

# New threat to U.S. health care: hospitals without nurses

by Linda Everett

Conservative revolutionaries are reeling from a national backlash to their proposed draconian cuts in Medicare and Medicaid—a backlash mounted by such organizations as the American Association of Retired Persons (AARP) and the American Hospital Association (AHA), whose members will be directly affected by the Republican leadership's proposals. Less publicized, but no less alarmed at the cuts, are America's 2 million-plus registered nurses (RNs). Nurses, who form the backbone of the country's health care system, are already waging war against hospital cuts whenever they hit the front lines—namely, at the patient's bedside. For more than a year, nursing organizations have been warning that the "demands of the marketplace" to drive down hospital costs, is forcing 70% of U.S. hospitals to undergo massive restructuring, to eliminate hospital beds, to drastically and dangerously shorten hospital stays, and to cut 40-50% of their registered nursing staff. The newly proposed massive cuts in Medicare and Medicaid will compound those horrors.

Responding to the Republicans' proposals, Geri Marulli, executive director of the American Nurses Association, said, "The effect of over a quarter of a trillion dollars of cuts in Medicare will be nothing short of disastrous. The impact . . . will affect every patient who is served by America's health care system, because the cuts in funding will hit the entire health care system, all health care institutions." Marullo explained that U.S. hospitals are *already* experiencing a "rapidly declining level of safety and quality," because of the growing problem that ever-fewer RNs are being used to care for a growing and increasingly acute patient care population.

It was exactly that issue of safety, that brought an unprecedented 35,000 RNs from across the country to Washington, D.C. on March 31, to protest against these policies. As Joan Swirsky, editor-in-chief of *Revolution, the Journal of Nurse Empowerment*, which organized the march, told *EIR*, "Cutbacks in Medicare and Medicaid are only part of the larger picture of depriving patients of true 'quality' health care." There isn't a hospital in the country not under enormous pressure to cut the cost of delivering hospital care—pressure from the health insurance industry, HMOs (health maintenance organizations), and managed care companies—which are all accruing billions in profits by refusing or limiting medical treatment. In such states as Massachusetts or California, where insurers are permitted to negotiate virtually unlimited discounts with hospitals, a hospital's survival depends

on its willingness and ability to continually undercut its own costs of delivering care—at huge risks to patients and its own staff—to underbid its competitor. Their only alternative is to lose their contracts and their patient base. Either way, patients lose. And the nation loses, too, as public hospitals hustle to shed "unprofitable" services, while attempting to serve as the safety net for the poorest populations.

At the same time, as Ann Twomey, vice president of the Federation of Nurses and Health Professionals, explained, "The hospital industry is being taken over by for-profit medical companies whose main concern is bottom-line care, not quality care." *Forbes* magazine reported in January 1994 that health care was the most profitable industry in the nation for the last five years. Hospital cartels and hospital mergers also force deep cost cuts, in order to maximize profits and increase their market share as competition intensifies.

Thus we have witnessed the proliferation of management consultants such as American Practice Management (APM), Booz-Allen, the Hunter Group, Ernst-Young, or any of the 30 accounting and consulting firms who specialize in "scorched-earth" hospital makeovers. These profiteers siphon billions in health-care dollars out of health-care delivery to redesign hospital delivery systems, in order to cut operating costs. Their first and main target is the allegedly "high labor costs" associated with a hospital's most highly skilled and experienced RNs. The "experts" then cut the hospital's licensed nursing staff, and substitute "aides" or "techs" with a few days or weeks of training to carry out patient care usually done by nurses with at least two to four years of training.

This dangerous prescription comes at a time when hospitals are increasingly coming to resemble huge intensive care wards, with patients far sicker today than ever before, and needing more skilled care than ever before.

## High skills save lives

Study after study finds that nurses have a direct impact on hospital mortality and morbidity levels. Not only do hospitals with a higher percentage of RNs, and hospitals with a higher staffing level (higher nurse-to-patient ratio), have lower mortality rates, but also, the higher the hospital's level of nurses' qualifications (registered nurses versus lesser-trained licensed practical nurses), the better the outcomes and quality of care of surgical patients. Other studies indicate that hospitals with favorable nurse staffing levels and high RN skill



Registered nurses march on Washington on March 31 to protest congressional cuts in hospital care.

mix, had a lower ratio of actual to predicted mortality rate. In 13 studies, a higher percentage of RNs to total nursing personnel is associated with lower than expected mortality rates. Other studies demonstrate that the higher the ratio of experienced RNs to patients, the quicker a patient's recovery with fewer complications, and the quicker the patient's discharge, with fewer readmissions.

Conversely, a study published in the November 1993 *Modern Healthcare* reports that a cut of just 7.75% of a hospital's registered nursing staff has been shown to increase morbidity rates by up to 400%.

Yet, hospitals are increasingly employing redesign plans that *de-skill* their staff. These schemes, promoted under such names as "Patient Focused Care," "Operation Excellence," and "Operation Improvement," allegedly shift "routine" nursing tasks to a team of "patient care assistants," "clinical technicians," or "multiskilled workers," so as to free registered nurses to give more time to patients. But invariably, the schemes never add *more* trained staff; instead, they radically reduce the number of registered nurses and other licensed specialized personnel, such as radiologists and respiratory therapists, replacing them with unlicensed *generic, cross-trained* employees, who are expected to provide hands-on patient care after a little "orientation."

For instance, under California law, even Certified Nurse Assistants who complete the 50 hours of classroom preparation, and the 100 hours of supervised clinical education which the state requires for certification, *are still not allowed to carry out invasive procedures*. But, restructuring plans for

California hospitals use unlicensed, unregulated, and non-certified "care associates" to perform invasive procedures that require substantial scientific knowledge and/or technical skill, including nutritional support, measuring and recording vital signs, bedside lab tests, and respiratory functions. Nationwide, hospital housekeeping staffs, wearing nurses' white uniforms, are recruited to dispense medicine, insert intravenous tubes, or draw blood. In one instance, a hospital assigned aides with some cardio-pulmonary resuscitation training to staple head wounds of emergency room patients. One APM restructuring project for Massachusetts hospitals has unlicensed aides carry out more than 100 duties usually done by nurses, including performing sterile techniques, insertion of catheters, EKG testing, phlebotomies, and changing feeding tubes. A comparative study in Boston hospitals attributed 15 patient deaths to such policies.

### Janitors treat patients

As hospitals' "savings" increase with what can only be called assembly-line medicine, so does the loss of patient lives and catastrophic injuries, such as those which occurred at Tampa's University Community Hospital, where surgeons removed the wrong leg of one patient; a technician mistakenly removed a ventilator from the wrong patient, causing him to die; a woman was mistakenly partially sterilized; and surgery was performed on the wrong knee of one patient. The Health Care Financing Administration (a federal body that oversees Medicare and Medicaid) found among that hospital's major problems, exactly the inadequate staffing and

poor training of technicians that the hospital consultants push in their cost-cutting schemes.

Such schemes are beginning to backfire, as hospitals begin to face massive legal settlements because of such blunders. In Massachusetts, a critically ill patient who was to have his vital signs checked every 15 minutes, died after an aide neglected to check on him for several hours. In Indiana, State Attorney General Pamela Carter warned consumers that some hospitals in the state allegedly allowed unlicensed persons (in one case, a hospital janitor) to treat patients. In California, an unlicensed substitute for a nurse dislodged a hospital patient's feeding tube. When the aide replaced it—into the patient's lung—the patient died.

Similarly, when managed care plans obsessed with the bottom line force laboratories into "artificially low price" deals, patients die. Last year, a Wisconsin woman with advanced cervical cancer who underwent nine surgeries, told Congress about it. Her overworked HMO's lab technician, forced to read five times the federally recommended number of slides, misread all but the last of her six PAP smears and tissue biopsies taken over three years. Others, too, died as a direct result of HMO lab misdiagnosis.

In California, where hospital reorganization is the most advanced in the nation, complaints and patient deaths caused by such policies have led to state hearings and new legislation requiring hospitals to publicly disclose the impact of their cost-cutting plans on patient care and on the community as a whole. Nurses report that Kaiser Permanente's 16 HMO hospitals in northern California are considering slashing their nursing staff to as low as 30% of the inpatient workforce. The Alta Bates Medical Center in Berkeley is aggressively pursuing its plan for one nurse to care for up to 9-14 acutely ill patients—thereby violating a dozen state laws, including the Department of Health Services regulations. The California Nurses Association (CNA) brought a class action lawsuit against Alta Bates and its parent corporation, California Healthcare System, for defrauding the public with its untested plan to cut skilled nursing staff by 50%. In the first decision of its kind in the nation, a U.S. District Court in April upheld the right of nurses, in this case, CNA, to challenge a hospital's restructuring plans that dangerously cut nursing staff.

Similar cases are being brought all over the country, as noted by the American Nurses Association in February, when it released its survey of U.S. nurses. The ANA warned that 79% of nurses report that hospital cutbacks are causing a severe reduction in the quality of patient care. Some 20% of nurses report an increase in the numbers of errors, involving patient falls, fractures, and deaths due to staff reductions and subsequent overloading on remaining nurses. At the same time, hospitals that chronically understaff shifts are forcing nurses who are trained in pediatrics or obstetrics to "float" and cover critically ill cardiac patients or emergency patients—regardless of whether the nurse protests that he or she has little training or experience with such patients. But it is the floaters, and not the hospital, who are then held liable

for the lives of patients to whom they are assigned.

Other surveys show that HMOs and hospitals have dangerously shortened hospital stays in order to cut costs, or, as some New York hospitals describe it, to increase the "turn-around" or "throughput" of their "customers." California's Kaiser Permanente HMO, which routes most of its emergency patients to their own clinics, has now replaced its registered clinic nurses with "aides" who are unable to recognize those patients who desperately need immediate hospital care. At the same time, the HMO makes it virtually impossible for any but the very sickest of enrollees to receive inpatient care. But even when they do get into the hospital, patients must still survive the HMO's planners, who aim to establish a ward in which one registered nurse oversees 30 to 40 acutely ill patients, with the help of a few unlicensed aides.

Most rational individuals would see such de-skilling of the U.S. health care delivery system to the backward levels imposed on Third World nations, as comparable to the "dumbing down" of today's schools by the Conservative Revolution's privatization schemes. They're right. What is under attack is the federal republic's Constitutionally-mandated, dirigist mission to assure every community and every citizen of adequate hospital care, as set forth in the 1946 Hill-Burton hospital building program. Instead, we see hospitals today skirting even the most minimal federal requirement for patient care. For instance, one nurse is required for every two intensive care unit (ICU) patients, usually among a hospital's most critically ill patients.

## Catch-22

As a way of cutting costs, hospitals are now downgrading intensive care patients to *general* care, and are then assigning one nurse and one aide to care for seven patients. The consequences are predictable: Patients who do not die, are often readmitted to ICU again, because they had declined so precipitously. But, some hospitals are even balking at providing any ICU services whatsoever. Several courts rulings have endorsed hospitals which have refused to provide what they facetiously claim would have been "futile" life-saving treatment.

In other words, the hospital's cost-cutting policy actually hastens a patient's decline, thereby necessitating the costliest of hospital treatment in ICU; yet the hospital can refuse such treatment, saying such care is ethically inappropriate or a waste of medical resources, given the patient's likely outcome.

It is certainly true, that advanced technologies and methodologies have allowed a shift of inpatient procedures to be safely performed on an outpatient basis. However, pressure by managed care groups to keep patients out of the hospital at all costs is also creating a patient safety crisis. Outpatient surgeries, with the promise of home care nurses to follow up surgical procedures, are plagued with the same ruthless policies: Nurses are assigned an impossible 18 home-care visits a day—15 minutes per patient, not including travel time—to change dressings, adjust medications, and to edu-

cate diabetic patients after amputations.

The same crisis confronts acutely ill hospital patients who have been shipped out of hospitals into understaffed sub-acute care nursing home programs. Similarly with those who are promised follow-up home care by such insurers as Blue Cross-Blue Shield, who instruct hospitals to dump patients with amputations below the knee out of the hospital within 48 hours of their surgery, or to force women to leave within 18 hours of their Caesarian.

Insurers' demands for "dumping" patients have become so barbaric, with no provision of home care, that some states are being forced to propose legislation to restrain the trend. Responding to the policy of ordering women with normal deliveries out of the hospital within 24 hours of giving birth—even if her infant's well-being requires her to stay—legislators in Maryland, New Jersey, and Arkansas have passed bills to require insurers and HMOs to pay for hospital care for mothers and their newborn infants for at least 48 hours of inpatient hospital care after childbirth when necessary, or else to provide the appropriate nursing follow-up. As Maryland leaders said, human life is precious, and so the extra stay is warranted.

### **Nurses won't be scapegoated**

When the 35,000 nurses marched in the nation's capital in March, they went to Congress as patient advocates—people who provide 24-hour care to all patients at the most vulnerable moments in their lives. They asked that Congress pass

basic protections for Americans, by having hospitals disclose how many RNs they employ, along with their nurse-to-patient ratios. They also asked for protection for nurses. Nurses currently lose their jobs and their licenses, and face hospital recriminations, when they protest dangerous hospital conditions. They need legal protections under the National Labor Relations Act.

One chilling example substantiates that need: A nurse with only an aide in an understaffed intensive care unit worked desperately to save her critically ill patient who went into cardiac arrest, while she simultaneously tried to guide the untrained aide in saving the life of the patient in the next ICU bed who also "arrested." Both patients died. Shaken, she complained to her administration about the unsafe staffing level, and was dismissed from her job. The hospital then threatened to have her charged with the murder of both patients, should she try to appeal their decision or go public with her claim.

As this new nursing crisis indicates, the aims of such free-market medicine—what Newt Gingrich promotes as Walmart-style health care—are treasonous, just as is the privatization of the nation's education system. This nation cannot sustain, and cannot afford to try to absorb, the Conservative Revolution's proposed Medicare and Medicaid cuts. To do so, would be comparable to hooking up the country's health care delivery infrastructure, including our highly skilled medical staff and scientists, to one of Dr. Kevorkian's suicide machines.

## **Who's kidding whom?**

Hospital and nursing home administrators insist that clinical restructuring and nursing layoffs are necessary because of "excess" hospital beds and lost revenues from falling occupancy rates; yet, they claim that such layoffs have not affected patient care. Patients, however, and their families, do not agree, and have found the trend so dangerous that Congress has commissioned the National Institute of Medicine, a private, non-profit research arm of the National Academy of Sciences, to undertake a two-year national study to determine the adequacy of nurse staffing in hospitals and nursing homes.

In its California hearings, the commission heard firsthand why the California Nurses Association, alarmed at the escalating "near-miss" incidents caused by work-re-design plans, instituted their Patient Watch campaign. Patients, relatives, and providers have sent CNA copious letters and documentation of the plummeting levels of care occurring under downsizing of nursing staffs. In one letter, a nurse describes the nightmare caused when her

hospital combined the pediatrics department with an adult cardiac step-down unit. With this mixed assignment, hospital management uniformly ignores the higher staff requirements for pediatric patients, so nurses are expected to care for as many as eight patients—babies as well as adults—at the same time. "What's a pediatric nurse supposed to do," she asks, "in the event of a cardiac arrest of one of our adult patients?" While she is tied up caring for the seriously ill adult, who will watch over the infants assigned to her? The same hospital repeatedly wants nurses to accept an assignment that is split between two floors, where it is impossible to watch over either floor of patients adequately. Management is then expected to close the pediatric unit, "but leave a dying child over there and have the nurses run back to the cardiac unit to care for an additional three pediatric patients plus the rest of her adult assignment." When a nurse objected, hospital management asked, "What did she care when the patient in the closed ward was a 'no code,' anyway?" Finally, the nurse was allowed to move the three pediatric patients back with the fourth child in pediatrics—so long as she was willing to travel back and forth to the cardiac unit to care for two more adult patients.—*Linda Everett*