics, their own homes and even on our nation's streets. Our association's recent action to circulate a list of Nightingale's advertisers to nurses follows offers by us to work with Spelling to develop a realistic, accurate program about nursing and nursing students. Neither the producer nor the network has responded. Because our interest is in improving the program, the association is urging nurses communicating with the show's advertisers to ask them to pass a meeting between Spelling and the ANA.

Spelling is right to want to focus on nursing. Let's show more of the nursing profession's diversity, demands and rewards on Nightingales.

TV show can't sully nurses' image

By Patricia Nelson Limerick
Guest columnist

BOULDER, Colo. — Wilbur Post, who was by profession an architect, spent most of his time talking to — and with — his horse, the famous Mr. Ed.

This was not a fair portrait of an architect. I know this for a fact: I'm married to one. While Jeff occasionally speaks a few words to the horse, he really hasn't the time to spend whole days in dialogue with animals.

My husband feels — rightly — that architects look like leisurely lightweights on TV; I feel — rightly — that professors look like added and/or pompous fools. But while neither of us is pleased with the way TV presents our profession, neither of us wants to take any action beyond an occasional cynical remark to a friend.

This is partly because we believe that the First Amendment protects the right of free speech, down to the right of TV shows to make architects and professors — and nurses — look like fools. But we also believe that people of some sense rest their conclusions on evidence drawn from sources other than TV screens.

Twelve years ago, in the hospital, I learned that there is no comfortable way to lie down after shoulder-blade surgery. In the middle of the night, my husband and turning finally pulled the TV tube out, and the result was a mean which I shall not describe. I pressed my call button, and a nurse came immediately and cleaned up the mess and reconnected my IV. She seemed to have the instinctive sense that someone whose shoulder blade had just been displaced would not have full control of her wills or of her movements, and so she did not scold me for what I had done.

I've remembered this for a long time. I thought it was wonderful that people of such extraordinary presence would be available at 1 a.m. to help people who'd gotten tangled in TV corners.

Seems like that wouldn't make for much of a TV series, but they are serious and lasting memories — considerably more influential than the images of empress-headed nurses that appear on our TVs — images that should and do disappear as fast as they appear.

If a TV show ever overpowers the memory of my 1 a.m. savior, then I'll know it is time to join Jeff in car- ing lung chains with the cat.
A.M.A. Backs New Category of Hospital Worker

Nurses' groups say the positions will duplicate the work of their aides.

BY ISABEL WILKERSON

CHICAGO, June 23 -- Against strong opposition from nurses groups, the American Medical Association today approved a plan to create a new category of hospital workers to alleviate a shortage of nurses.

The association's House of Delegates, convening for its annual meeting here, also approved a proposal to expand the eligibility requirements for Medicare, a plan that would add 27 million more to the Medicare rolls at an additional cost of $3.5 billion.

"Technologists"

The association said it would vigorously pursue legislation to enact the proposed Medicare changes and would soon begin a formal program to train a new category of hospital workers, to be called "registered technologists."

After 2 to 16 months of training, such technologists would administer routine bedside care as well as prepare and administer certain medications under supervision. In military hospitals, carpenters now directly care for patients in a similar way, the medical association's officials said.

The medical association said that the nation's hospitals were currently short about 36,000 nurses, a figure that the group says will double by the yearend if the trend continues. The shortage, particularly acute at large hospitals in Northeastern cities, has caused the temporary closing of emergency rooms and delays in scheduling of surgery at hospitals nationwide.

"We need to do something."

"This profession is not going to tolerate not having people at the bedside to take care of their patients," said Dr. James H. Simmons, the executive vice-president of the American Medical Association. "The magnitude of the deficit is such that we need to do something."

The technologists "would give nurses more time for patient care and provide a pool for future nurses," the physicians said.

Nurses to reconsider. "We still have a shortage and we're committed to solving it," Dr. Nelson said at the hearing. "I plead with you to let us try this limited demonstration project so that we can see if it was workable and evaluate it." The nurses' groups question whether the new positions can be filled. "We're having enough trouble attracting nurses already because of the salaries," Mr. Cawley said. "I don't think nursing is a glamorous occupation. We would be surprised if it were more attractive. It would be difficult to recruit well-qualified people to do what seems to be menial tasks."

Some physicians have expressed serious reservations as well. "I find it unacceptable for a high-school graduate to be on the payroll of a hospital association," said Dr. Joseph H. Donato, an A.M.A. delegate from Binghamton, N.Y.

"Improving Conditions Urged"

Nurses' groups have demanded higher pay and improved working conditions as the best way to alleviate the shortage. They also say that nurses could be more effective if they were relieved of routine administrative duties. "Nurses have to do so many other things -- ordering supplies, arranging the phone," said Mrs. Royce, the A.M.A. delegate. "We need to free-up the nurses to care for the patients, rather than for the unit."

The medical association said the technologists would be trained at hospitals in appropriate programs. They would then be certified and registered "under an arm of the state medical boards." The proposal said, "to assure minimum standards of practice and protect the public." The American Hospital Association said it was reviewing the proposal but had no immediate concerns. "There are many, many practical questions which the A.M.A. has not yet heard," said Dr. Alexander Williams, Jr., the executive vice-president of the association.

"Medicaid Changes Approved"

In another battle, the medical association agreed to pursue federal and state approval of major changes in the Medicaid program. The proposal would change the formula that determines eligibility and bring $27 million more people under the protection of Medicaid, more than twice the 12 million people now receiving benefits.

States now can determine the income requirements for Medicaid eligibility. The physicians' proposal would bring uniformity by requiring each state to use a formula based on its per-capita income as a percentage of the national per-capita income. Under that formula, the number of people eligible for Medicaid in Georgia, for example, would triple, from 45 million to 1.2 million, at a cost of $1.4 million, against $3.5 million currently.

"I don't see where the money would come from," said Aaron Johnson, the state commissioner of Georgia's Department of Medical Assistance. "This would add $27 million to the budget, but it's not clear where the money would come from."

In New York, the number of recipients would double, from 2 million to 4 million, at a cost of $1.4 million, compared with $6.5 million now. Peter Studin, a spokesman for New York's State Department of Health, said the Medicaid eligibility was part of a larger budget of the state legislature.

"This would be a major and radical change," said Dr. William Winkler, senior, a special assistant in Health Care Financing Administration's Division of Health and Human Services. "Something of that magnitude would require extensive study and thorough debate by the Congress if it were to ever come about."

Dr. Winkler expressed concern in supporting a proposal costing $6 billion, about a sixth the Federal budget deficit. But the medical association's officials said that excess dollars were already being spent on care for the poor and uninsured.

"More Effective Care Needed"

"Because individuals in these groups cannot afford regular doctor visits, they often come to emergency rooms more frequently than other patients and require the most expensive medical care, the medical association said. Such costly procedures as intensive care for premature infants had to be provided, they said."

The medical association also said that assuring payment for services would be provided for inpatient and outpatient hospitalization and physicians to meet costs and provide more effective care.

"Nobody ever said it was going to be easy," said Dr. Simmons, the A.M.A.'s executive vice president. "It just depends on your priorities. As physicians, our priority is to take care of people."

Sources:

The New York Times June 23-25
On the Silly Season...

In spring, the old Life magazine used to catalog goldfish swallowing and phone booths stuffed with undergraduates. It was the "silly season." This particular spring we have a new example of how the return to nice weather makes silliness sprout, in the form of a proposal by the American Medical Association (AMA) to create a new category of personnel for hospitals, the "Registered Care Technologist." We did not make this up.

The Registered Care Technologist (RCT) will "execute the medical protocols at the bedside with special emphasis on technical skills." The basic RCT (there is an advanced one proposed too) would deliver "low-tech" care. High-tech care, as we read it, is medical care. We did think that one of these days it would become clear that modern medicine is increasingly the exercise of technology. But "at the bedside?"

The AMA says "consistent with the goal of nursing to achieve autonomous professional status, hospital-based programs preparing bedside care nurses are being phased out." (They refer to LPN programs as well as diploma schools.) The solution, therefore, is this new category of people, who would be licensed by the states, as graduates of programs accredited by the Committee on Allied Health Education and Accreditation, run by, guess who? Registered nurses could "challenge [the new licensing examination] if comparable experience at the bedside can be validated."

Honest, we didn't make this up.

The RCT is a non-leadership, technical role in contrast to professional nursing care that is labeled (emphasis added) as autonomous, managerial, and holistic.

There are lots of ways of thinking about this proposal and most of them make our blood pressure spray out our ears. The easiest way to think about it, however, is that it is just part of the silly season.

The RCT is proposed as an answer to the nursing shortage. We are rather more impressed with some of the things we are hearing about all over the country, ways in which nursing is acting to relieve the pressures on our scarce resource. We heard, for example, of a hospital in the mid-Atlantic area that has created essentially two nursing shifts. Nurses who wish to go to school are hired full time in the summer months and work one or two shifts a week during the academic year. Nurses who wish to be at home with their families during their children's summer vacation are hired to work full time during the academic year and a couple of shifts a week in the summer. Nice idea.

The Today show recently had a whole series of programs about nursing. On one of them, a vice president for nursing from Florida talked about how he had dealt with shortages in his institution. First, salaries were raised and that made recruitment for the day shift easy. Then, he experimented with salary increments for the evening, night and weekend and holiday times that are more difficult. Over a series of moves, he found out what the "price" should be for an unpopular shift, and paid it. Problem solved.

In another hospital, the management decided to ask nurses what would make their jobs better. The management was astonished to find a number of problems they didn't know about. Among them: the impossibility of parking and the unavailability of linens and other stock floor supplies. Solution? Restrict one floor of the parking garage for the evening shift (since those nurses had the most trouble finding a place to park) and tell the purchasing department to stop trying to save pennies by ordering less than needed. It costs the hospital a lot more to be short of nurses than to truckload of diapers or Chux.

On that same Today show, Joyce Clifford, Vice President for Nursing at Boston's Beth Israel Hospital, put the whole thing into perspective. "We expect nurses to make serious decisions involving people's lives," she said. "So why not let nurses make serious decisions involving institutional policy too?"

Spring may bring out silliness, and crises such as the nursing shortage do provoke odd proposals. To nursing's credit, our professional organizations have avoided hysterical reaction to some of the sillier notions about the work. For us, this spring is the sensible season.

Donna Diers
Editor
TO: The ANA Board of Directors
SNA Presidents and Executive Directors

FROM: ANA Communications Unit
Division of Business and Professional Services

DATE: November 18, 1988

RE: Health Care Magazine Articles on the Nursing Shortage and the RCT Proposal

Enclosed, for your information, are copies of articles from health care magazines about the nursing shortage and the American Medical Association's RCT proposal, including:


The last article is a summary of the results of the study, "Implementing Nursing's Short Term Strategies for the Management of the Nursing Shortage," prepared for the Tri-Council for Nursing by the American Nurses' Association and the American Organization of Nurse Executives. This report was shared with participants in the October 7, 1988 meeting of nursing with the hospital and long-term care industry, medicine, consumer groups, and health care educators.

Please note that copyright law does not permit you to reprint or use these articles without permission of their publishers.

We look forward to sharing a complete digest of news clippings about the nursing shortage and the RCT proposal when you are in Kansas City for the Constituent Forum meeting.

Please call us if you have any questions, or if there is anything with which we may help you.

Attachments

cc: SNA Media Liaison Representatives
Participants in the Nursing Organization Liaison Forum
The Nursing Shortage—Shortchanging Quality of Care

By Jane Margaretten-Ohring, RN

Many nurses barely have time to provide basic care, let alone address patients’ emotional needs.

Profound for relieving the nursing shortage book
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"I see a very tired, harried group of people trying to stem an overwhelming flood of patient needs," says Barry Lachover, MD, assistant director of ambulatory services, pediatrics, at Kings County Hospital, in Brooklyn, and past president of the Doctors Council, a doctors union. A 1987 American Hospital Association (AHA) survey found that 76.6% of hospitals have a shortage, with more than half describing it as moderate or severe.

The Secretary’s Committee on Nursing, established by Secretary of Health and Human Services (HHS) Otis Bowen, MD, to examine the crisis, issued its interim report this past summer. It attributes the rising demand for nurses to a multiplicity of factors, including the impact of prospective payment implementation in 1983), the AIDS epidemic, the increase in high technology and an aging population.

Cost-cutting efforts have led to a growth in ambulatory care and a sicker patient population at both ends of an abbreviated hospital stay. The 1987 AHA survey reported that 81.3% of hospitals admitted patients having a greater severity of illness than in 1980, a trend also seen in nursing home and home care populations. To further shave costs, hospitals eliminated auxiliary staff positions in favor of adding nurses, who, they reasoned could assume these duties in add-

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The Nursing Shortage—Shorthanging Quality of Care

Medicare. "No one ever talked about patient outcomes used a year or two ago," said Ms. Curran. But with increased federal involvement in health care, the growth of third-party payers and heightened consumer awareness, regulatory agencies are paying more than just visits—which is limited in its ability to gauge the impact of nursing-service providers on patient outcomes in observable patient care.

Last November, the New York State Department of Health closed Houses County Medical Center, a large public hospital on Long Island, for deficiencies in many departments, including medicine and surgery. At the time, the report concluding that the "ratio of registered professional nurses in patient care unit was not adequate to provide proper supervision of patient care" inspectors found essential medical staff nearly powerless to tend to themselves. Tube feedings and IVs not infusing or running four hours behind schedule, with up to 18 inches of blood backed up in one tubing; patients being removed without physician orders; and numerous instances of "failure to conform with physician relative to patient care," evidenced by lack of documentation in the charts. The hospital, which serves a large indigent patient population, has 80 vacancies out of 250 budgeted positions. 412 of which are staff nurses, says Catherine Hampton, RN, MS, director of nursing. Short-staffing forced the department to give up primary nursing, which preserves continuity of care by having one nurse responsible for the total care of a small group of patients, and switch to segmented delivery of patient care, known as team nursing. With the need to cut costs, Nassau County had reduced an

"You physically run out. Eight critically ill patients—one needing platelets, another chemotherapy a third who required feeding. When a terminally ill woman told me she wanted to die, I mentally said to her, 'You have five minutes to discuss it.'"
Two Nursing Programs That Work

The crisis in nursing is by no means universal. Hospitals literally down the street from each other may differ radically—one with an adequate number of nurses, the other with a shortage, says Carole Peterson of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Although raising both starting salaries and those of experienced nurses is one of the most common and necessary—measures, it alone is not enough, say nursing leaders.

The American Nurses Association sees professionalizing the work environment as key to resolving the shortage. Two institutions have taken major steps to do so:

"Feeling like you are in control of your work life is important to how you feel about yourself and also changes how you relate to colleagues."
—Ms. Arenth

American College of Physicians Observer, October 1988

"The only person who is listening at the most people for the present is the nurse," says Laura Sissom, RN, MBA, vice president of Henry Mayo Newhall Memorial Hospital. The hospital's nurses have been redesignated to reflect their philosophy: Departmental including general surgeons, dietary, housekeeping, and admitting report to nursing.

Making the best use of the nurses' time has meant "unlearning some old rules," she says. "Nurses were brainwashed years ago to keep records on every patient with an IV. Today, everyone has an IV. Why are we doing I and Us on someone that doesn't have electrolyte imbalance or severe dehydration?" It doesn't help the nurse get work, it's easy doing it," says Ms. Sissom. Although the average turnover in the area has doubled for 30-to-40% of new staffing, Henry Mayo Newhall has not done that for four and a half years, she says.

Other changes in unit at various hospitals include:
- Flexible scheduling. Using shifts ranging from four to 12 hours over three to five days to recruit nurses with young children or those desiring shorter work weeks
- Reaching from nurse. Designing career counseling and orientation assistance to non-nursing staff who want to enter nursing
- High school programs. Teaching in graduation ceremonies and students to understand negative stereotypes in the role of the nurse or to be a nurse assistant
- Inducing nursing assistants. Helping with rotation in exchange for the Graduates agreeing to work for the hospital. Establishing summer internships for top students
- Starting other specialties. Allowing nurses to work on a year- at- with RN switching permanent assignments

JCAHO
Opinion

Guest Editorial: Doctors and Nurses Finding Solutions Together

By Jack Summers, MD

AMA tips hand on RCTs, infuriates nurses

By David Burda

The American Nurses' Association's planned release of details of its controversial registered clinical technology program has further put hospitals and infuriated nurses.

By accidently tapping its hand in the association's weekly newspaper, the American Nurses' News, the Chicago-based ANA appears to have virtually ensured that the RCT debate will be resolved through confrontation rather than compromise.

The details of the RCT plan contained in the article were a shock to the American Nurses' Association and the American Hospital Association, two groups that had been monitoring the ANA's program in developing a proposal.

The inadvertent release of information to physicians before nurse and hospital groups may have undermined cooperativeness on the issue. On Oct. 12, the ANA's board of trustees released a three-paragraph statement that said the association had developed the RCT training curriculum and the criteria for selecting hospitals to test the RCT concept. The statement also said the association would evaluate such programs that resembled the RCT concept.

The AMA declined to release details of the RCT curriculum and the selection criteria for the 10 sites currently operating the program. However, eight days later, American Medical News reported that the ANA's plan and the name of a hospital that already has been approved to be included by the ANA's (Oct. 28, p. 10)

"A representative from the newspaper frequently attends the board meetings for background only," said Steve Sevrin, the ANA's vice president for public and professional communications. "There was some confusion over the policy this time.

The Kansas City, Mo.-based ANA and other nursing groups oppose the use of RCTs, saying the plan is duplicative, costly and a threat to patient care. RCTs would be a new category of caregivers who would perform routine bedside tasks. The ANA feels nurses should manage patient care and have oversight of bedside care to patients, the association said.

In August, representatives of the ANA, AMA and national nursing organizations met in Chicago to discuss the RCT proposal. They agreed to continue discussion. In September, the ANA hosted a nationwide teleconference and heard comments from nurses. In October, the American Organization of Nurse Executives, an ANA subsidiary, hosted a roundtable on the nursing shortage that the ANA executive attended.

"We were surprised by the details in the article. All we saw was the Oct. 13 statement," said Alexander William, ANA's senior vice president. Despite the ANA's offer of help, the AMA didn't seek its input in developing the RCT curriculum or establishing criteria of the program, Mr. Williams said.

The AMA doesn't support the RCT concept in its present form, but nothing in the newspaper article changed that, Mr. Williams said. But the ANA feels support study of nursing programs that resemble the RCT plan and will help the ANA identify programs to evaluate. At the October meeting sponsored by ANO, AMA executives gave no indication that the RCT plan had been developed to the extent suggested by the newspaper article. ANA President Lucille Joel said."

The 'Nurse-extender' programs favored

To increase the time registered nurses spend with patients, 86% of the hospitals that responded to a recent survey have started "nurse-extender" programs. These programs use support personnel to relieve nurses of housekeeping, clerical and managerial activities. The study's results indicate that hospitals are widely employing nurse-extender programs to address the shortage of registered nurses.

Survey results also clarify claims of the American Medical Association that it is the only group trying to solve the nursing shortage. The AMA wants to create a new class of workers, called registered-care technicians, to alleviate the shortage of bedside caregivers.

The survey of nurse executives at nearly 1,000 hospitals was conducted by the American Nurses' Association, Kansas City, Mo., and the American Organization of Nurse Executives, a sub-
Nurses Unite To Oppose AMA Plan For Registered Care Technologist

In a striking display of unity, nursing associations from around the country are organizing to oppose an American Medical Association (AMA) plan to introduce a new type of health care worker, the registered care technologist (RCT). The AMA approved the plan at its annual meeting on June 28.

Earlier in the year, the AMA had recommended creation of this new category of health worker as a way to solve the nursing shortage. H. Roy Schwait, M.D., assistant executive vice president of the AMA, described the RCT as "a non-nurse bedside caregiver...who will be responsible for implementing physicians' orders" and "the bedside". He claimed "there is intense public interest in the proposal."9

Nursing leaders reacted swiftly to the plan, calling it "bureaucratized," "pernicious," and "disastrous." At the AMA annual convention (June 18) the 615 member House of Delegates voted unanimously to take action at its annual meeting. Representatives of half the state nurses associations and 50 other nursing organizations said plans to defeat the RCT proposal and quickly raised $20,000 to launch the effort.

Leading the opposition in New York, NYxMA contacted state delegates to the AMA convention who would be voting on the proposal and warned that the RCTs would further fragment patient care, increase confusion among nurses in the health care field, and lead to an overlap of services among direct providers that would blur lines of responsibility and increase costs to consumers, hospitals, and third-party payors.

According to the AMA proposal, registered care technologist (RCT) would be hospital workers trained at three different levels to provide varying degrees of bedside patient care. At the first level would be assistant RCTs who would need two months of training and perform duties new handled by nursing assistants. At the second level would be RCTs who after seven months of basic training would "quintly" to care for patients requiring custodial care or relatively simple bedside care in homes, hospitals, and long-term care facilities. The duties of basic RCTs would parallel those of current LPNs. Advanced RCTs would receive an additional nine months of training to "quintly" care for those requiring high technology care needed in acute care facilities. The MA noted that "current RNs who wish to remain at the bedside" could become advanced RCTs.

The AMA didn't explain why an RN would want to become an RCT, but the statement reveals one of the faulty assumptions behind the RCT proposal - that today's RNs are abandoning the bedside care of hospital patients. In fact, according to a survey by the American Association of Colleges of Nursing, 1% of current RNs currently work in hospitals.

In her letter to delegates to the AMA Convention, NYxMA President Juanita Jones urged physicians to cooperate with the nursing community to increase enrollment in nursing programs and to retain bedside nurses. She pointed to a previously recommended short-term strategies for solving the nursing shortage, including:

- increasing ancillary personnel
- improving nurse salaries and benefits
- increasing use of information and systems technology to support patient care
- helping RNs who work part-time return to full-time work.

MDs, Hospital CEOs Also Oppose RCTs

Just because the American Medical Association is proposing the Registered Care Technologist, that doesn't mean physicians and hospitals are behind it. In fact, our admittedly non-scientific survey of physicians and hospital administrators state-wide turned up minimal support for RCTs.

Many physicians and hospital administrators, who would have to implement the proposal, have never even heard of it.

Perhaps because the immediate response from nurses was so uniformly hostile, the AMA has kept a low profile on the RCT issue. Not a single mention has been made of it in the AMA's weekly publication, American Medical News, in the last six months.

Albany Medical Center president, Dr. J. Richard Gatmier, however, is anything but quiet in his appraisal. "It attempts to recast the role of the nurse who was a professional...and declare the RCTs as quinlly techs." he said. Gatmier also criticizes the AMA for presenting the RCT idea without consulting with nurses and other hospital professionals. Admissions is rising in from left field.

"It's not fair to be able to make stupid, silly, insane suggestions when you're dealing with a serious problem. So I forgive the AMA," he said.

The AMA ought to recommend more support staff, so nurses can concentrate on bedside care, not move from patient to patient, he said.

Not all physicians and hospital administrators are opposed to RCTs, of course. Dr. Milton Stade, president of the Montefiore Hospital, believes RCTs could improve patient care. "We're going to have to come to the point where nurses are paid what they deserve, and when that happens, they'll be too expensive to be a commodity to be doing so," he said.

Some leaders in the nursing community have labeled the RCT proposal nothing more than a tense attempt to put nursing under the control of physicians. Mount Sinai's Metzler maintains that it's just one more attempt to put nurses in the same box as all other hospital professionals.

"You've got to be able to make stupid, silly, insane suggestions when you're dealing with a serious problem. So I forgive the AMA," he said.
RESOLUTION NO. 71-88

Helicopter Ambulance Safety

THE COMMITTEE HAS PLACED THIS RESOLUTION ON THE CONSENT CALENDAR.

(See the last section of this report.)

SUBSTITUTE EMERGENCY RESOLUTION NO. O2-88

Nursing Shortage--Implementation of American Medical Association
Board of Trustees Report CC 1-88

(Replacing No. 02 & 03)

THE COMMITTEE RECOMMENDS ADOPTION OF SUBSTITUTE EMERGENCY RESOLUTION NO.
02-88 AND I SO MOVE

COMMENTS: None.

P. The House now has before it Substitute Emergency Resolution No. 02-
88. The Committee recommends a yes vote.

WHEREAS, The American Medical Association House of Delegates adopted
Board of Trustees Report CC ("Nursing Education and the Supply of Nursing
Personnel in the United States") during its interim session in 1987; and

WHEREAS, Report CC recommended support of all levels of nursing
education, economic and professional incentives for recruitment and
retention, and hospital-based continuing education programs -- all with
the primary mission of increasing the quality and quantity of caregivers
at the bedside; and

WHEREAS, An implementation plan by the AMA Board of Trustees
summarized in FEDNET release on April 11, 1988, deviates from the
recommendations of Report CC by calling for creation of "Registered Care
Technologists" to meet the demand for "high quality, technical care at the
bedside; and

WHEREAS, This proposal to add a new category of caregiver would
delay and complicate the process of recruitment and retention of bedside
nurses, would further dilute the pool of available individuals for the
nursing profession, and would increase the cost of medical care by
creating a new category of health care provider; therefore be it

RESOLVED, That the Ohio State Medical Association support CC's
recommendations within the framework of current levels of nursing
education: and, be it further
RESOLVED, That OSMA urge the AMA to open dialogue with the American Nurses Association to discover creative methods to increase enrollment in nursing education programs, to retain bedside nurses, to provide financial incentives, and to provide incentives for "retired nurses" to return to bedside nursing; and be it further

RESOLVED, That upon adoption by the OSMA House of Delegates, this resolution be forwarded to the AMA for consideration by the House of Delegates in June, 1988.
ACTION PLAN
FOR
STRATEGIC MANAGEMENT
OF
NURSE SUPPLY

Over the past several months, each member of the Tri Council for Nursing has engaged in various activities designed to impact nurse supply. The American Association of Colleges of Nursing has focused on enrollments in baccalaureate programs and on teaching schools' enrollment management strategies. The American Organization of Nurse Executives has documented the issues of demand and supply in the acute care setting and worked with AHA in launching long-range recruitment efforts. The American Nurses' Association has worked through its constituent states, the American Journal of Nursing and The American Nurse surveying and documenting the impact of the shortage on nurses and on nursing practice. The National League for Nursing has documented nurse supply across educational programs and raised critical questions with the public about the impact of supply problems on quality of nursing education and nursing services.

In order to provide a framework within which these four organizations might continue to work together to address those activities still to be accomplished, the Tri Council for Nursing has developed the Action Plan attached.

Restructuring of health financing, massive shifts in this country's population and dramatic changes in the attitudes, values and aspirations of the recruitment pool for nursing have compounded these causes.1

Causes of imbalance in nurse supply and demand can be summarized as follows:

Salary

Nurses' wages are low relative to other health professionals

Salary compression

Absence of Clinical Authority

Nurses' authority for the clinical practice of nursing is limited

Nurses are absent from policy making roles in clinical management

Nurses' involvement in decisions regarding standards of practice and essential support services is insufficient

Absence of Participatory Management

Nurses are under represented at top management (policy development) level

Nurses do not have authoritative input at the clinical/case management level


Escalating Demand/inappropriate Use of Nurse Manpower

Massive restructuring of the way in which health services are delivered and paid for has escalated the demand for nursing services

- There is a greater human need for nursing services
- There is an expanded job market for nurses
- Adequate support services to nursing are absent

Demographic/Social Change

There is demographically-driven decline in the number of people entering college

There has been a dramatic change in the attitudes, values and aspirations of potential recruitment pool for generic nursing programs
STRATEGIC GOALS

The Tri Council for Nursing then established ten strategic goals that were derived from these causes:

Goal I. Document Nature And Scope Of Shortage
Goal II. Document Changes In Education To Meet The Demands Of Practice
Goal III. Educate The Public
Goal IV. Reauthorize Nurse Education Act
Goal V. Increase Salaries
Goal VI. Establish Nursing Control Over Nursing Plan of Care
Goal VII. Establish Standards For Organized Nursing Services That Require Nurse Involvement In Management Decisions
Goal VIII. Increase Proportion Of Potential "First Time College Freshman" Pool To Enter Nursing
Goal IX. Appeal To Changing Values, Aspirations Of Applicant Pool
Goal X. Address Demand For Nursing Services

The following joint activities/assignments to the accountable organizations and time frames were then set.
## Goal I. Document Nature and Scope of Shortage

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<tr>
<th>Proposed Activity</th>
<th>Organizational Responsibility</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitor institutional trends in budgeted vacancies, costs/time frames for recruitment, distribution of vacancies, relative salary levels, use of manpower pools, incidence of part time work, etc.</td>
<td>AONE Hospitals</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>ANA Specialty Nursing Organizations</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>NLN</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ANA Long Term Care Settings</td>
<td>1988</td>
</tr>
<tr>
<td></td>
<td>AHCA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ANA Analyze supply and demand projections in Division of Nursing biennial report to Congress</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NLN Home Health Care Settings</td>
<td>1988</td>
</tr>
<tr>
<td></td>
<td>NAHC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NLN Aggregate Enrollment Data</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>AACN Recruitment Enrollment Data, Baccalaureate and Higher Degree Programs Monitor UCLA Kenneth Green work</td>
<td>1988</td>
</tr>
<tr>
<td>Monitor trends in recruitment/enrollment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitor Aggregate Labor Department Statistics</td>
<td>ANA Analyze return on investment in nursing education</td>
<td>Annual</td>
</tr>
<tr>
<td></td>
<td>ANA Conduct comparative studies of salary progression patterns between nursing and other disciplines</td>
<td></td>
</tr>
<tr>
<td>Monitor Impact of Shortage on Practice</td>
<td>NLN Monitor impact of AIDS, increasing demand for LTC on quality of care in accredited agencies</td>
<td>Annual</td>
</tr>
<tr>
<td>Organization</td>
<td>Activity Description</td>
<td>Timeframe</td>
</tr>
<tr>
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</tr>
<tr>
<td>ANA</td>
<td>Job Satisfaction Surveys</td>
<td>Annual</td>
</tr>
<tr>
<td>AJN</td>
<td>Studies of Iatrogenic Illness</td>
<td>Ongoing</td>
</tr>
<tr>
<td>FDA</td>
<td>Compare measures of safety and patient outcomes with measures of nursing supply and distribution</td>
<td></td>
</tr>
<tr>
<td>NCNR</td>
<td>Investigate private sources of funding for comparative analysis of safety and patient outcome indicators</td>
<td></td>
</tr>
<tr>
<td>NLN</td>
<td>Explore ongoing nurse supply studies being conducted by the Division of Nursing and National Center for Nursing Research</td>
<td>2/5/88</td>
</tr>
<tr>
<td>NLN</td>
<td>Coordinate efforts with Secretary's Commission on Nursing</td>
<td>2/18-19/88</td>
</tr>
<tr>
<td>NLN</td>
<td>Incorporate ANA Standards for Organized Nursing Services and NCNIP features for high quality cost effective community based nursing services into standards for accreditation for home health care</td>
<td>2/21-24/88</td>
</tr>
<tr>
<td>NLN</td>
<td>Conduct survey of nurse satisfaction</td>
<td>1988</td>
</tr>
</tbody>
</table>
### GOAL II. DOCUMENT CHANGES IN EDUCATION TO MEET THE DEMANDS OF PRACTICE

<table>
<thead>
<tr>
<th>Proposed Activity</th>
<th>Organizational Responsibility</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitor changes in education to meet practice demands</td>
<td>NILN</td>
<td></td>
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<tr>
<td></td>
<td>AACN</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Div. of Nrsq.</td>
<td>4/13/88</td>
</tr>
<tr>
<td></td>
<td>Studies of practice in acute and community care and related changes in education, Synthesis Conference Milwaukee</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NILN</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Monitoring integration between practice and education in the accreditation process</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AACN</td>
<td>Ongoing</td>
</tr>
<tr>
<td></td>
<td>Surveys of the integration of practice and education</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NILN</td>
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<tr>
<td></td>
<td>Integrate essentials of baccalaureate education into accreditation criteria</td>
<td></td>
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<tr>
<td></td>
<td>AACN</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Monitor curriculum changes</td>
<td></td>
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<tr>
<td></td>
<td>AONE</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Document changes occurring in practice through the use of the computer in control of information</td>
<td></td>
</tr>
</tbody>
</table>
GOAL III. EDUCATE THE PUBLIC

**Proposed Activity**

Conduct a joint public relations initiative:

**Target Population**

The general public

**Theme/Message**

Educate public regarding what they have a right to expect from nurses

**Content**

*What Is A Nurse*

Utilize the work Chaska has done regarding "What A Nurse Does"

Utilize the work Diers published regarding "What A Nurse Is"

Consider the following descriptors:

- male/female
- smart
- skilled
- caring
- competent
- compassionate
- only safeguard in the system
- integrator of care
- case manager across settings

**Organizational Responsibility**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAGN</td>
<td>Meet with Clare Fagin and representatives of PEW Foundation</td>
</tr>
<tr>
<td>ANA</td>
<td>to explore joint interest in funding project to recruit students into nursing</td>
</tr>
<tr>
<td>AUNE</td>
<td>NCNIP</td>
</tr>
<tr>
<td>NLN</td>
<td>ANA</td>
</tr>
<tr>
<td></td>
<td>Distribution of Miss America PSA</td>
</tr>
</tbody>
</table>

**Timeframe**

- NCNIP: Explore possibility of the National Advertising Council designating NCNIP proposal for a public service announcement (PSA)
24 hour day worker
patient advocate
patient educator
high level manager
special

Nursing Care Is Undervalued
Economically

Highly technically skilled
critical thinkers are taken
for granted

Care is not consistently given
by all nursing personnel

Identify need for pay for services
that are recognized to be
important

Identify the Rewards of the Role

Career mobility

Immediacy of reward in clinical
care situation

Demonstrate that bedside nursing
is an excellent foundation for
prestigious financially rewarding
positions

Techniques

Maximize use of nurses
themselves in public relations
efforts
## Goal IV. Reauthorize Nurse Education Act

<table>
<thead>
<tr>
<th>Proposed Activity</th>
<th>Organization Responsibility</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redesign Nurse Education Act and provide incentives for:</td>
<td></td>
<td>1988</td>
</tr>
<tr>
<td>o recruitment into nursing</td>
<td>AACN</td>
<td></td>
</tr>
<tr>
<td>o educational mobility</td>
<td>ANA</td>
<td></td>
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<tr>
<td>o innovative practice demonstrations</td>
<td>AONE</td>
<td></td>
</tr>
<tr>
<td>o cost saving strategies</td>
<td>NJN</td>
<td></td>
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<tr>
<td>o increasing number of minorities into nursing</td>
<td></td>
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<tr>
<td>Conduct a joint activity in Washington, D.C. on May 5, 1988 to focus attention on</td>
<td></td>
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<tr>
<td>reauthorization of the Nurse Education Act, reimbursement for nursing services in</td>
<td></td>
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<tr>
<td>long term care and Community Nursing Organization demonstration sites</td>
<td></td>
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</tbody>
</table>
### GOAL V. INCREASE SALARIES

<table>
<thead>
<tr>
<th>Proposed Activity</th>
<th>Organization Responsible</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adopt and promulgate standards for nursing employment</td>
<td>ANA</td>
<td>AONE</td>
</tr>
<tr>
<td></td>
<td>to review salary guidelines and the whole issue of restructuring compensation for nurses</td>
<td></td>
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<tr>
<td></td>
<td>o Document the feasibility of the salary goal that the professional nurse who continues to advance in clinical practice should be able to double her/his salary in ten years and triple her/his salary by retirement. After documenting the reality, propose a unified public position that the Tri Council for Nursing can promulgate with regard to nursing salaries</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ANA</td>
<td>AONE</td>
</tr>
<tr>
<td></td>
<td>o Develop model that would be acceptable to the Tri Council for Nursing for comparative salary ranges in a differentiated practice setting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ANA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Frame argument regarding return on investment in nursing education</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ANA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Conduct comparative study of salary growth patterns of successful employee groups</td>
<td></td>
</tr>
</tbody>
</table>
Raise capital jointly and set up a subsidiary to enable nurses to form professional corporations and contract for services.

Propose a NCNP implementation activity that will identify emerging models for the management of nursing services and define how the personnel related dollars are distributed within the various models, i.e. across salaries, contractual services, bonuses, benefits, etc.

Forward findings of the Tri Council to the AHA Task Force on Nursing Shortage.

Monitor progress of the AHA Committee studying salary progression over time.
GOAL VI. ESTABLISH NURSING CONTROL OVER NURSING PLAN OF CARE

<table>
<thead>
<tr>
<th>Proposed Activity</th>
<th>Organization Responsible</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pursue strategies that would base financing for long term care on a nursing model</td>
<td>AACN, ANA, AONE, NLN</td>
<td></td>
</tr>
<tr>
<td>Achieve Medicare reimbursement for gerontological nurse practitioners and gerontology nurse specialists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pursue recognition of nurse as provider under Medicare</td>
<td>AACN, ANA, AONE, NLN</td>
<td></td>
</tr>
<tr>
<td>Establish minimum staffing standards and revise reimbursement formulas for long term care so nursing salaries are competitive with acute care marketplace</td>
<td>AACN, ANA, AONE, NLN</td>
<td></td>
</tr>
<tr>
<td>Propose strategies that would empower the nurse in clinical practice</td>
<td>AACN, ANA, AONE, NLN</td>
<td></td>
</tr>
<tr>
<td>Educate hospital boards of trustees to the quality of nursing care provided in hospitals and develop a plan to market it</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Promote participation/appointment of nurse executives in/to hospital boards of trustees</td>
<td>AACN, ANA, AONE, NLN</td>
<td></td>
</tr>
<tr>
<td>Secure place for Tri Council for Nursing representative to speak at the annual meeting of the National Congress of Hospital Governing Boards</td>
<td>AONE</td>
<td></td>
</tr>
<tr>
<td>Develop an article for publication in the Journal of the National Congress of Hospital Governing Boards</td>
<td>AACN, AONE</td>
<td></td>
</tr>
</tbody>
</table>
AONE Influence firms involved with training of hospital boards
NIN
AONE Consider issue and suggest any number of alternate strategies
ANA Refer to the NCNIP Steering Committee to consider an implementation activity that focuses on practice/policy issues and on management/staff interface in practice setting
ANA Revise JCAH Standards for Hospital Nursing Services
AONE
JCAH
TASK
FORCE
### GOAL VII. ESTABLISH STANDARDS FOR ORGANIZED NURSING SERVICES WHICH REQUIRE NURSE INVOLVEMENT IN MANAGEMENT DECISIONS

<table>
<thead>
<tr>
<th>Proposed Activity</th>
<th>Organization Responsibility</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide for nurse revision of JCAH Standards of Hospital Nursing Services</td>
<td>ANA, AONE: Joint Task Force to revise Standards for Hospital Nursing Services</td>
<td>1988</td>
</tr>
<tr>
<td>Establish nursing mechanism for accreditation of nursing services</td>
<td>AONE: Work with AHA Commissioners to achieve nursing control of standards</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AACN, ANA: Support proposal for deemed status of NLN's Community Health Accreditation Programs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ANA, AONE: Develop a strategy to achieve nursing organization representation on the Joint Commission on Accreditation of Hospitals</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ANA, AONE: Consider establishment of an independent accrediting service for hospital nursing services</td>
<td></td>
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</tbody>
</table>

Tri Council organizations meet with Barbara Donoho to discuss development of an action plan by which nursing organizations may seek representation on the JCAH Board of Commissioners.
GOAL VIII. INCREASE PROPORTION OF POTENTIAL "FIRST TIME COLLEGE FRESHMAN" POOL TO ENTER NURSING

<table>
<thead>
<tr>
<th>Proposed Activity</th>
<th>Organization Responsibility</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educate schools of nursing re: Enrollment Management Strategies</td>
<td>AACN</td>
<td></td>
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<tr>
<td></td>
<td>Develop data base about why students are choosing or not choosing nursing as a career</td>
<td></td>
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<tr>
<td></td>
<td>o Review Green's analysis of changing attitudes, values, beliefs, and assist schools to be sensitive about what students want as a product</td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Review strategies proposed by Kalish</td>
<td></td>
</tr>
<tr>
<td>Recommend nurse to serve on Board, Biological Sciences Curriculum Study</td>
<td>AACN</td>
<td></td>
</tr>
<tr>
<td>Develop article on new recruitment strategies for The American Nurse</td>
<td>ANA</td>
<td></td>
</tr>
<tr>
<td>Organize nursing sections of State Academy of Sciences</td>
<td>AACN</td>
<td></td>
</tr>
<tr>
<td>Publish special issue of The American Nurse on nursing shortage</td>
<td>ANA</td>
<td></td>
</tr>
</tbody>
</table>
Poll secondary schools

- establish coop/work study programs
- locate jobs for high school students

Develop joint Tri Council Proposal to PEW for Recruitment Project

AACN
ANA
AONE
NLN
**GOAL IX. APPEAL TO CHANGING VALUES, ASPIRATIONS OF APPLICANT POOL**

<table>
<thead>
<tr>
<th>Proposed Activity</th>
<th>Organization Responsibility</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrate that bedside nursing is an excellent foundation for prestigious, financially rewarding positions</td>
<td>Target funding sources for project to recruit and work with the &quot;brightest and best&quot; undergraduate college students to consider nursing careers</td>
<td></td>
</tr>
<tr>
<td>Demonstrate appeal of nursing as a second career</td>
<td>Forward letter to Monsignor Fahy at Fordham Center requesting that he frame an initiative for nursing as a second career</td>
<td></td>
</tr>
</tbody>
</table>
# GOAL X. ADDRESS DEMAND FOR NURSING SERVICES

<table>
<thead>
<tr>
<th>Proposed Activity</th>
<th>Organization Responsibility</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redefine/restructure nursing roles in practice setting</td>
<td>Disseminate NCNIP work regarding identification and promulgation of differentiated practice sites</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AONE Conduct series of programs regarding continuing education models and develop publication on case management</td>
<td>1988</td>
</tr>
<tr>
<td></td>
<td>Participate in annual symposium case mix management conducted by Zander New England Medical Center</td>
<td></td>
</tr>
</tbody>
</table>
BIBLIOGRAPHY


American Nurses' Association, Inc.
2420 Pershing Road, Kansas City, Missouri 64108

Lucile A. Joel, Ed D., R.N., FA AN
President
Judith A. Ryan, Ph D., R.N.
Executive Director

TO: ANA Board of Directors
Constituent Forum Executive Committee
State Nurses' Associations
Presidents
Executive Directors
ANA Cabinets
ANA Councils

FROM: Karen S. O'Connor, M.A., R.N.
Director, Division of Nursing Practice and Economics

DATE: September 16, 1988

RE: Update on ANA RCT Proposal and Nursing's Solution to the Shortage

The purpose of this communication is to 1) provide an update on the American Nurses' Association's (ANA) strategies to oppose the RCT and promote nursing's solutions to the shortage, 2) to provide an update on the October 7, 1988 invitational meeting convened by ANA, Tri-Council Organizations, National Council of State Boards of Nursing (NCSBN) and National Federation for Specialty Nursing Organizations (NFSNO) and 3) to provide an update on the October 6, 1988 invitational conference convened by the NFSNO.

Attachment I provides a summary of progress to date related to activities called for by the ANA 1988 House of Delegates and the ANA Board of Directors to address the RCT proposal and to strengthen nursing's solutions to the shortage.

A major focus following the June, 1988 ANA Convention has been to strengthen coalitions and planning toward a national invitational meeting of representatives from major health care organizations to discuss short- and long-term strategies to alleviate the nursing shortage. The meeting is scheduled October 7 in Chicago, Illinois with representatives from organized nursing, organized medicine, the hospital and nursing home industries, consumer organizations, and medical and nursing academia. More details about this invitational meeting can be found on pages 2-4 of the summary.
Subsequent to the planning for the October 7 meeting, the National Federation of Specialty Nursing Organizations met in July, 1988. The Federation unanimously voted to convene a fall '88 conference for organized nursing, including L.P.N. organizations to address strategies for the education and rapid deployment of entry level technical nursing personnel and to identify the role of the various national nursing organization in the implementation of these strategies.

To that end, the National Federation for Specialty Nursing Organizations invited representatives from national nursing organizations to convene for a working conference on the nursing shortage Thursday, October 6, 1988 from 9:00 a.m. to 4:00 p.m. at the Marriott O'Hare Hotel, Chicago, Illinois. The president, first vice-president, executive director, chairperson of the Constituent Forum, chairperson, Nursing Organization Liaison Forum and staff are attending the conference. Each state nurses' association is invited to participate as an observer.

If a representative from your state is interested in attending, please contact Rita Rupp, M.A., R.N., American Association of Nurses Anesthetists, 216 W. Higgins Road, Park Ridge, IL 60068, (312)-692-7050 before September 23, 1988. The SNA will be responsible for all expenses to attend the conference.

KSG:BJL
9-14-88
Since the ANA House of Delegates in June, ANA has undertaken numerous activities to address opposition to the establishment of RCTs. They include activities by various official and administrative units in the areas of policy and data analysis, labor relations, communications, legislation and regulation, and external representation of ANA's position regarding the RCT. The purpose of this report is to provide a summary of these activities. Please note that the ANA cabinets will receive reports on the RCT at their October meetings. The Constituent Forum Executive Committee has met by conference call to receive a report from the SNA task force on the nursing shortage and the RCT.

Review of Actions of the 1988 ANA House of Delegates

The 1988 ANA House of Delegates adopted an action report on opposition to the RCT (Report BOD-L, ANA Opposition to the AMA Proposal to Create Registered Care Technologists). The report called for the following:

1. That ANA oppose the introduction by other professions of new categories of health care personnel (including registered care technologists) who would assume nursing functions.

2. That ANA oppose the implementation of new categories of health care personnel as a solution to the nursing shortage.

3. That ANA reaffirm its desire to work with medicine, providers, and all other interested parties toward effective short-term and long-range resolution of the nursing shortage.

4. That ANA reaffirm the accountability of registered nurses for nursing practice and all nursing personnel.

5. That ANA identify and promote measures to enable the more judicious use of registered nurses' time.

6. That ANA promote meaningful workplace incentives that will attract and retain nurses in full-time employment.

7. That ANA promote the recruitment and retention of students into nursing education programs.

The ANA Board of Directors, at the June 1988 ANA House of Delegates adopted several immediate and continuing strategies. They include:

1. Stimulate discussion and debate within ANA and at the upcoming House of Delegates, through personal contact with delegates and membership at the state level and ANA participation at the AMA meeting.
2. Strengthen coalitions at the state and national level to defeat the introduction of the RCT.

3. Provide materials and consultation for SNAs that address: a) political strategies, b) media strategies, c) regulatory strategies, and d) workplace strategies.

4. Serve as a central clearinghouse/rumor control center for state and national nurses' associations.

5. Launch a coordinated public education campaign with other nursing organizations and interested groups.

6. Disseminate to SNAs and state boards of nursing model language that makes explicit the accountability of the registered nurse for nursing practice and for all nursing personnel.

7. Ratify the actions taken at the May 5 summit meeting relative to short-range strategies to resolve the nursing shortage.

Progress To Date

Strengthening National Coalitions

Following the ANA House of Delegates meeting, a statement regarding ANA's opposition to the RCT was prepared for dissemination to the AMA reference committee at the AMA House of Delegates on June 26, 1988.

ANA representatives at the ANA convention were: Lucille A. Joel, Ed.D., R.N., F.A.A.N., president; Virginia Trotter Betts, J.D., M.S.N., R.N., first vice president; Judy Huntington, M.N., R.N., second vice president; Juanita W. Fleming, Ph.D., R.N., F.A.A.N., secretary; Mary Beth Strauss, Ph.D., R.N., chairperson, Constituent Forum; Louise Shores, Ed.D., R.N., executive director, Illinois Nurses Association; Judith A. Ryan, Ph.D., R.N., executive director, ANA; Eunice A. Turner, M.Ed., R.N., senior staff specialist, Government Affairs, Division of Nursing Practice and Economics; and Nancy M. Perrin, publications manager, Communications Unit. Representatives from other nursing organizations were: Sheila McCarthy, M.S.N., R.N., president, American Organization of Nurse Executives (AONE); Carol Boston, M.S., R.N., acting executive director, American Organization of Nurse Executives (AONE); Nancy Sharp, R.N., M.S.N., director for practice/legislation, The Organization for Obstetric, Gynecologic, and Neonatal Nurses (NAACOG); and Peggy McFadden, C.R.N.A., B.S., past president, American Association of Nurse Anesthetists (AANA).

The organizational representatives voiced strong opposition to the RCT. The American Medical Association took action to refer the RCT proposal and a related amendment, which would provide that RCTs will be certified and registered under state medical boards, rather than licensed, to the AMA Board for action.

ANA and the Tri-Council organizations moved immediately to strengthen national coalitions and began planning for a national meeting to discuss strategies for meeting the immediate need for nursing care in the United States in acute and long-term care facilities. The Tri-Council
organizations proposed a meeting in early October of organized nursing, organized medicine, the hospital and nursing home industries, consumer organizations, and medical and nursing academia. The objectives of the meeting are: 1) to educate medicine, academia, the hospital and nursing home industries and consumers to nursing's agenda for short- and long-term solutions to the nursing shortage; 2) to report progress to date on resolving the shortage; and 3) to elicit support of participant groups for advancing nursing's agenda to solve the shortage. The following groups are specifically invited:

Organized Nursing:
American Association of Colleges of Nursing
American Nurses' Association, including the chairperson of ANA Constituent Forum and Nursing Organizational Liaison Forum
American Organization of Nurse Executives
National Council of State Boards of Nursing
National Federation of Licensed Practical Nurses
National Federation of Specialty Nursing Organizations through the Chairpersons of the Practice Committee and Planning Committee for the National League for Nursing

Academia:
American Association of Junior and Community Colleges
Assembly of Hospital Schools of Nursing
Association of Academic Health Centers
Association of American Medical Colleges
National Association of Practical Nursing Education and Services
National Organization for Advancement of Associate Degree Nursing

Organized Medicine
American College of Physicians
American College of Surgeons
American Geriatrics Society
American Medical Association, including Council of Medical Education and Hospitals Medical Staff Section
American Osteopathic Association
American Society of Internal Medicine
Council of Medical Specialty Societies

Hospital Industry:
American Hospital Association, including Division of Medical Affairs
Federation of American Health Systems
National Rural Health Association

Nursing Home Industry:
American Association of Homes for the Aged
American Health Care Association
Early in the planning, the Tri-Council organizations invited a representative from the National Federation of Specialty Nursing Organizations and the National Council of State Boards of Nursing to join as sponsors of the October meeting. Representatives from these organizations have made themselves available for planning sessions. The American Association of Nurse Executives is hosting the October 6-7 meeting on behalf of the sponsoring organizations at the Marriott Hotel in Chicago, Illinois. The letters of invitation have been mailed.

In preparation for the October 6-7 meeting, the Tri-Council organizations have worked to further refine the short-term strategies (Attachment 2). The data from the National Commission on Nursing Implementation Project on sites that have implemented two categories of professional and technical nursing will be shared to demonstrate cost-effective utilization of nursing personnel (professional and technical) as a means to alleviate the nursing shortage. Additionally, the American Nurses’ Association and the American Organization of Nurse Executives designed a survey which was mailed to a random sample of 2,000 member hospitals of the American Hospital Association. The survey data will be analyzed at ANA and be ready for the October meeting. This survey asked nurse executives of the surveyed hospitals to describe their use of various strategies to increase the supply of nurses.

Subsequent to the planning for the October meeting, the National Federation of Specialty Nursing Organizations met on July 22-23, 1988. The federation unanimously voted to convene a fall '88 consensus conference for organized nursing, which would include the LPN organizations. The conference agenda will be to adopt a set of strategies for meeting the increased demand for technical nursing personnel and to identify the role of the various national nursing organizations in the implementation of these strategies.

A conference call of the Tri-Council organizations, the National Federation of Specialty Nursing Organizations and the National Council of State Boards of Nursing was immediately convened to consider the implications of this summit related to monitoring unity within the profession and moving forward with the strategies adopted at previous summits (May 5, June 14 and July 12, 1988). It was agreed to convene a meeting on October 6 in Chicago, Illinois of organized nursing to provide for an overview and summary of progress to date on nursing solutions to the shortage and opposition to the RCT and to address the issue of the educational preparation and utilization of technical personnel in today and tomorrow's marketplace. The organizations who are invited to participate in this conference include the same organizations that are invited to participate on October 7, 1988. Observers and the nursing press will be
auditing this meeting. The state nurses' associations will be invited to attend at their expense.

AMA convened the AMA Nursing Advisory Panel and other organizational representatives August 7-8 to discuss the RCT. AMA clarified its intent to proceed with the establishment of demonstration projects for the RCT. ANA's representative, Diana Taylor, M.S., R.N., member, ANA Cabinet on Nursing Practice and panel participant, attended on behalf of ANA.

Identifying Strategy at the State Level

On August 10-12, an SNA Nursing Shortage Task Force met to deliberate on political, media, regulatory and workplace strategies to alleviate the shortage and defeat the RCT. The task force, appointed by the Executive Committee of the Constituent Forum, included: Marilyn Badura, M.S.N., R.N., chairperson and president, Illinois Nurses Association; Concetta Tynan, M.A., R.N., C.N.A., president, Arizona Nurses Association; Jean R. Marshall, B.A., R.N., president, New Jersey State Nurses Association; Jo Anne F. Ensterling, M.S.N., R.N., executive director, Ohio Nurses Association; Clair B. Jordan, M.S.N., R.N., executive director, Texas Nurses Association; and Paula A. McNeil, B.S.N., R.N., executive director, Oregon Nurses Association, Inc.

Guests included: Vivien DeBack, Ph.D., director, National Commission on Nursing Implementation Project (NCNIP); Marie Snyder, M.S., J.D., president, Massachusetts Nurses Association and ANA consultant and legal counsel; and Ann Napier, M.S., R.N., chairperson, ANA Cabinet on Nursing Practice.

The objectives of the task force were 1) to use available data, determine the needs of state nurses' associations to address management of nurse supply as the profession is challenged with the increasing demand for nursing services and a reduced supply of nurses, 2) to develop political, media, regulatory and workplace strategies to address this challenge and defeat the RCT, 3) to identify materials for the SNAs, and 4) to determine criteria for the provision of consultation to the SNAs. Task force members also shared information about the nursing summits that have been convened in the states. The states include California, Illinois, Minnesota, Florida, Texas, Ohio, New Jersey and Oregon.

Rumor Control and Clearinghouse

Communication has been increased to the state nurses' associations and the Nursing Organization Liaison Forum (NOLF) in order to provide organized nursing with up-to-date information about activities related to the opposition to the RCT. During this period of time, ANA staff have investigated the feasibility of establishing an electronic mail system and bulletin board. It is now possible for the state nurses' associations to lease a mailbox from MCI to enable the SNAs to have electronic communication with ANA, as well as have access to the Dow Jones News Service and any other MCI mailbox user. ANA has established two MCI bulletin boards addressing information about the Commission on Organizational Assessment and Renewal (COAR). "ANA COAR NEWS" and information about activities around the registered care technologist (RCT). "ANA RCT NEWS."
Media and the Public Education Campaign

Comments of ANA officials and spokespersons concerning the nursing shortage and nursing's opposition to the RCT reached an audience of over 45 million during June, July and August.

The association has been featured in the following:

- Associated Press wire service
- United Press International
- U.S. News & World Report
- Wall Street Journal
- New York Times
- Chicago Tribune
- St. Louis Post Dispatch
- Newark, New Jersey Sunday Star-Ledger
- HealthWeek
- "CBS Evening News"
- ABC's "The Health Show"
- ABC's "Good Morning America"
- Cable News Network's "Sonya Live"
- National Public Radio
- United States Information Agency (satellite to military bases and diplomatic corps around the world)
- MacNeil-Lehrer News Hour
- NBC Sunday Morning

The AP and UPI wire stories were picked up and published in a number of daily newspapers across the country, including:

- The Boston Herald
- The Kansas City Times
- The Atlanta Constitution
- The Kansas City Star
- Evening Sun (Baltimore)
- Rocky Mountain News (Denver)
- The Charlotte Observer (North Carolina)
- Houston Chronicle
- The Washington Post
- The Philadelphia Inquirer

Editorials indicating opposition to the RCT proposal have been published in a variety of major newspapers. An editorial by Colman McCarthy, syndicated columnist for The Washington Post, was featured in newspapers across the United States.

State nurses' associations have also been working with the media and comments of SNA officials have appeared in multiple state and local media outlets.

The American Nurse newspaper, in a departure from its regular editorial format, devoted the first four pages of the July/August issue to matters related to the nursing shortage and ANA's RCT proposal. Copies of the newspaper were made available to state nurses' associations and other nursing organizations and groups at a nominal fee for their use for nurses and the public.
As of September 1, national nursing organizations had contributed $44,000 to assist ANA in efforts to launch a public education campaign designed to accomplish the following:

To continue to educate the public about the nursing shortage.

To redirect public attention from the negative aspects of the shortage to positive gains that are being made in order to enhance the image of the profession before the public.

To evoke public sentiment against the RCT proposal as an effective solution to the shortage by identifying effective steps that the nursing profession is taking to resolve the shortage.

To educate members of the health care community, consumer groups and other prospective allies about nursing's efforts to resolve the shortage and opposition to the RCT proposal.

To educate the nursing community about nursing's solutions to the shortage and elicit the support of SNA members and non-members to defeat ANA's proposal to create a registered care technologist.

To unify the nursing profession by creating a common sense of purpose in resolving the nursing shortage and defeating the RCT proposal.

An ad has been developed carrying the message, "Nurses Caring for Nursing," from "Nursing's National and State Professional Organizations." The purpose of the ad is to alert and unite the profession around efforts to solve the nursing shortage and oppose proposals to create new kinds of health care givers. The ad is scheduled to appear in the September issues of The American Nurse and RN magazine, the October issues of the American Journal of Nursing and Nursing '88, and in the November/December issue of Imprint. Advertising space in RN, AJN, Nursing '88, and Imprint was donated. Camera-ready slicks of the ad will be distributed to health organizations and nursing journals nationwide with the encouragement that they too donate space in their publications. ANA staff are contacting other nursing journals to solicit interest in placing the ad.

Other major components planned for the public education campaign include:

Development and refinement of a media message for use by elected and appointed officials of ANA, the Nursing Organization Liaison Forum and SNAs. The message will be shared with other nursing organizations and groups for their information and use as desired.

Development of a brochure about nursing's goals to solve the nursing shortage, effective steps already being taken to solve the shortage, and nursing's opposition to the RCT proposal. Brochures will be distributed by October 1 in bulk to SNAs and other nursing organizations and groups for use with nurses, consumer groups, legislators and the public as desired. The brochure will be distributed from the national level in response to inquiries generated by the advertisement and in response to inquiries received on ANA's WATS line.
Ongoing features and progress on solving the nursing shortage in articles and special features in *The American Nurse*.

A media tour designed in collaboration with individual SNAs to occur around official trips and schedules of ANA elected and appointed officials and the leadership of other national nursing organizations and groups.

**Model Language for Nursing Practice Act**

The Cabinet on Nursing Practice Task Force which was charged with revising ANA's model language for Nursing Practice Act met on August 11-12 to make explicit the accountability of the registered nurse for nursing practice and for all nursing personnel. The task force discussed the adequacy of the language differentiating regulation of the two categories of nursing practice and the need for language that specifies the role of the state board of nursing in regulation of the practice of those who assist in the practice of nursing. Final revisions will be made by the task force during September, with special attention to the language specifying the role of the state board of nursing in regulation of the practice of those who assist in the practice of nursing.

The revised language will be forwarded to the Cabinet on Nursing Practice for review during their regular meeting of November 3-4. It is anticipated that publication of the model legislation for Nursing Practice Act will occur in early 1989.

Additionally, staff dialogue with the National Council of State Boards of Nursing have resulted in an agreement to develop a joint position statement between ANA and NCSBN on the nursing shortage and implications related to regulation, particularly delegation. This position statement will be reviewed by the Cabinet on Nursing Practice and the ANA Board.

**Activities in Progress:**

Ongoing staff activities related to opposition to the RCT include continuing media contacts and coverage; analysis and promotion of strategies to implement the two categories of professional and technical nursing in the workplace; continued analysis of the appropriate mix of personnel in acute and long-term care; clarification of the categories of those who assist in the functions of nursing; continued study of wages, salaries and working conditions of nurses; and support of legislative and regulatory initiatives related to the nursing shortage. These issues will be addressed during the fall meetings of the Cabinet on Nursing Services, the Cabinet on Nursing Education, the Cabinet on Economic and General Welfare and the Cabinet on Nursing Practice.

KSO:ds

9/8/88
TO: ANA Board of Directors  
Constituent Forum Executive Committee  
State Nurses' Associations  
Presidents  
Executive Directors  
ANA Cabinets  
ANA Councils

FROM: Mary Beth Strauss, Ph.D., R.N.  
Chairperson, ANA Constituent Forum

DATE: September 16, 1988

RE: Recommendations of SNA Nursing Shortage Task Force on Nursing Shortage and RCT

The Executive Committee of the Constituent Forum met by conference call on September 9, 1988, to review the recommendations of the SNA Nursing Shortage Task Force on nursing shortage and RCT. (Attachment I). Maribeth Badura, M.S.N., R.N., chairperson, SNA Task Force reviewed the report and recommendations with the executive committee.

The Executive Committee of the Constituent Forum made the following recommendations:

- That ANA take the lead in developing and disseminating the public education message to SNAs about the RCT and the shortage.

- That the Constituent Forum Executive Committee requests the ANA Cabinet on Nursing Education to develop a self-assessment tool for states to use in implementing two categories of professional and technical nursing in the workplace. The tool is to include a checklist to assess readiness to introduce legislation.

- That the issue of implementation of two categories of professional and technical nursing be a major focus of the December Constituent Forum meeting.
That regional SNA conference calls of the presidents and executive directors be convened before the end of the year to:

- share information and provide for updates regarding strategies to oppose the RCT at the national and state level
- to plan for the implementation of strategies

That the SNA task force recommendations regarding national regulatory activities be referred to the appropriate ANA organizational unit or staff unit for implementation.

That the SNA task force recommendations regarding states’ regulatory activities be considered for implementation by each SNA.

That the ANA Marketing Unit develop promotion/recruitment materials regarding the RCT that can be used by the SNAs as appropriate to take advantage of a “window of opportunity” through December, 1988.

That a progress report on the status of the "Model Nursing Practice Act" be sent to the SNAs immediately.

That the SNA task force recommendations regarding strategies in the workplace be considered by each SNA.

ANA staff will be contacting your states to arrange for the conference calls. The regions will be divided into 4 to 5 states in order to provide for a more orderly call. An agenda for the call will be shared with you in the immediate future. A member of the ANA Board, Constituent Forum Executive Committee, SNA task force and staff will be available for the call. I would like to take this opportunity to thank the SNA Nursing Shortage Task Force for their work and recommendations. I believe that you will agree that the recommendations are viable and will advance nursing’s solutions to the shortage.

KSO:BJL
09/14/88

cc: SNA Nursing Shortage Task Force
MINUTES

Task Force Members:

Maribeth Badura, M.S.N., R.N., Chairperson
President, Illinois Nurses Association

Concetta Tyman, M.A., R.N., C.N.A.A.
President, Arizona Nurses Association

Jean R. Marshall, B.A., R.N.
President, New Jersey State Nurses Association

Jo Anne F. Easterling, M.S.N., R.N.
Executive Director, Ohio Nurses Association

Clair B. Jordan, M.S.N., R.N.
Executive Director, Texas Nurses Association

Paula A. McNeill, B.S.N., R.N.
Executive Director, Oregon Nurses Association, Inc.

Staff Resources:

Karen S. O'Connor, M.A., R.N., Director, Division of Nursing Practice and Economics.

Irma Lou Hirsch, M.N., R.N., Program Manager, SNA Practice Liaison, Center for Nursing Practice.

Cynthia L Cizmek, M.S.N., R.N., Director, Communications

Patricia A. Ford-Roegner, M.S.W., R.N., Director, Political Education, Division of Governmental Affairs

Joanne Symons, Consultant, Washington, D.C.

Debra Svoboda, Director, Marketing Services

Julie Fry Gibson, J.D., R.N., Director, Center for Labor Relations, Economic and Social Policy

Barbara Lalk, Administrative Assistant, RCT Project Staff

Jacki S. Witt, M.S.N., R.N., RCT Project Staff

Guests:

Vivien DeBack, Ph.D., Director, National Commission on Nursing Implementation Project (NCNIP)

Marie Snyder, M.S., J.D., President, Massachusetts Nurses Association and ANA Legal Counsel

Ann Napier, M.S., R.N., Chairperson, ANA Cabinet on Nursing Practice
Subject and Discussion | Action
--- | ---
**Call to Order**

The meeting was called to order by Maribeth Badura, Chairperson, at 9:15 a.m. in Conference Room A, of the ANA Headquarters. The Task Force and staff introduced themselves and reviewed the committee list. Ms. Badura asked the task force to review and comment on the proposed agenda and timetable.

**Clarification of Charge to the Task Force**

Karen O'Connor offered background information about the objectives for the meeting.

- Using available data, determine the needs of state nurses' associations to address management of nursing supply as the profession is challenged with an increasing demand for nursing services and a reduced supply of nurses
- Develop political, media, regulatory and workplace strategies to address this challenge and the RCT
- Identify materials for SNAs
- Determine criteria for the provision of consultation to the SNAs

Task force members asked questions about the August 7-8, 1988 ANA-hosted meeting and the October 6-7, 1988 ACNE-hosted meeting.

Karen O'Connor offered updates on both meetings:

**October 6-7, 1988 Meeting - Chicago**

ACNE is hosting the meeting on behalf of ANA, the National League for Nursing (NLN), the American Association of Colleges of Nursing (AACN), the
Subject and Discussion

Clarification of Charge to the Task Force continued...

National Federation of Specialty Nursing Organizations (NFSNO), and the National Council of State Boards of Nursing (NCSBN) and sending invitational letters to representatives of organized nursing, organized medicine, nursing and medical academia, members of the hospital and nursing home care industry and consumer groups. There will be a meeting of organized nursing on October 6 before the larger group meets. The purpose of this meeting is to prepare for October 7 and discuss issues about the preparation and utilization of LPNs and other technical nursing personnel.

August 7-8, 1988 Meeting - Chicago

Diana Taylor, M.S.N., R.N., was ANA's representative to AMA's August 7-8 meeting. She has communicated to ANA that the AMA presented the usual rationale and materials about the RCT. Most representatives raised questions about AMA's data. Diana Taylor and other nursing representatives made it clear that ANA stood firm on opposing the RCT. Diana Taylor also reiterated that nursing believes there are models which are working now, without the addition of an additional worker.

Review of Policy Related to Management of Nurse Supply, Encroachment and the RCT

Ms. Badura briefly reviewed materials which task force members had been asked to read. The task force developed a list of assumptions regarding the role and functions of the SNAs and ANA in implementing strategies related to management of nurse supply, encroachment and the RCT.
Review of Policy Related to Management of Nurse Supply, Encroachment and the RCT continued...

Assumptions adopted by the group are as follows:

1. The issue of "entry into practice" is intertwined with the nursing shortage but is not the cause of the shortage.
2. Hospital employment practices contribute to the nursing shortage.
3. The number of college freshman are decreasing which will impact nursing.
4. There is an increased demand for nursing services. The full impact of a decreased supply is not being felt yet.
5. The implementation of the registered care technologist in even one site would affect all nursing.
6. The RCT pilot project may occur in states less able to oppose the movement because of resources, particular demographic variables, severe nursing shortage, or other political or legislative trends in the state.
7. The opposition to the RCT and the response to the nursing shortage may have a unifying effect on nursing and is possibly creating an opportunity to recruit SNA members.
8. ANA and the SNAs must maintain visibility and leadership in the opposition to the RCT and the strategies for solving the nursing shortage.
9. Nursing should control the entire scope of the occupation of nursing; therefore nurses should have control over those who assist in the practice of nursing.
10. Nursing care encompasses all care provided by licensed nurses and those who assist nursing.
Subject and Discussion

Review of Policy Related to Management of Nurse Supply, Encroachment and the RCT continued...

11. Selection of strategies to solve the nursing shortage is dependent on environmental assessment, resources available, and desired outcome.
12. Nurses' workplace identity is very strong.

Public Relations Campaign

Cynthia Cizmek, M.S.N., R.N., director, Communications, presented ANA's proposed media plan. Objectives for the public education campaign were reviewed by the task force. Ms. Cizmek noted that the current plan reflects a desire to redirect the public message toward a positive viewpoint. The media message will be double-edged, offering nursing's shortage solutions while opposing the AMA's RCT.

There was general consensus that the following terminology be used when discussing the future scope of practice for nursing: two categories of nursing, professional and technical; two pathways to a nursing career; education and utilization of nurses in two categories. The task force asked that the videotape interviews with the President and AMA spokespersons be made available to SNAs.

Educational Preparation and Utilization of Nursing Personnel

Dr. Vivien DeBack, director of the National Commission on Nursing (NCP) opened the discussion by reminding participants that NCNIP enjoys the "luxury" of living in the future and that data presented are projections.

The task force approved the public education campaign and requested that the objectives, message and related materials to be distributed to the states, including guidelines on how to utilize media contacts to advance and clarify nursing's solutions to the shortage. It was agreed that ANA take the lead in developing and disseminating the public education message.
The task force reviewed and agreed with strategies to move forward to explore differentiated practice in the workplace.

The task force discussed the feasibility of convening a one-half day meeting in conjunction with the Constituent Forum in December on strategies to implement the two categories of professional and technical nursing. The meeting will be sponsored by the Constituent Forum Executive Committee, Cabinet on Nursing Education, and National Commission on Nursing Implementation Project (NCNIP). Following the Constituent Forum Executive Committee's September 26-27, 1988 meeting, an advisory will be sent to the states regarding the timing of the joint workshop.

Call to Order

Maribeth Badura called the meeting to order at 9:05 a.m.
Political Strategies

Pat Ford-Roegner, M.S.W., R.N., Director, Political Education and JoAnn Symons, consultant from the Washington office introduced this section and facilitated the discussion. The group discussed the importance of ANA/SNAs being seen as leaders in solving the nursing shortage and in opposing the RCT. The group asked about the possibility of ANA producing a brochure or pamphlet with nursing’s message regarding the solution to the nursing shortage. The Communications Unit will produce a pamphlet from the existing fact sheet.

The task force determined that regional meetings of the states this fall would facilitate communication and dissemination of information about nursing’s short and long-range solutions to the shortage and POLITICAL STRATEGIES to defeat the RCT. The task force is recommending that SNA presidents and executive directors meet together in each of the four (4) regions in September or October to deliberate the recommended political strategies for implementation in each state. ANA will convene these meetings and provide for speakers and materials. Each SNA will be responsible for the travel of president and executive director. ANA will begin work with representatives of each region to schedule a data and a site immediately.

Regulatory Implications

Irma Lou Hirsch, M.N., R.N., Program Manager, SNA Practice Liaison, presented the topic. Discussion addressed national and state strategies and regulatory implications. Members expressed the need for ANA to provide direction regarding the types of

The task force recommended the following activities:

That national activities include:

- The monitoring, review, and opposition of national and state
Subject and Discussion

Regulatory Implications
continued...

data to be collected at the state level and the sources for this data. It was also suggested that ANA develop a list of legal experts familiar with legal regulation of nursing practice. Members also discussed the feasibility of antitrust charges.

- policy formation, legislative efforts, and funding designed to create new health care personnel and/or to substitute unqualified personnel for qualified practitioners of nursing.
- The collection, compiling, and analysis of data from state nurses' associations and other sources on the geographical area and types of shortages of nursing personnel and the promotion of studies on the effect of substitution on the cost and quality of care.
- The design and promotion of the implementation of comprehensive support systems for nursing personnel, to include monitoring of the nature, type, training, and functions of personnel who serve in assistive capacities to nurses.
- The use of differentiated practice as a means for further refining nursing practice roles and defending against inappropriate substitution of nursing personnel.
- The monitoring of federal funds and medicare pass-through monies used to fund RCT education.
- The monitoring of vocational-technical education funds for RCT programs.
- The monitoring of the use of Medicare/Medicaid law to authorize new providers.
Regulatory Implications
continued...

- Clarifying the legal accountability of licensed nurses for those assisting nursing
- Compiling data on the presence and characteristics in each state on mandatory review process for new providers.
- Clarifying the role and functions of those who assist nursing

The state activities are directed to defeat the development of a Registered Care Technologist, or any other new provider that duplicates nursing personnel. The recommended activities are:

- Establish a base-line of information through a state audit to assess:
  - presence and characteristics of a mandatory review process for new providers
  - authority in the Nurse Practice Act of the registered nurse and licensed practical nurse for the supervision of unlicensed personnel
  - language of the Medical Practice Act relative to delegation of activities and general authority or categories of providers
  - sources of funding and accreditation requirements for technical nursing personnel
Subject and Discussion  

**Regulatory Implications continued...**

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<td>Monitor through networks of nurse educators and administrators the development of technical training programs for new health care providers</td>
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<td>If technical programs similar to nursing emerge, consider seeking an interpretation of the Attorney General relative to violation of state antitrust laws</td>
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<td>If technical programs similar to nursing emerge, work with the state board of nursing on an interpretation of the proposed scope of practice relative to the potential illegal practice of nursing</td>
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<td>Monitor mandatory renewal process for new providers (several already in place)</td>
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<td>Monitor hospital licensures</td>
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<td>Collaborate with state boards of nursing to collect data regarding Nurse Practice and Medical Practice Acts</td>
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**SNA Recruitment Strategies**

Debra Svoboda, director of Marketing Services offered background information and the task force contributed additional information. There was discussion regarding what states were already doing to recruit members. Examples included "each one reach one" programs, with members receiving a $20.00 bonus for each new member recruited. Specific strategies for recruitment.

The task force requested ANA to forward to SNAs the names/addresses of non-SNA member phone calls regarding RCT.

The task force requested the Marketing Unit to develop promotion/recruitment materials regarding the RCT for SNAs to use as appropriate.
Subject and Discussion

SNA Recruitment Strategies continued...

were offered by task force members and Ms. Svoboda. They include:

- six-week window of opportunity — 1/2 price membership

- "Each one reach one" (dollar incentive for members who recruit new members)

- New graduates - offer two years membership for one year dues.

- ANA will look at strategies to reach medical/surgical staff nurses

The task force agreed that the RCT issue and the nursing shortage could be positive for recruitment of new members and that the window of opportunity is available through December, 1988.

FRIDAY, AUGUST 12, 1988

Call to Order

The meeting was called to order at 9:05 a.m. by Maribeth Badura

Timetable for Dissemination of Strategies to SNAs

The group discussed methods and timetable for dissemination of strategies to SNAs:
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<td><strong>Timetable for Dissemination of Strategies to SNAs continued...</strong></td>
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<td>o Public education campaign August-September 1988</td>
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<td>o Regulation of nursing practice strategies: September 1988</td>
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<td>o SNA nursing recruitment strategies: September 1988</td>
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<td>o Workplace strategies: September 1988</td>
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<td>o Political strategies: October 1988</td>
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<td>o Education Strategies December 1988</td>
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<td><strong>Model Legislation for Nursing Practice Act</strong></td>
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| Marie Snyder, M.S., J.D., president of the Massachusetts Nurses Association and Ann Napier, M.S., R.N., chairperson of NNA's Cabinet on Nursing Practice, presented information on the revision of "Model Legislation for a Nursing Practice Act."
There was discussion regarding the difference between "assigning" and "delegating." | The task force requested that the use of "assign" and "delegate" be reviewed by the committee to revise the model legislation. |
<p>| <strong>Workplace Strategies:</strong>                                                                |                                                                                            |
| Julie Fry Gibson, J.D., R.N., director, Center for Labor Relations, Economic and Social Policy presented background information related to workplace strategies, including risks and protections to be considered. | The task force recommended the following additional, short-term, immediate workplace strategies: |</p>
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<td>Workplace Strategies</td>
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- Communicate with supplemental staffing agency leadership (i.e. Upjohn, Kimberly, etc.)

- Develop fact sheets for staff nurses related to how to spot warning signs that the RCT is imminent (i.e. communication with other units: respiratory therapy, physical therapy, occupational therapy, etc.)
  Signs include:
  - changing job descriptions
  - personnel performing different tasks than before.

- Develop fact sheets for staff nurses on how to express opposition to RCT.

- Maintain or initiate communication with Directors of Nursing regarding utilization of nurses, etc.

- Communication/monitor AMI, Humana Corp.

- Initiate communication with nurses in management regarding assistive workers.
Subject and Discussion

Workplace Strategies continued...

- Assist nurses in management to obtain information about income as well as cost of running unit.

Summary of Outcomes

Maribeth Badura asked that task force members review strategies and recommendations.

It was agreed that the timetable was appropriate.

The group recommended that ANA provide SNAs with materials and data to support the SNAs strategies.

Adjournment

The meeting was adjourned by Maribeth Badura at 12:40 p.m.
NAPNES Takes a Positive Position on AMA Proposal

The National Association for Practical Nurse Education and Service, Inc. (NAPNES) adopted a resolution at its 47th Annual Convention stating its intent to "collaborate with the American Medical Association in exploration of the Registered Care Technologist Proposal by sharing the expertise which has developed one of the most valuable health-care providers; the licensed practical/vocational nurse."

NAPNES is the first national nursing organization to take a non-opposing position on the proposal, which would establish a non-nurse bedside health-care provider.

"In its 47-year history, NAPNES has never opposed the development of any level of health-care provider," said NAPNES Executive Director John H. Word, L.P.N. "I do not see the RCT proposal as a threat to nursing, and certainly not to quality care. As the resolution says, NAPNES views the proposal as an opportunity to explore another option for those interested in providing care and for those receiving care."

In this respect, it appears that NAPNES stands alone among nursing organizations. The general consensus among organized nursing is that the AMA proposal is an attempt to limit nursing's autonomy. Word argues that this should not even be an issue.

"Where is it written that nurses have a monopoly on how or by whom health-care is provided?" asked Word. "Our health-care system is developed around medicine—not nursing. Physicians demand quality health care by competent health-care providers because they prescribe it.

"But make no mistake about it, NAPNES steadfastly represents, promotes and educates licensed practical/vocational nurses; that will never change," he continued. "However, we believe that we can support a multiplicity of choices without shooting ourselves in the foot."

Established in 1941, NAPNES is the oldest and largest national professional association for licensed practical/vocational nurses.

47th Annual Convention

RESOLUTION # 2

Whereas, The American Medical Association has shown initiative and leadership by proposing a solution to the critical shortage of patient care providers; and

Whereas, They demonstrate their willingness to collaborate with NAPNES and other health care organizations in perfecting a plan to meet societal needs for patient care by opening doors of communication to accomplish this tremendous task; and

Whereas, The American Medical Association has always and continues to support all recognized programs that educate nurses;

Resolved, That NAPNES recognize and commend the AMA for their innovative approach; and

Resolved, That NAPNES collaborate with the American Medical Association in exploration of the Registered Care Technologist Proposal by sharing the expertise which has developed one of the most valuable health care providers: the licensed practical/vocational nurse; and

Resolved, That a copy of this resolution be sent to the American Medical Association and that it be duly published in relevant health care publications.

Adopted
May 24, 1988
Nursing Organizations React to AAMA Proposal

Nursing organizations have been quick to react to the American Medical Association’s proposal to establish a bedside health-care provider-the registered care technologist. The proposal, which was approved by the AMA Board of Trustees, was first published in May. Since then, it has become the most talked about issue in nursing.

In order to provide our readers with accurate, up-to-date information regarding this proposal, the NAPNES Forum has compiled a list of actions taken in recent weeks by various nursing organizations.

NAPNES

NAPNES is the first nursing organization to take a non-opposing position on the RCT proposal. NAPNES adopted a resolution at its 35th Annual Convention stating its intent to “collaborate with the American Medical Association in exploration of the Registered Care Technologist Proposal by sharing the expertise which has developed one of the most valuable health-care providers: the licensed practical/vocational nurse.”

Since the adoption of this resolution, NAPNES has been inundated with inquiries from nursing organizations and the media.

“I’m not surprised by all the attention this resolution has received,” said NAPNES Executive Director John Ward, L.P.N. “Most nursing organizations think we are crazy for agreeing to collaborate with the AMA on its proposal. They say that all nurses should band together and fight the doctors.

“However, why should we fight the AMA? They support all levels of nursing, including licensed practical nursing. I don’t think the AMA or the NLN can honestly say they support us,” Ward said. “We have spent more than 20 years fighting a proposal, which was introduced by a nursing organization, that would eliminate licensed practical nursing. How can anyone criticize us, as a national practical nursing organization, for simply agreeing to share our expertise with the AMA?”

ANA

The American Nurses’ Association House of Delegates unanimously passed a resolution to oppose the RCT proposal because it would be “unsafe, duplicative, costly and would bring confusion and fragmentation to the current health care delivery system.” The delegates met at the ANA convention in June.

“Nursing is a proven profession,” said ANA President Lucille Joel, R.N., Ed.D. “The demand in the marketplace is clearly for qualified nurses, not another category of worker.”

Tri-Council for Nursing

On May 5, the Tri-Council for Nursing gathered representatives from national nursing organizations to discuss the RCT proposal and to find ways to resolve the nursing shortage. The result of the meeting was a position paper, entitled “Short Term Strategies to Resolve the Nursing Shortage.” The paper stated that nursing organizations supported the following short-term strategies:

1. Immediately increase the time that registered and licensed practical nurses spend with patients by reallocating resources and designing new staffing systems to:
   - expand utilization and employment of ancillary personnel responsible to nurses to assist in the clinical and non-clinical support tasks essential to nursing care;
   - increase the retention of experienced nurses by improving salary and benefit structures;
   - increase the use of information and systems technology to support patient care.

(continued on back page)
Attached, for your information, are articles concerning nursing, the shortage, and the AMA's registered care technologist proposal, from the August 1988 issue of *McCall's Magazine* and the July 11, 1988 edition of *U.S. News & World Report*. *McCall's* reports a circulation of 5,275,428 and *U.S. News* claims a circulation of 2,287,061. ANA worked with both these publications in the preparation of these articles.

The association also worked with ABC News for a segment on the RCT proposal for the network's weekly "Health Show," aired the weekend of July 9-10, 1988. ANA President Lucille Joel, Ed.D., R.N., F.A.A.N., was interviewed for the program, which has an estimated viewing audience of 2,000,000.

President Joel also provided ANA's response to the RCT proposal and nursing's solutions to the shortage on Cable News Network's "Sonya Live," on June 28, and ABC's "Good Morning America," on June 29. ANA First Vice President Virginia Trotter Betts, M.N., J.D., R.N., provided comments on the RCT proposal aired on CBS Evening News on June 30.

We hope this information is useful to you. Please call Cynthia Cizmek, Cathy Koeppen, or Carol Grimaldi if you have any questions or if there is anything with which we may help you.

Attachments

cc: SNA Media Liaison Representatives
Money alone will not solve the nursing shortage. The profession today, say those in it, “is sicker than its patients.”

NURSING in Crisis
BY EVELYN S. RINGOLD

The nursing shortage is scary—and growing scarier. The American Nurses Association reports that nursing vacancies in hospitals are now close to 20 percent nationwide, almost double the number of vacancies one year ago. With no remedy in sight, the shortage threatens to grow at an alarming rate. In nursing circles they’re predicting the worst shortage ever by 1990.

Hospitals are playing a strong money card this time, attempting to resolve the shortage with an impressive run-up in salaries. For example, a large university hospital in Philadelphia offers a new nurse a yearly salary of $28,000; this is exclusive of any additional income she may earn from working overtime or working on the more highly paid evening and night shifts. Ten years ago, the same job in the same hospital paid $13,400.

But there is an overriding suspicion out there that this shortage is different; that money and economics by themselves will not solve the problem; that the climate in nursing is discouraged and defeatist; that the nurse as we know her may be an endangered species.

Recent polls in nursing magazines confirm that money is not first on the nurses’ wish list. What they want most now is relief from working without adequate staff, a firm promise of help in an emergency and, at a personal level, a reduction in the burdensome amount of overtime, double shifts and number of weekends on duty. Then comes the desire for an “adequate” salary. Also high on the charts are some wants that were around long before this shortage became acute. The nurse wants support from her own nursing administration, support from hospital administration and—the hottest chestnut of all—an improved working relationship with the doctors.

At the core of all her discontent is a hunger for recognition and respect. She has heard too often that she is “only” a nurse. She wants recognition within the health care hierarchy of her hospital (please turn to page 56).
NURSING
in Crisis
continued from page 54

knowledge, skills and dedication. If she works in a hospital, she wants a voice there commensurate with the responsibility she assumes for her patient's wellbeing and very survival.

The fight for recognition is uphill all the way, because nursing traditionally belongs to the "invisible" "silent" helping professions that serve nursing. Nurses, like teachers and social workers, seem to attract attention only when they are not there.

Joanne M. Bias, RN, PhD, clinical director of medical nursing at the Hospital of the University of Pennsylvania, has a somewhat more current slant on the situation. She considers the increased professionalism of nursing the best-kept secret in health care. In the past 20 or more years, she explains, nursing has taken a quantum leap forward in terms of knowledge, skills and advanced degrees. But no one seems to notice, and nursing cannot quite discard the old discard of image of its practitioners as subservient, sweet-natured and not overly bright. How many people know (or care), asks Dr. Biasch, that some 6,000 nurses have their Ph.D.'s, 70,000 their master's degrees and almost a half million are "registered" nurses? How many people realize that there are nurses legally empowered to write prescriptions? And nurses who run private health practices—much like doctors?

According to a speaker at a recent nursing convention, it would take a $40 million Madison Avenue public relations campaign to deslodge the old image and replace it with a picture of the nurse who has remodeled herself to fit the high-tech health-care world. Unfortunately, it might take more than $40 million to resolve the dyslexia, rivalries and conflicts that divide the profession against itself.

Nurses don't even seem to fit into one national nursing organization. By some quirk, there are two: the American Nurses Association and the National League for Nursing. Between them they have only some 200,000 paid members—out of two million nurses who actually maintain their licenses. In addition, there are at most 100,000 RN's who belong to the AFT-CIO and independent unions. Whatever the explanation, the result is that nurses do not master the big numbers that could give them some clout.

Education is one of nursing's greatest advantages. The letters BSN—which indicate a state license—not a nursing degree—can be obtained on an equal footing by a nurse who has a two-year or a four-year degree from a community college, a three-year diploma from a hospital affiliated nursing school or a bachelor of nursing degree from a four-year program at an accredited college or university. The BSN, which has long urged the bachelor's degree as the minimal education, entry requirement for nurses, believes that this modern head education could bring on the demise of the profession.

Nursing also has some poor habits for a profession. Elton Ginzberg, director of the Conservation of Human Resources at Columbia University, says, "I don't know of any profession that has as many part timers as nursing." He adds, "Lapsed licenses together with part time employment do not speak of a high order of professionalism."

But even if nurses did have better professional habits if they were needed, if they were fitter, they would still have to cope with the turbulent economics of the changing health care situation. Hospitals have moved into a new form of rationalization: a revolutionary evolutionary phase in which the concepts of charity and service have been obliterated by red ink. Hospitals are now busily marketing patient care as a product, with unfailing attention to the profit and loss margin. A recent number of hospitals closed last year, and those that have survived bear a clear message: "Save a dollar, save a dime, save this hospital.

If we turn aside from the monolithic group of 1.6 million working nurses and see individual nurses close up, how critical is the case?

To get the sense of this moment in nursing firsthand, we talked with four nurses. Each of them does a different type of work yet all have three things in common: excellence on the job, a love of the profession and a volatile mix of anxiety and hope for the future.

Roberta Guertin, 22, is a staff nurse on unit 7C at a prestigious university teaching hospital. She was graduated magna cum laude just over a year ago with her B.S.N., a bachelor of science degree in nursing. Guertin does what is considered the hardest job in nursing.

A staff nurse on a medical-surgical unit is the nurse the public is most familiar with. Amid dozens of nursing specialties, the staff nurse is still a generalist. She moves up and down the halls, in and out of the patients' rooms at a good pace without noticeable breaks for chatting or eating. When she stops at a patient's bedside (definitely not as often as a staff nurse used to stop), she takes his vital signs, changes dressings, checks the intravenous equipment, records the fluid intake and output, turns him and gives him his medication.

When Guertin talks with the patient, her manner is sweet and gentle. But this is not particularly an emotional closer. She is there for a purpose to explain his condition or treatment. This is a precept held in the short-stay surgical patient—education—for which the label bats now.

But what she must find time for is the sometimes insatiable curiosity about her patients. Roberta Guertin's love and enthusiasm for nursing began when she was eight. She "always" wanted to be a nurse, like a nurse in her first grade novel. Now that she has entered the "system" storybook time is over. "As a student," Guertin says, "I had two patients in my care. I was superstitious and spoon-fed by my instructor. Now I'm responsible for six to twelve very sick patients. Nothing in the classroom prepared me for this degree of sickness."

Ready or not, Guertin is in the front rank of the nursing society battle lines: nursing and coping with a problem that is universal among staff nurses in hospitals throughout the country. The situation results, in part, from hospital regulations and constraints instituted within the past two or three years. The new regulations have been lashed almost exclusively by very sick patients. "Three or four years ago," comments an old hand nurse of 40, "these situations have been in the intensive care unit. Now they're on floor care and need constant attention." Patients on the recuperative end of surgery or an illness are released "quickly and sicker" to do their getting well at home.

Guertin admits the huge responsibility she faces. She tries to shrug off the difficulties and frustrations she experiences on the unit by telling herself she would have good days and bad days in any profession. But there is one bad day she cannot forget.

"It was a Saturday, just seven weeks after I came on the unit," Guertin recalls. "I was slated to work twelve-hour shifts both Saturday and Sunday. I got up at six on Saturday morning and was at work by seven. I found that I was alone with ten patients—except for a nursing assistant. I guess nobody had really looked at the staffing for that day."

"We had just finished serving breakfast when I discovered that one of my patients had developed a blood clot in his lungs. The intern came up at once and ordered the patient sent to intensive care. But the ICU didn't have a bed available, so we had to keep the patient alive. I spent the whole morning in that emergency room entire time..."
NURSING
in Crisis
continued

patient's room. I practically gave up on the other nine patients I had to care for. I can still remember rushing around the hospital trying to locate an EKG machine—then wheeling it down the stairs and through the corridors. When I got it to the room, it didn't work. I had to find another.

"I tried to get help. The nursing office said they couldn't send anybody to the floor until after lunch. And my friend Lisa on the next unit couldn't help me.

She had ten patients of her own.

In the meantime, an older woman called out from her bed as I hurried past. 'I would have moved just for money. We have such a wonderful unit here.'"

Yet Guertin can hardly be inured to what is happening around her. The climate in nursing has changed so drastically that enrollment in nursing schools is down more than 30 percent since she was a student. And she can actually hear older nurses greeting new graduates with remarks like: 'Why on earth do you want to do this?'

What will happen to the idealistic impulses that brought Guertin into nursing? How many hard days can she sustain? How long will she accept ten patient assignments that block out the personal aspect of nursing?

At last report Guertin was planning to stay on 7C. But many other nurses at her stage see a move into intensive care nursing as a way out of the grinding routines and shortage conditions of a unit like 7C. They look upon their time on a general med surg unit as basic training. The intensive care unit, by comparison, seems a place of privilege where they will have only two or three patients, where she can give those patients full attention and feel at the end of a day that she has done what needed to be done.

In the public perception, the intensive care unit (ICU) of a hospital is a place for the sickest patients who are cared for by supernurses. "Supernurse is right," says Eileen Markmann, who has worked as an intensive care nurse for nine years at the community hospital in Doylestown, Pennsylvania. "Patients who are "only" very sick are on floor care in a med surg unit like Robert's unit. The patients in intensive care have probably come so close to death that in another era, without the high-tech machinery, they wouldn't have survived to get to a hospital. Every patient in the unit needs constant monitoring." Markmann, described as "one of the ablest ICU nurses I've ever seen" by a former nursing colleague at Doylestown.
hesitates to accept the hierarchy implied in "supernurse," but she admits that in some hospitals the intensive care nurses are considered the elite, the "glamour" nurses. Markmann, who is straightforward and easy to talk with and has a competence and self-containment that allow her to be modest, doesn't talk much about the discontent and dissatisfaction in nursing. No ifs, ands or buts. She likes ICU nursing. "There's always something new to learn. I have to keep right up there with new medications, new procedures, new machines. I can't allow myself to get stale." When she goes to the annual meeting of critical-care nurses, Markmann says, she sees the huge tractor-trailer trucks pull up and unload hundreds of thousands of dollars' worth of the latest high-tech machinery onto the exhibit floor.

"Sophisticated and sensitive as these machines are, they do not serve as a nurse. I am the nurse," Markmann says. "I must go in and assess the patient's condition with my eyes, using my experience and intuition to pick up on any subtle changes." As an example, she points out that she cannot call a code based only on an alert from the monitor. "There's always a chance that the machine is registering a blip or an alteration. I must go into the patient's room and make a very quick decision."

Like each nurse in her unit, Markmann is responsible for two patients. The nurses all have equal status and take turns being in charge. Markmann works the day shift, with a schedule that calls for ten working days out of 14, including working every other weekend.

Markmann, who came into nursing with a diploma from a three-year hospital program, was awarded her BSN in June. With her nine years of experience in ICU, she is earning approximately $27,000 at Doylestown. This is actually less than Roberta Guerlin is earning in her first year at Jefferson. "I know if I wanted to go elsewhere I could earn a lot more," says Markmann, "but I like working here, in my own community."

Although Markmann feels completely accepted on the job for her professional skills, she still doesn't sense the recognition nurses want. "I'm respected by the doctors. That's not it," she says. "Sometimes they'll tell me, by way of praise, 'You made a good call.' But they don't have an inkling of how much we know, what our education entails or what we actually do. A doctor just gives his orders and expects them to be carried out."

Maybe because she is pragmatic and positive by nature, maybe because she is not being bothered by the shortage, as Roberta Guerlin is, Eileen Markmann says, "I want to believe that this short-
is Liz Bull at the Princeton Medical Center, in Princeton, New Jersey. As the "numbers person" outside the hospital, Bull does not think her job has to do with the health of anyone on the nurses' floor. If that makes her sound a bit like a good-news, Bull points to her record as evidence that she is right. "The organization should enable nurses to give complete, high-level care." She has already proved that she can make the system revolve around the caregiver, not the caregiver around the system.

When she came to Princeton Hospital as the vice-president for nursing more than seven years ago, she literally turned around the hospital. She raised morale and salaries and lowered the turnover rate. Nurses became a force in the hospital, even a somewhat privileged group.

Princeton is one of the most elite, expensive areas in the East, but its upper-class nurses did not keep from feeling the impact of the nursing shortage. By 1989, some of the nurses were being paid away by higher salaries to the prosperous new areas developing around Princeton.

"We were forced to take nurses out of tight, smoothly running units and send them off to desperately staffed units," Bull says. "Nurses were having to work double shifts. The hardest thing for me was to have to talk to the nurses' agent, the nurses, to give them a hard time, to say, 'I love you, but I need you to work more.'"

When she saw her years of work falling apart, Liz Bull took steps. The first step was money. "I went to my board and got more money for my nurses. But that was just a start. This thing goes deeper than money." As a second step, Bull invited hospital staff nurses—nurses who are certified nursing assistants and who manage, train, and hire—on an ongoing basis to explore the real problems. Sixty nurses responded and met with her all through last summer. They were flown into a specially chosen location, away from all the noise, so they could talk. It was a good housekeeping week for them, she says. "It's a week of listening, talking, talking, talking, talking, talking."

"But when we did that," says Bull, "we learned that it's not just one thing, or one group of nurses, or one hospital. It's a nationwide problem. We need to start solving it at the national level."

Throughout the country, nurses are using every resource at their disposal to get the message out. They're talking to the media, to the public, to their traditional nursing jobs in schools. They're writing to their legislators, to the White House. They're having meetings with hospital administrators, trustees, and government officials. The message is clear: The nursing shortage is a nationwide problem. We need to start solving it at the national level."

The old idea of nurses' recruitment efforts to enhance the status and pay of their profession—a key approach in filling the estimated 200,000 nursing positions across the nation—no longer works. Nurses seek more freedom to treat patients independently, and to be paid directly by the consumer for their services. Nurses are fighting back with a vengeance. In the last few weeks, the two groups clashed head on when the American Medical Association unveiled its own solution to the nursing shortage: Creating an entirely new class of health-care workers. Nurse practitioners—people who supply services typically provided by doctors—are going to be allowed to do things that could possibly make nurses worse.

"The greatest threat to the nurses' profession is the new class of health-care workers—the nurse practitioners," says Dr. Alan L. Ackerman, president of the American Nurses' Association. "They're going to take away nurses' jobs, and they're going to take away nurses' autonomy."

But in the last few weeks, the two groups clashed head on when the American Medical Association unveiled its own solution to the nursing shortage: Creating an entirely new class of health-care workers. Nurse practitioners—people who supply services typically provided by doctors—are going to be allowed to do things that could possibly make nurses worse.

Calling the shots in health care

The nationwide nursing shortage is a growing turf war between doctors and nurses.

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TO: ANA Board of Directors
Constituent Forum Executive Committee
State Nurses' Associations
Presidents
Executive Directors
ANA Cabinets
ANA Council Executive Committees
Nursing Organization Liaison Forum

FROM: Lucille A. Joel, Ed.D., R.N., F.A.A.N.
President

DATE: July 1, 1988

RE: Update on AMA RCT Proposal

Important developments have occurred regarding the American Medical Association's (AMA) new health care worker, the registered care technologist (RCT). The purpose of this communication is to provide an update on these developments and to convey ANA's current strategies for opposing AMA's efforts to implement the RCT and promote organized nursing's solutions to the shortage.

Background

The RCT proposal (see Attachment 1: AMA Board of Trustee Report SS) was one of the key items on the agenda for AMA's annual convention, held in Chicago, Illinois starting June 26, 1988. Representatives of ANA at this convention were: Lucille A. Joel, president; Virginia Trotter Betts, first vice president; Judy Huntington, second vice president; Juanita W. Fleming, secretary; Mary Beth Strauss, chairperson, Constituent Forum; Louise Shores, executive director, Illinois Nurses Association; Judith A. Ryan, executive director, ANA; Eunice A. Turner, senior staff specialist, Government Affairs, Division of Nursing Practice and Economics, and Nancy M. Perrin, publications manager, Communications Unit. Representatives from other nursing organizations were: Sheila McCarthy, president, American Organization of Nurse Executives (ACNE); Carol Boston, acting executive director, American Organization of Nurse Executives (AONE); Nancy Sharp, director for Practice/Legislation, The Organization for Obstetric, Gynecologic, and Neonatal Nurses (NAACOG); and Peggy McFadden, American Association of Nurse Anesthetists (ANNA).
From the outset, it was clear that there was a very high level of interest in the RCT proposal among the delegates and other convention attendees. In opening ceremony remarks, one speaker greeted the assembly with "Mr. Speaker, Mr. President, fellow delegates, nurses and RCTs." It was also evident that various individual nurses supportive of the RCT proposal had been invited to speak.

On Monday, June 27, 1988, Reference Committee C formally considered the RCT proposal. Because the interest in this issue was known to be high, this committee's hearing was moved to the Hilton's ballroom. Discussion on the proposal continued for more than 3 hours. Comments and questions by delegates made it clear that SNAs, national nursing organizations and individual nurses had been very effective in communicating nursing's concerns about the RCT proposal. Concerns were raised by the delegates about the fact that the RCT proposal went far beyond what the AMA House had approved in Report CC on the nursing shortage in December, 1987; that the proposed training of these personnel is minimal and that these personnel will adversely affect quality. ANA president Lucille Joel spoke against the RCT proposal and copies of ANA's statement (see memorandum of June 24) were circulated to all members of the Reference Committee and all others interested. Other resolutions to address the nursing shortage were introduced by delegates from Kansas, Ohio, Pennsylvania and the AMA Hospital Medical Staff Section (Attachment 2). Of these, ANA was highly supportive of those from Ohio and AMA's Hospital Medical Staff Section. However, it was clear that AMA supporters of the RCT concept, including AMA Board members, had strategized effectively to promote its acceptance at the hearing. They minimized its impact by emphasizing that it was only a proposal for "pilot studies," downplayed the role of the RCT in terms of their functions, and claimed that RCTs would not be in competition with nursing. The report of Reference Committee C (see Attachment 3, especially pp.9-11) was released the next morning, June 28.

On Wednesday, June 29, the AMA House considered the report of Reference Committee C. The recommendation of the Committee was to refer Report SS "to the Board of Trustees for action." (Note: Rules of order used by AMA define referral for action to mean: ... the House delegates to the Board of Trustees the decision as to what action is appropriate.)

The House voted overwhelmingly to refer the RCT proposal and a related amendment, which would provide that RCTs will be certified and registered under state medical boards, rather than licensed, to the Board for action.

Following the action of the House, Alan Nelson, outgoing Board chairman, outlined the following 5-point plan for action to implement the RCT:

- The AMA Board of Directors will consider all information heard at Reference Committee C and at the House;
- The AMA Board will continue to seek input from and dialogue with organized nursing and has scheduled a meeting for August 9 to which all major nursing organizations have been invited; (Note: On a conference call post-AMA House of Delegates, nursing organizations reported that they had not received organizational invitations to such a meeting.)
AHA will work with AMA to develop a limited number of RCT pilot programs; (Note: On the previously mentioned conference call, it was reported that AHA's official position was not accurately reflected in the statement of the AMA Board.)

AMA will assure the public that their plans will evolve carefully; and

AMA will report back on progress relative to RCTs to each House (twice yearly).

ANA believes the next steps to be taken to effectively oppose AMA's efforts to implement the RCT concept and effectively promote nursing's solutions to the shortage must take several forms. These include:

- Effectively use media contacts to oppose the RCT and use these contacts to promote nursing's solution to the shortage (attached please find a copy of ANA's press release dated June 30, 1988).

- Continue coalition building with AMA delegates and physicians by initiating personal contact with AMA delegates with which you have a working relationship and make it clear that nursing remains adamantly opposed to the RCT and emphasize nursing's solutions.

- Determine the institution or employment site with which the AMA delegate is associated and contact and educate the director of nursing or nursing leadership. Also, try to track the occurrence of plans for pilot projects in these institutions.

- Continue to make it clear to the state medical societies that nursing is opposed to the RCT proposal because it is not a viable solution to the nursing shortage.

- Continue to build coalitions with licensed practical nurse groups, state hospital associations and consumer groups.

- Evaluate the status of the SNA's relationship with the governor and other members of the executive branch (It is highly possible that the approach to implementation of the RCT concept may be through the executive branch in the form of certification/registration).

- Inform SNA members and LPNs. Perhaps summit meetings would be planned for this purpose.

- Educate state legislators to nursing's position on this issue.

- Inform state boards of nursing.

ANA remains adamantly opposed to the RCT concept and proposal. Nursing has been very clear from the outset about its reasons for opposing the RCT proposal. AMA has been invited to work with organized nursing to resolve solutions to the nursing shortage but organized medicine does not concur with the nursing profession's recommendations related to the shortage or to the way
in which to train and to educate nursing assistants, licensed practical nurses, associate degree, diploma or baccalaureate degree nurses. AMA must assume full responsibility for the creation and development of the registered care technologist. Nursing will not educate this new category of health care worker. There are serious legal questions about nursing's liability related to this new category of health care worker. This worker, by its very nature, infringes on the legitimate role of nurses and the legal scope of nursing practice. Finally, introduction of 3 levels of new occupational health workers does not represent a viable solution to the nursing shortage.

LAJ: EAT: RCM: ds
7/1/88

cc: Participants of first and second summit meetings
REPORT OF THE BOARD OF TRUSTEES

Report: SS (A-88)

Subject: Registered Care Technologists

Presented by: Alan R. Nelson, M.D., Chairman

Referred to: Reference Committee C
(John J. Gaughan, M.D., Chairman)

Attachment 1

At its February 1988 meeting the Board of Trustees approved a proposal to develop a non-nurse, bedside care technician, to be called a Registered Care Technologist. The goal of the proposed Registered Care Technologists (RCT) program is to contribute an innovative solution to the shortage of bedside personnel that will be timely, cost effective, and efficient. The purpose of the plan is to provide a dependable supply of technically oriented bedside caregivers that will improve access of patients to needed medical care in hospitals. It is also the intention of the proposal to 1) provide support services for nurses at the bedside and a recruitment pool for higher education in the health professions, 2) coordinate the fragmented education of certain hospital based technicians, and 3) organize and implement accredited hospital based apprenticeship programs and hospital based inservice programs to teach technical skills to RCTs.

Background

At the Interim meeting 1987, Report CC, "Nursing Education and the Supply of Nursing Personnel in the United States," was adopted by the House of Delegates. The recommendations supported the efforts of nursing to facilitate the recruitment, retention, and education of nurses to provide care at the bedside. In response to the growing shortage of bedside caregivers, the report also recommended support for hospital based programs to promote the education of non-nurse caregivers for acute and long term facilities. The report recommended that the AMA cooperate with other organizations to develop and accredit programs to increase the availability of caregivers at the bedside in order to meet the medical needs of the public.

Initiatives of Organized Nursing to Solve the Shortage of Nurses at the Bedside

Organized nursing has promoted several initiatives to solve the problems of bedside nursing shortage. These include the solicitation of funds from Congress to support higher education of nurses. Funds have been acquired for demonstration projects to differentiate practice between the two levels of entry into practice, the two year Associate Degree (ADN) for the "technical" nurse, and the four year Bachelor of Science in Nursing degree (BSN) for the "professional" nurse. It is the goal of nursing to promote the technical nurse as the bedside caregiver in long term care facilities, to replace LPNs, and to place professional nurses in hospitals as case managers and providers of comprehensive care at the bedside. This strategy is consistent with the goals of the nursing profession to upgrade education for nurses. Organized nursing has also convened several conferences on the nursing shortage and has been the major influence in promoting Secretary Bowen's Commission on the Nursing Shortage. The Commission is charged to offer solutions for the registered nurse shortage by the end of 1988. An AMA representative sits on the Commission.

In response to the shortage of nurses, the nation's hospitals have adopted various measures to maintain access to medical care. Substantial increases in nursing salaries have occurred. Nurse registries have provided bedside care on a temporary basis in places where the need is urgent. On-the-job training of technicians in various hospital units is taking place. Many hospitals have engaged recruitment firms to sponsor nurses to come to the United States from the Far East and Europe. The House of Delegates adopted Resolution 121 (I-87) supporting efforts of members of the health care field to extend H-1 visas for nurses actively practicing clinical nursing. While all these are necessary responses, a new approach is required to provide safe, effective, quality care for the basic and technical needs of patients at the bedside in the immediate and long term future.

The Proposal for a Program to Prepare Registered Care Technologists (RCTs)

The RCT program is designed to meet the variable needs of patients for bedside care during the current shortage and beyond. The RCTs would work with nursing personnel and assist with bedside care at non-managerial levels. These technologists, however, will be oriented to the highly technical environment of modern medicine. The RCT would be part of a medical support system that will be of assistance to nursing in hospitals.
1. There are several kinds of technicians who already deliver direct patient care in hospitals and provide a safe environment and support for physicians and the health care team. Surgical Technologists, Respiratory Therapy Technicians, and Emergency Medical Technicians, among others, have programs that are accredited by the Committee on Allied Health Education Accreditation (CAHRA). Many technician roles at the bedside are not accredited by CAHRA such as cardio-pulmonary and dialysis technicians. In some hospitals where bed closures impede access to medical care, physicians report the training and supervision of technicians to monitor medical services in critical care and other highly technical units. The RCT program will offer a mechanism to coordinate and extend the current training of technicians delivering direct patient services and assure consistent standards of education necessary for quality care.

17. RCTs will form a recruitment pool of experienced, skillful bedside care technologists who may consider advancement in the health field through higher education as part of their future career plans. At the same time RCT training could provide a potential source of revenue for technologists seeking to defray the costs of higher education in the health disciplines of their choice. The RCT will maintain a special role, oriented to bedside care and assure access to needed medical care in an increasingly technological environment that requires highly personalized services.

26. Scope of Practice of RCT's

29. The RCTs scope of practice would be to continuously monitor and implement physicians orders at the bedside in order to support and promote the welfare of patients in institutions. Three levels of competence would be included in the program: 1) assistant, 2) basic, and 3) advanced levels. The RCT is a resource for nurses but not a direct substitute for nurses in long term care institutions and in acute care hospitals.

36. Functions of the Three Levels of Competence of RCTs

39. The assistant to the RCT would be able to function as a bedside aide equal to assistants now required by the new federal law (PL 100-203 Omnibus Reconciliation Act, 1987) for long term care facilities. The basic RCT would subsidize work now performed at the level of licensed practical nurses. Licensure as an RCT would be available to LPNs who desire to monitor and implement bedside medical care, administer routine, non intravenous medications, with supervision. Advanced RCTs would require an additional nine months of experience in several hospital intensive care units. RNs and
hospital technicians already experienced in the delivery of direct
patient care would be eligible to complete this course which will be
sufficiently rigorous to serve as a practical orientation program
for new graduates from schools of nursing.

Structure of Educational Program for NCTS
Education for Registered Care Technologists would be offered at
a post high school level and provide instruction for three
contiguous levels of competence: assistant, basic, and advanced
Registered Care Technologist. An assistant RCT would require two
months of training; the basic level would be completed after an
additional seven months, after which the RCT would be eligible for
licensure. An additional nine months of highly technical education
would provide certification as an advanced RCT. The total program
could be completed in eighteen months. The program is stringent but
flexible and can be accessed at any level at the discretion of the
student, or the RCT could be recruited for service by the hospital
on completion of any stage of preparation.

Accountability
The Registered Care Technologist would require licensure to
assure minimal standards of practice and protect the public good.
To avoid a multiplicity of licensure boards, the RCT would be
licensed under an arm of the State Medical Boards. To assure
quality of education, accreditation through a national body such as
the Committee on Allied Health Education Accreditation (CAHEA) would
be essential. Liability insurance would be under the auspices of
the hospital employer which would also be responsible for assuring
technicians and relevant resources to the appropriate departments.
The RCT would be accountable for physician orders for patient care
in accordance with the scope of practice and would report to the
head of the unit where they are assigned.

Recruitment
The program would be marketed to high school students, with
emphasis on low income groups. The program may also attract male
and female students who are uncertain about their choice of health
care career. LPNs and many kinds of technicians with experience in
the delivery of direct patient care may also be recruited for
advanced training as RCTs. The program would be offered in
hospitals in cooperation with local vocational schools or community
colleges. Apprenticeship programs ordinarily pay partial salaries
during the period of education. Current costs of hospital inservice
education might be appropriately applied against salaries.
Interorganizational Coordination

A meeting between the executive directors of Associations concerned with providing safe bedside care in long term and acute care settings and the AMA is planned in the near future. The following organizations have been invited to help plan this initiative: the American Hospital Association, the American Academy of Physician Assistants, the American Association of Community and Junior Colleges, the American Association of Retired Persons, the American Health Care Association, the Federation of American Health Systems, the Joint Commission on Accreditation of Healthcare Organizations, and the National Association of Practical Nurse Education and Service. The purpose of the meeting is to coordinate the concerns of non-physician associations regarding the bedside care shortage and to focus their efforts on a possible long term solution.

Plan of Action

- The Federation will be consulted to identify States where the shortage of bedside personnel is crucial and where there is a willingness to participate in a demonstration project for educating BCTs.
- A grant proposal will be completed to further develop and implement the BCT demonstration projects through the selected Federation members.
- The cooperation of non-physician associations to improve and market the proposal will be sought.
- Cooperation with nursing will continue to be sought to assure that the BCT project provides a recruitment base for nursing.
- Support for nursing in its efforts to recruit and educate nurses for the bedside will continue as an important aspect of this initiative.
Whereas, There is currently a shortage of nursing personnel to take care of hospitalized and other patients; and

Whereas, The demand for nursing services for the care of hospitalized patients continues to increase; and

Whereas, Hospitals compete with each other to attract nurses, which impacts adversely on the cost of health care; and

Whereas, The previous supply of nurses was largely nurses trained in a diploma school of nursing and, more recently, baccalaureate degree nurses are being trained, as advocated by the American Nurses' Association; and

Whereas, The investment in tuition to become trained as a baccalaureate degree nurse is high compared to the traditional earning expectations of a nurse; and

Whereas, Aspects of nursing care may be met by individuals trained to accomplish specific tasks; therefore be it

RESOLVED, That the American Medical Association continue to study the current and future needs for nurses in the United States; and be it further

RESOLVED, That the AMA formulate a plan to train health care workers to meet the nursing care needs of the country; and be it further

RESOLVED, That the AMA report on progress in the development of this plan to the House of Delegates.

Fiscal Note: $80,000
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 24
(A-88)

Introduced by: Kansas Delegation

Subject: Nursing Shortage

Referred to: Reference Committee C
(John J. Gaughan, M.D., Chairman)

Whereas, It is estimated that there is a shortage of approximately 200,000 nurses in the United States and all signs indicate this shortage will not be abated in the foreseeable future; and

Whereas, By this shortage of qualified nursing personnel the quality, availability and quantity of medical care will be adversely affected; and

Whereas, Most physicians feel that graduates of three year nursing education programs are quite capable and qualified to provide the required nursing care; and

Whereas, The reestablishment of the three year training programs appears to be a realistic, economical and practical solution to resolving the nursing shortage; therefore be it

RESOLVED, That the American Medical Association endorse the reactivation of the three year nursing education programs; and be it further

RESOLVED, That the AMA Board of Trustees initiate a dialogue with the American Nurses' Association requesting that the ANA reconsider its position supporting the closing of all three year non-degree nursing education programs and that these types of programs be reestablished as soon as possible.

Fiscal Note: $2,000

Past House Action: 1-87:99-106
WHEREAS, the American Medical Association House of Delegates adopted Board of Trustees Report CC, Nursing Education and the Supply of Nursing Personnel in the United States, during its 1987 Interim Meeting; and

WHEREAS, Board of Trustees Report CC (I-87) recommended support of all levels of nursing education, economic and professional incentives for recruitment and retention, and hospital-based continuing education programs — all with the primary mission of increasing the quality and quantity of caregivers at the bedside; and

WHEREAS, an implementation plan by the AMA Board of Trustees summarized in the FEDNET release on April 11, 1988 deviates from the recommendations of Board of Trustees Report CC by calling for creation of "Registered Care Technologists" to meet the demand for high quality technical care at the bedside; and

WHEREAS, this proposal to add a new category of caregiver would delay and complicate the process of recruitment and retention of bedside nurses, would further dilute the pool of available individuals for the nursing profession, and would increase the cost of medical care by creating a new category of health care provider; therefore be it

RESOLVED, That the American Medical Association implement the recommendations contained in Report CC of the Board of Trustees (I-87), Nursing Education and the Supply of Nursing Personnel in the United States, within the framework of current levels of nursing education; and be it further

RESOLVED, That the AMA open dialogue with the American Nurses' Association to discover creative methods to increase enrollment in nursing education programs, to retain bedside nurses, to provide financial incentives, and to provide incentives for "retired nurses" to return to bedside nursing.

Fiscal Note: $10,000
AMERICAN MEDICAL ASSOCIATION HOUSE OF DElegates

Resolution: 190
(A-88)

Introduced by: Hospital Medical Staff Section
Subject: Nursing Shortage
Referred to: Reference Committee C
(John J. Gaughan, M.D., Chairman)

Whereas, The American Medical Association adopted Board of Trustees Report CC ("Nursing Education and the Supply of Nursing Personnel in the United States") during the 1-87 meeting; and

Whereas, A recent implementation plan by the AMA Board of Trustees (Report SS, A-88) calls for the creation of "Registered Care Technologists" to meet the demand for technical care at the bedside; and

Whereas, The American Organization of Nurse Executives has formally requested AMA to discontinue its initiative to implement the proposal to develop alternative health care providers; and

Whereas, The AMA supports recommendations within the framework of current levels of nursing education, and supports Report CC; and

Whereas, This response to the shortage of nurses will be discussed at the 1988 Annual Meeting of the House of Delegates and deserves emergency input from the HMO’s; therefore be it

RESOLVED, That the American Medical Association accept the recent invitation extended by the Nursing Tri Council and collaborate with the Hospital Medical Staff Section, American Hospital Association, organized nursing and other appropriate agencies to develop and implement strategies which address the demands for qualified nursing personnel.

Fiscal Note: Not to exceed $1000
Mr. Speaker and Members of the House of Delegates:

Reference Committee C gave careful consideration to the several items referred to it and submits the following report:

(1) REPORT P OF BOARD OF TRUSTEES — PHYSICIAN MANPOWER

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Report P of the Board of Trustees be filed.

Report P of the Board of Trustees provides the House of Delegates with information on recent activities of AMA Councils on matters related to physician manpower, and summarizes key findings in the second monograph of the AMA manpower research program, Physician Supply and Utilization by Specialty: Trends and Projections.

Report P is an excellent summary of available data and a valuable resource for students and young physicians. Your Reference Committee calls to the attention of readers the definitions of "forecast" and "projections," and recognizes concerns expressed by speakers about the projections for obstetricians and gynecologists, the statistics for emergency medicine physicians, and demographic projections for the immediate future and the beginning of the twenty-first century.
(2) REPORT V OF BOARD OF TRUSTEES
COMPUTERIZED GME SERVICE
INFORMATIONAL STATUS REPORT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Report V of the Board of Trustees be filed.

Report V of the Board of Trustees is a progress report to the House of Delegates on the development of the AMA-Fellowship and Residency Electronic Interactive Database Access System (AMA-FREIDA).

Report V describes progress toward the development of AMA-FREIDA. Your Reference Committee heard support for the proposal as well as hopes for early operation of the system.

Your Reference Committee was requested to make cost projections available to the House. Your Committee is advised that expenses for the period 1988-93 are projected to be $3.51 million. Income for the same period (derived from listing fees and software packages) is projected to be $3.71 million.

(3) REPORT W OF BOARD OF TRUSTEES
MATERNITY/PATERNITY LEAVE POLICY:
INFORMATIONAL STATUS REPORT

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Report W of the Board of Trustees be filed.

Report W of the Board of Trustees states that the Committee on Structure and Functions of the Accreditation Council for Graduate Medical Education is now considering an AMA request to amend the General Requirements of the Essentials of Accredited Residencies to require information on maternity and paternity leaves in resident contracts. Report W states that 5798 of 6300 residency programs surveyed in 1987 responded to a question on maternity and paternity leave policies. Seventy-three percent of respondents reported the existence of a maternity leave policy, and 21% the existence of a paternity leave policy.

Your Reference Committee notes that this informational report responds to the request of the House of Delegates (A-87) for periodic reports on the status of maternity/paternity leave policies in accredited residency programs until such time as all accredited residencies have stated policies. Your Committee declines referral as requested by two speakers who asked for descriptions and analyses of existing policies in over 4000 residency programs. Such activity goes beyond the prior action of the House and requires a significant budget allocation.
Reference Committee C, page 3

(4) RESOLUTION 184 - HEALTH, LIFE AND DISABILITY INSURANCE FOR RESIDENTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the following Substitute Resolution 184 be adopted.

RESOLVED, That the AMA urge the Accreditation Council for Graduate Medical Education to consider promptly and fully a requirement in the General Requirements of The Essentials of Accredited Residencies in Graduate Medical Education that sponsoring institutions make available health, life, and disability insurance for all residents.

Resolution 184 asks that the AMA urge the Accreditation Council for Graduate Medical Education to require in the General Requirements that institutions provide adequate health, life and disability insurance to all residents.

Your Reference Committee has been advised that the Accreditation Council for Graduate Medical Education (ACGME) is now drafting a revision of the General Requirements. Also, a Task Force of the AMA Council on Medical Education is examining the General Requirements in preparation for recommendations to the ACGME.

Your Reference Committee was impressed by speakers that availability of these benefits is extremely important to residents. Your Committee lacks necessary data on the financial implications and anticipates that these and other data will be acquired by the ACGME as the subject is discussed.

(5) REPORT A OF COUNCIL ON MEDICAL EDUCATION - RESIDENT PHYSICIAN

EDUCATION (RESOLUTION 101, I-87)

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that

1) Report A of the Council on Medical Education be amended beginning on page 2, line 10 as follows:
Reference Committee C, page 4

in the House of Delegates, urges concerned
program directors and sponsoring institutions
to take prompt and direct action, and reminds
all physicians of their moral responsibility
to teach.

2) Report A of the Council on Medical Education
as amended be adopted in lieu of Resolution
101. (T-47).

Report A of the Council on Medical Education responds to
Resolution 101 (T-47) which asks the AMA to "urge hospital medical
departments and medical specialty organizations to encourage
cross-training among the various specialties and provide access to
medical education for all specialties." Noting that the resolution
was prompted by deficiencies in instruction in some residency
programs, the Council supports the Reference Committee which
recommended against adoption and urged concerned local program
directors to take direct action to correct the educational
deficiencies of their programs.

Your Reference Committee has amended Report A as requested by
several speakers. Some speakers related problems faced by residents
in family practice and other residency programs in acquiring
training in certain subject areas, and others stressed the need for
interdisciplinary cooperation. Members of the Council on Medical
Education described the roles of the Residency Review Committees and
the Accreditation Council for Graduate Medical Education and
reminded those dissatisfied with the report that exhortations to
reluctant physician teachers by the AMA will not correct
deficiencies in educational programs for residents.

Your Reference Committee underscores the comments and advice of
the Council on Medical Education and urges all parties to employ
proper channels to correct educational deficiencies.

(6) RESOLUTION 119 - MEDICAL EDUCATION
SHORT COURSES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends
that the sponsor of Resolution 119 be granted
leave to withdraw.

Resolution 119 asks the AMA to recognize that certificates
issued at the completion of short medical education courses do not
attest to a physician's competence and to discourage the use of such
certificates as measures of competency in the hiring and
credentialing of physicians.

The sponsor requested leave to withdraw. Your Committee
supports the request.
(7) RESOLUTION 126 - ANNUAL REPORT OF
DISCIPLINARY ACTIONS FROM THE
FEDERATION OF STATE MEDICAL BOARDS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that the following Substitute Resolution 126 be adopted:

RESOLVED, That the American Medical Association work in support of the Federation of State Medical Board's efforts to assure that organizations that use the Federation's copyrighted disciplinary data secure permission to do so and accompany their publications with an explanation that comparison between states based on those data alone is misleading to the public and does a disservice to the work of the state medical boards, and be it further

RESOLVED, That American Medical News be requested to report the Federation of State Medical Board's annual disciplinary data as presented by the Federation.

Resolution 126 asks the AMA to do the following: 1) work with the Federation of State Medical Boards to develop standard categories and a uniform reporting system of disciplinary actions taken by state boards against licensed physicians; and 2) cooperate with the Federation to assure that organizations that use the Federation's copyrighted data secure permission and agree to explain that comparisons between states on the basis of these data are invalid.

Your Reference Committee heard detailed testimony from the delegate from Maryland on the misuse/incorrect interpretations of disciplinary data from state medical boards. This testimony was corroborated and amplified by the chief executive officer of the Federation of State Medical Boards. Incorrect presentation of Federation data in American Medical News was also reported.

Your Reference Committee was advised that a uniform coding and reporting system already exists. Your Committee shares the serious concerns of all who testified on this important issue and urges adoption of Substitute Resolution 126.
Reference Committee C, page 6

(8) RESOLUTION 26 - REQUIREMENTS FOR A MEDICAL LICENSE

RECOMMENDATION:
Mr. Speaker, your Reference Committee recommends that Resolution 26 be adopted.

Resolution 26 asks the AMA to oppose any social, economic or political regulations which have no bearing on a physician's competence as requirements for issuing a medical license.

Your Reference Committee was advised that Resolution 26 conforms to existing AMA policy. All speakers offered strong support of Resolution 26. Your Committee regards this subject as extremely important and worthy of reaffirmation by the House of Delegates.

(9) REPORT B OF COUNCIL ON MEDICAL EDUCATION - LICENSURE CONFIDENTIALITY

RECOMMENDATION:
Mr. Speaker, your Reference Committee recommends that

1) Report B of the Council on Medical Education be amended as follows:

a) Addition on page 3, line 8, so that the sentence beginning on line 6 will read:

When boards feel that they must require reports of these activities, the Council feels that, at a minimum, the replies to questions should be kept confidential unless they result in an adverse board action.

b) Addition on page 3, line 47, so that Recommendation 3 beginning on line 45 will read:

Encourage state licensing boards to exclude from license application forms information that refers to psychoanalysis, counseling, or psychotherapy required or undertaken as part of medical training.

c) The transfer of the sentence beginning on page 4, line 12 to follow Recommendation 4 and to serve as Recommendation 5:
If the applicant has had psychiatric treatment or psychological counseling, the Council recommends that the physician or psychologist who has provided the treatment be asked to provide the board with an official statement that the applicant's current state of health does not interfere with his or her ability to practice medicine.

2) Report B of the Council on Medical Education be adopted as amended.

Report B of the Council on Medical Education responds to Resolution 87 (A-87) which called upon the AMA to study the public availability of information contained in applications for state licensure and to develop policy as to what licensure information should be publicly available. The Council describes a survey sent to state and territorial licensing boards, provides survey results, and presents specific recommendations for AMA action.

Your Reference Committee heard testimony supporting Report B and its recommendations, and agrees that the suggested amendments clarify the intent of Report B.

(10) RESOLUTION 15 - POSTGRADUATE TRAINING REQUIREMENTS FOR OBTAINING PERMANENT MEDICAL LICENSURE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 15 be referred.

Resolution 15 asks the AMA to do the following: 1) study the impact of increasing the duration of postgraduate training required for licensure on resident physicians and patient care; and 2) oppose any further increases in postgraduate training for licensure until research indicates that increases improve the quality of resident education and patient care.

Your Reference Committee was advised that several states now require graduates of accredited medical schools to complete two years of graduate medical education instead of one year for a medical license. One state now requires three years. The Federation of State Medical Boards has recommended a two year requirement. Testimony indicated that many residency program directors and some state boards require that second year residents be licensed. Testimony indicated that the Council on Medical Education has opposed an extension of the residency requirement for licensure until valid reasons for this change are available. Further testimony indicated that an analysis of this issue is needed but a definitive study of the impact may not be feasible. There was an absence of testimony to provide objective evidence that two years are better than one year of residency as a requirement.
Reference Committee C, page 8

Your Reference Committee was advised that prolongation of postgraduate requirements for licensure beyond one year will have serious and undesirable impact on the activities of military medicine.

(11) RESOLUTION 47 - EQUALITY OF TESTING

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 47 not be adopted.

Resolution 47 asks the AMA to call upon the National Board of Medical Examiners and the Educational Commission for Foreign Medical Graduates to promptly administer a single test to all applicants for graduate medical education in the U.S.

Your Reference Committee heard testimony that the National Board of Medical Examiners has agreed in principle with the Educational Commission for Foreign Medical Graduates (ECFMG) to make its Part I and Part II examinations available to candidates seeking ECFMG certification. Your Reference Committee believes that the intent of Resolution 47 to permit graduates of foreign medical schools to qualify by passing Part I and Part II examinations is being accomplished and Resolution 47 is not necessary. Your Committee notes further that graduates of medical schools accredited by the Liaison Committee on Medical Education are eligible for admission to accredited residencies without examination.

(12) RESOLUTION 44 - FREEDOM OF CHOICE FOR RESIDENCY PROGRAM DIRECTORS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 44 not be adopted.

Resolution 44 asks the AMA to support two positions: 1) that candidates for residency programs be selected on the basis of qualifications and merit by local program directors and selection committees; and 2) that no governmental agency be allowed to impose financial restrictions that affect the composition of residents selected for accredited programs.

Your Reference Committee observes that the AMA has consistently supported the selection of residents by program directors on the basis of merit and that a new policy is not required. Your Committee knows of no pending state or federal legislation that would restrict the choices of residents by program directors. Your Committee believes that the proposed second resolve is intended to ensure the uninhibited choice of residents by program directors. However, this resolve, if adopted, would restrict the AMA's full consideration of future state or federal bills concerned with the financing of graduate medical education.
Mr. Speaker, your Reference Committee recommends that Resolution 154 be referred.

Resolution 154 asks the AMA to implement the recommendations of Report CC of the Board of Trustees (I-87) within the framework of current levels of nursing education, and to discuss with the American Nurses Association creative methods to increase enrollment in nursing education programs, retain bedside nurses, and provide incentives for retired nurses to return to bedside nursing.
Your Reference Committee heard support for the intent of Resolution 154 and was advised that efforts are continuing to accomplish its general intent. Concern was expressed that adoption of Resolution 154 may limit the options that may be considered to address the shortage of bedside care providers. Therefore, referral for further consideration is recommended.

(15) RESOLUTION 191 - EXTENSION OF FOREIGN NURSES' VISAS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 191 be referred for action.

Resolution 191 asks the AMA to support legislation that would grant year-to-year extensions of visas for foreign nurses actively employed in nursing.

Your Reference Committee was advised that the Immigration and Naturalization Service (INS) has recently granted a one year extension of the non-immigrant visas of foreign nurses. Testimony stated that legislation is needed to avoid dependence on the INS to understand the necessity for one year extensions. Referral for action is recommended because of the need to coordinate the legislative effort proposed by Resolution 191 with other continuing efforts to address the shortage of nurses.

(16) RESOLUTION 190 - NURSING SHORTAGE

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that Resolution 190 be referred for action.

Resolution 190 asks the AMA to collaborate with the Hospital Medical Staff Section, American Hospital Association, organized nursing and other appropriate agencies to develop and implement strategies addressing demands for qualified nursing personnel.

Your Reference Committee heard testimony supporting Resolution 190 and was advised that other organizations could be considered for inclusion in the discussion of strategies to obtain nursing personnel. The National Association of Practical Nurse Education and Service was mentioned. Referral for action is recommended so that the intent of Resolution 190 can be considered in conjunction with other activities which address the shortage of nurses.
RECOMMENDED FOR ADOPTION:

(17) Report C of Council on Medical Education - Use of Oral Exams for the Endorsement of Licenses to Practice Medicine

(18) Resolution 149 - Parental and Sick Leave Policies in Residency Programs

(19) Report X of Board of Trustees - Study on the Relationships Between Physicians (in lieu of Resolution 43, I-87)

(20) Report BBB of Board of Trustees - International Medical Scholars Program, Inc.


(22) Resolution 201 - Recredentialing of Physicians

(23) Resolution 42 - Licensure by Endorsement

RECOMMENDED FOR REFERRAL TO THE BOARD OF TRUSTEES:

(24) Resolution 168 - Response to Declining Medical School Applicant Pool

(25) Resolution 180 - Minority Students and Faculty in U.S. Medical Schools

(26) Resolution 17 - Training of Allied Health Personnel

(27) Resolution 18 - Training of Patient Care Personnel

(28) Resolution 24 - Nursing Shortage

RECOMMENDED FOR FILING:

(29) Report T of Board of Trustees - Resident Physician Working Hours and Supervision

(30) Report AA of Board of Trustees - AMA Initiative on Substance Abuse in Medical Schools and Residency Programs
Mr. Speaker, this concludes the report of Reference Committee C. Your Reference Committee wishes to thank all who participated in the hearing and contributed to the preparation of this report.

Seymour Diamond, M.D.
American Society for Clinical Pharmacology and Therapeutics

Ted H. Forsythe, M.D.
Texas

John D. Riesch, M.D.
Wisconsin

James A. Zimble, M.D.
U.S. Navy

John J. Gaughan, M.D., Chairman
Ohio
TO: Participants  
Second Summit Meeting - June 14, 1988  
Louisville, Kentucky  

FROM: Karen S. O'Connor, M.A., R.N.  
Director, Division of Nursing Practice and Economics  

DATE: June 23, 1988  
RE: Corrected Meeting Summary  

During the second summit meeting scheduled last week on June 14, 1988, in Louisville, Kentucky, strategies to defeat the American Medical Association's proposal for registered care technologists were developed for distribution and use by all participants. Because the RCT proposal was scheduled for consideration by the AMA House in less than two weeks, it was urgent that these materials be forwarded without delay. Unfortunately, in our haste to mail the summary and strategies to you last week, several errors were overlooked. A revised meeting summary of the strategies from the June 14, 1988 meeting is attached to this memorandum.

KSO:ds  
6/22/88  

Attachments
SECOND NURSING SUMMIT MEETING TO ADDRESS THE NURSING SHORTAGE
June 14, 1988
7:30 p.m. - 9:30 p.m.

Mezzanine Room
Seelbach Hotel
500 Fourth Avenue
Louisville, Kentucky 40202

SUMMARY AND STRATEGIES

Over half of the state nurses associations and thirty nursing organizations met June 14, 1988 for two hours to discuss strategies to defeat the American Medical Association's proposal for Registered Care Technologists. Participants shared information on their own state and organizational activities related to the proposal. Many reported that several national medical specialty groups and allied health organizations had expressed strong opposition to the AMA proposal. It was agreed that a small SWAT team be assigned to coordinate information and strategies. ANA will serve as the central clearinghouse, and will explore some electronic means of communication.

The American Nurses' Association will assign a full time staff person for five (5) months to coordinate activities. AONE pledged similar staff support. The American Red Cross pledged the support of their Media Relations Manager. The American Journal of Nursing Company agreed to donate a free ad page (a $5,000 value) and to solicit all nurse readers to contribute to this effort.

Twenty thousand dollars was contributed to this initial effort. The Organization for Obstetric, Gynecologic and Neonatal Nurses contributed $5,000 and challenged other organizations to contribute. The Association of Operating Room Nurses contributed $10,000. American Organization of Nurse Executives contributed $5,000. Several other organizations pledged support upon confirmation of governing boards.

It was also agreed that should the initial effort to defeat the RCT proposal fail, a major public education campaign would be initiated. The audience was united in its commitment to resolve the nursing shortage using strategies in the best interest of consumers and to march ahead in its opposition to the RCT proposal.
STRATEGIES TO DEFEAT THE RCT PROPOSAL

Influencing the leadership of the American Medical Association

- Identify, educate and solicit support from "select friends of nursing" in Congress who serve in leadership positions of importance to the AMA.

- Identify, educate and solicit support from "select friends of nursing," at the state and local level who serve in leadership positions of importance to the ANA (Clearinghouse at state levels through state nurses associations).

- Identify major industry leaders (i.e., insurance, media, business) who may share nursing's perspective. Ascertain who within nursing is a direct link to these leaders and activate network.

- Involve other organized health care providers and consumer groups at both national and state levels to solicit their support regarding the nursing position on the shortage.

Influencing the Delegates and Membership of the American Medical Association

- Present/disseminate the points of information contained in ANA House of Delegate's report, ANA Opposition to AMA Proposal to Create Registered Care Technologists and the position paper on short term strategies developed at the first nursing summit -- requesting abandonment of the AMA RCT proposal.

  - SNAs to immediately communicate points of information to delegates in writing with a follow-up phone call.

  - Specialty organizations to contact influencers in their medical counterpart organizations to communicate points of concern and request their contacting delegates and other physician influentials.

  - AONE to contact membership through "emergency mailing" to provide points of information and request their personal contact with influential physicians within their agencies. Communicate to them the points of concern and request their contacting influential delegates.
Influencing Physician Grass-Roots Membership of the American Medical Association

- Individual nurses contact their personal physicians and physicians with whom they work to share points of interest and request that they contact delegates and other physicians.

Points of Information

- The present nursing shortage cannot be solved by introducing an additional "technical worker."
- The response to the nursing shortage requires a cooperative effort rather than a competitive effort in order to assure cost-effective, efficient, and quality patient care.
- The introduction of a new technical worker as proposed by AMA staff does not resolve the complex problems associated with the shortage of nurses in that:
  - Support services required for patient care will not be provided.
  - The basic issues contributing to the shortage, which are workload, salary, the patient care environment, and lack of financial support for nursing education are not addressed.
- The dollars for new technical programs are better spent for nursing education programs.
- The declining number of students should not be siphoned into new technical programs.
- Substituting minimally prepared technicians for nurses places vulnerable patient populations at risk.
- Health care costs will increase with recruitment, training and establishment of a totally new and duplicative technical worker.

Influencing Specialty Physician Delegates to AMA Convention

- Align specialty nursing organization with specialty physician organization and request nursing organizations to work with specialty physicians.
Contact delegates

- share information regarding his/her organization position
- share recommendations for defeating issue at the AMA House of Delegates
- Share information regarding Ohio resolution
- Share information regarding other state delegates and organizational delegates supportive of our position
- share information regarding alternative emergency proposal or strategies for "friendly" resolution

- Repeat the above process at the state level.

- Assignments of Specialty Nursing Organizations to Contact Specialty Physician Delegates

AORN Association of Operating Room Nurses
- American Association for Thoracic Surgery
- American Society of Abdominal Surgeons
- International College of Surgeons
- Society of Thoracic Surgeons
- American Society for Clinical Pathologists

AANN American Association of Neuroscience Nurses
- American Association of Neurological Surgeons
- Congress of Neurological Surgeons
- American Academy of Neurology

SOHN Society of Otorhinolaryngology and Head-Neck Nurses
- American Academy of Facial Plastic and Reconstructive Surgery
- American Academy of Otolaryngology-Head and Neck Surgery, Inc.
- American Laryngological Rhinological and Otological Society

AAANA American Association of Ambulatory Nursing Administration
- American Academy of Medical Directors
- American College of Preventive Medicine
- American Group Practice Association
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<tr>
<th>Acronym</th>
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<tr>
<td>AGHN</td>
<td>Association of Occupational Health Nurses</td>
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<td>BSORN</td>
<td>American Society of Ophthalmic Registered Nurses</td>
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<td>NAON</td>
<td>National Association of Orthopedic Nurses</td>
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<td>NAPNAP</td>
<td>National Association of Pediatric Nurse Associates and Practitioners</td>
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<td>ASFRN</td>
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<td>AACN</td>
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- American Academy of Occupational Medicine
- American Occupational Medical Association
- American Academy of Ophthalmology
- American Society of Cataract and Refractive Surgery
- Contact Lens Association of Ophthalmologists, Inc.
- American Academy of Orthopedic Surgeons
- American Academy of Pediatrics
- American Pediatric Surgical Association
- American Association of Plastic Surgeons
- American Society of Plastic and Reconstructive Surgeons
- American College of Cardiology
- American College of Chest Physicians
- American College of Emergency Physicians
- National Association of Medical Examiners
SGA  Society for Gastrointestinal Nursing
- American College of Gastroenterology
- American Gastroenterological Association
- American Society for GI Endoscopy

IAET  International Association for Enterostomal Therapy
- American Society of Colon and Rectal Surgeons

APHA  Nurses Section of the American Public Health Association
- American Association of Public Health Physicians

TAANA  The American Association of Nurse Attorneys
- American College of Legal Medicine

NAACOG  The Organization for Obstetric, Gynecologic and Neonatal Nurses

ANA  ANA Council on Medical-Surgical Nursing
- American College of Physicians
- American Association of Internal Medicine
- American Thoracic Society

AUAA  American Urological Association Allied

AANA  American Association of Nurse Anesthetists
- American Society of Anesthesiologists

Federal Chiefs  Chiefs of Military Corps
- Association of Military Surgeons of the U.S.
- Society of Medical Consultants to Armed Forces
Influence AMA to Join with ANA to Effectively Address the Nursing Shortage

Organized medicine and physicians at the institutional level have a long history of successfully influencing legislators, hospital administrators, and boards of trustees to invest significantly in new medical technology and services to advance medical practice. Medicine needs to exert this same influence to effect the following:

- Substantial increases in resource allocation, human, financial, and technological at the institutional level to immediately
  - correct nursing salary compression
  - improve incentives for night and weekend shift work
  - provide support for additional FTEs to support nursing functions across all settings
    * additional R.N. and L.P.N. FTEs to improve staffing ratios
    * additional nonclinical FTEs to relieve the R.N. at the bedside of nondirect care duties, e.g. transporters, secretaries
  - initiate and/or assist with provision of child care services

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Support for nurse administrators' initiatives to improve quality of work life

Support for federal, state, and local initiatives to provide funding for nursing education
- Nursing Education Act (federal)
- Support for private and public institutions providing nursing education
- Community scholarship/loan programs through business and community groups
- Institutional scholarships, tuition forgiveness, and other incentive programs
- Improve physician/nurse relations at the bedside
  * Support collaborative practice models
  * Institute verbal abuse policies
- Support application and use of technology to support the nurse manager and staff nurse
  * Computer assisted staffing/scheduling programs and care planning systems

Promote the image of nursing and nurses as a positive, progressive profession for career-minded women and men
- Support positive portrayals of nursing
- Support and assist with implementation of recruitment and retention strategies
- Combat sexism and promote collegial communication

In addition, the ANA and its state and local medical societies and specialty practice societies must work collaboratively with organized nursing at the local, state, and national levels and across all specialties to mutually develop additional short and long-term strategies to address the nursing shortage.

KSO: sbb: 005
6/22/88
SUBJECT: AHA Opposition to the AMA Proposal to Create Registered Care Technologists

INTRODUCED BY: Margretta M. Styles, Ed.D., R.N., F.A.A.N.
President, ANA Board of Directors

REFERRED TO: Reference Hearing E

1988 ANA House of Delegates

Report: BOD-L

Use of health care workers who are not properly trained or qualified to perform nursing functions is a longstanding concern of the American Nurses' Association. A report from the ANA Board on "Manpower Substitution as a Means to Alleviate the Nursing Shortage" (BOD-F) addresses long-range strategies related to encroachment issues generally.

Very recently, it has become clear that the American Medical Association is prepared to move forward to conduct prototype training programs for the proposed Registered Care Technologist (RCT). Additionally, AMA is establishing national coalitions of providers and interested groups in support of this proposal.

AMA Recommends Initiatives to Address Nurse Supply

In December 1987, the House of Delegates of the American Medical Association called for a report on nursing education and the supply of nursing personnel in the United States. Submitted to the AMA House in December 1987, this report provided historical background on organized medicine's concern with nursing education and its influence on the availability of nurses at the bedside. It also set forth medicine's concerns regarding the critical shortage of bedside care-givers to monitor long-term care facilities.

Repeatedly, it was suggested that the movement toward BSN-prepared professional nurses and ADN-prepared technical nurses is eliminating those nurses who traditionally have functioned as bedside care-givers. According to the report, "increasing the level of education of nurses provides options that remove them from the bedside." It was concluded that incentives should be implemented to insure the continuing formal education of skilled personnel who will work at the bedside in hospitals. To this end, the AMA Board of Trustees recommended the following five initiatives, which were adopted by the 1987 AMA House of Delegates:

1. Support all levels of nursing education, at least until the crisis in the supply of bedside care personnel is resolved.

2. Support government and private initiatives that would facilitate the recruitment and education of nurses to provide care at the bedside.

3. Support economic and professional incentives to attract and retain high quality individuals to provide bedside nursing care.
4. Support hospital-based continuing education programs to promote the education of care-givers who assist in the implementation of medical procedures in critical care units, the operating and emergency rooms, and medical-surgical care.

5. Cooperate with other organizations concerned with acute and chronic hospital care to develop quality educational programs and methods of accreditation of programs to increase the availability of care-givers at the bedside and to meet the medical needs of the public.

The American Nurses’ Association spoke to the AHA report in reference committee and proposed alternative courses of action. ANA set forth nursing’s concern about the critical shortage of nurses and reaffirmed our position about the educational preparation for professional and technical nursing.

AMA Proposes New Category of Health Care Person

In February 1988, the AMA Board of Trustees adopted a plan to implement its report. Among other things, AMA’s implementation plan calls for the preparation of Registered Care Technologists (RCTs). It is intended that this new category of personnel will execute medical protocols at the bedside with special emphasis on technical skills. Individuals prepared as RCTs will reflect three levels of preparation. The assistant RCT who receives two months of training. Basic training, which is seven months, would prepare individuals to provide care of all patients requiring custodial care and/or relatively low technology bedside care in homes, hospitals, and long-term care facilities. An additional nine months of training would qualify RCTs as an advance RCT. According to AMA, these advanced RCTs would provide the type of high technology care in acute care facilities that has been provided in the past by nurses prepared in hospital-based diploma programs. It is intended that status as an advanced RCT be made available to “current RNs who wish to remain at the bedside.”

It is proposed that the bedside care technologists be licensed to practice as RCTs through state statutes and that advanced RCTs receive national certification as specialists in highly technical care at the bedside. The training programs would be offered through technical and community colleges in cooperation with hospitals and agencies throughout the United States. The American Medical Association has made it clear that RCT education is intended to “supplement and eventually replace those hospital-based programs that are being phased out by organized nursing.” AMA further contends that the availability of Registered Care Technologists “will assist business and administration to access interchangeable pools of bedside technologists and nurses for acute and long-term facilities.”

Shortcomings of AMA’s Proposal

Rather than addressing resolution of the nursing shortage, AMA’s proposal is designed to strengthen medicine’s control over bedside care-givers and to weaken nursing’s control of nursing personnel and undermine nursing’s efforts.
to standardize nursing education. A major weakness in AMA's proposal is the
false assumption that standardization of nursing education will lead to the
elimination of nurses prepared to deliver bedside care. Another weakness is
the failure to acknowledge the use of nursing assistants.

The introduction of the Registered Care Technologist, whose primary functions
would be nursing-related tasks under medicine's supervision, clearly would be
encroachment on nursing. The proposed scope of practice of RCTs is a
duplication of the functions of the technical nurse. RCTs would, however,
have much more limited training. Consequently, to the extent that RCTs
substitute for nurses, their use could compromise/jeopardize the quality of
care. Moreover, the presence of an additional level of health care personnel
would further complicate the coordination of safe, effective care in acute and
long-term facilities.

AMA Response to RCT

The ANA Board received the implementation plan on March 29, 1988, and the
Executive Committee of the ANA Board of Directors discussed the proposal with
the ANA Executive Committee during the regularly scheduled joint meeting of
ANA and AMA on Monday, April 4, 1988. At this time, ANA raised a number of
questions about the proposal and asked that AMA consider its modification or
withdrawal. ANA opposed the creation of registered care technologists as a
solution to the shortage of nurses and focused on all matters related to
retention of nurses in the health care system. ANA moved immediately to
schedule a meeting on April 20, 1988, with representatives of the American
Medical Association. Representatives of the ANA Board and staff and the
president of the American Organization of Nurse Executives (AONE) met in
Chicago to discuss AMA's proposal in depth. ANA made it clear that its
proposal remained intact and that it would serve as the basis for ANA's
attempts to address the nursing shortage.

AMA also shared the information that AMA would host an invitational meeting to
inform providers and other interested parties about the RCT proposal. ANA
shared the fact that national nursing organizations would meet to continue to
work together to address the nursing shortage and would achieve a common
strategy to address the shortage short-range.

Both ANA and AONE made it clear that they were opposed to the introduction of
the RCT and were not interested in meeting to negotiate around the ANA
proposal to introduce new levels of medical/technical personnel into an
already fragmented patient care environment. Nursing was unanimous, however,
in its desire to continue to work with medicine and all other interested
parties toward effective short-range and long-range resolution of the nursing
shortage.

Organized Nursing Holds Summit Meeting To Identify Short-Term Strategies

In light of AMA's proposal and a variety of other proposed solutions to the
nursing shortage that jeopardized the quality of care delivered to consumers,
the Tri-Council for Nursing (composed of ANA, the National League for Nursing,
the American Organization of Nurse Executives, and the American Association of
Colleges of Nursing), already scheduled to meet May 5th, invited
representatives from the ANA Constituent Forum, regional representatives of
the state nurses' associations and all national nursing organizations to
attend a summit meeting in ANA's Washington, D.C. offices The focus of this
meeting was twofold: 1) to consider the implications of proposals to introduce
new categories of caregivers in response to the nursing shortage and 2) to
mount a unified strategic offensive to resolve the nation's continuing
shortage of nurses. Foremost on the agenda was the identification of short-
rage solutions and the establishment of a plan for timely execution of
related strategies. Meeting participants included representatives of state
nurses' associations, specialty nursing organizations, federal and state
governments, associate degree nurses, licensed practical nurses, students and
ethnic/minority groups.

Summit Participants Identify Factors Contributing to Shortage
Participants at the May 5 summit readily agreed that the demand for nursing
services has outstripped the supply of nurses. While RN vacancy rates appear
to have stabilized, they continue in excess of 10 percent. A wide variety of
factors have contributed to the shortage of nurses.

Frequently, too much of nurses' time is spent in non-nursing tasks. Increased
patient acuity, increasingly complex care, and greater use of more
sophisticated equipment have prompted hospitals to use more RNs in comparison
to other nursing-related personnel. In addition, since the advent of
prospective payment and related cost containment measures, hospitals have
turned to RNs more than other personnel for various duties. Because RNs are
more versatile and flexible employees than either more narrowly-train
personnel and RNs wages are relatively comparable to other nursing personnel.

The rapid growth of alternative delivery systems (e.g. HMOs, PPOs) has
increased the demand for nurses outside the hospital setting. There are
growing demands for nurses practicing in such community settings as nursing
homes and home health agencies. Reliance on long-term care facilities is
expected to continue to grow substantially as a result of extended life
expectancies with greater likelihood of chronic disabling diseases. The so-
called "greying" of America, significant increases in the numbers of
chronically ill children and individuals suffering from chronic mental
illness, and the rise in alcohol and drug addiction have contributed to the
growing demand for nurses in long-term care facilities.

The marketplace has been relatively unresponsive to the increasing demand for
nursing services. Although there have been recent upward adjustments in RN
salaries, salaries for beginning and experienced RNs have barely kept pace
with inflation over the past decade. Nursing salaries are also subject to
severe salary compression and are not comparable to career earnings' growth in
other professions. Nurses' employee benefits are frequently inferior to
those in other professions. Poor working conditions further contribute to the
inability to attract and retain nurses.

Finally, the potential pool from which to attract individuals into nursing is
dwindling. With more career options available today, especially for women
more qualified students are entering other fields of study. Consequently,
there has been a steady decline in nursing school enrollments. Further
compounding the problem is the fact that there are fewer individuals within
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The summit marked toward consensus that nurses spend too much time with patients to take on new staffing, education, and work patterns. The goal was to improve utilization and employment, develop nurse educational programs, and increase financial aid to career changers. The consensus was that any proposal to introduce new categories of health care technicians is unnecessary, duplicative, and costly, and would only serve to further fragment patient care. It was reaffirmed that nursing's major occupation has always been and will continue to be providing nursing care at the bedside. These beliefs align with the group's position.