Some of the photos used in this article have been provided courtesy of the CNA and the School of Nursing at SCSF.

Nurses under siege

Feeling the pressures of managed care and an escalating nursing shortage that threaten their traditional role as patient advocates, nurses are rethinking their place in the health-care system.

by Sigrid Bathen

Biology made the female the nurse of the species. The first mother who leaned over the first cradle of leaves in the primitive forest was the first nurse.

—Victor Robinson, M.D.
White Caps, a history of nursing (1946)

When Jill Furillo was an emergency room nurse in the early 1980s at Brookdale Hospital in Brooklyn, New York, she wasn't making much of a salary — far from a doctor's salary — but she and the more experienced nurses routinely trained the new, inexperienced physicians. Brookdale — a large teaching hospital in a "medically underserved community" with an impoverished and largely uninsured patient population that used the ER as its

primary care physician — had one of the highest volumes of trauma cases in the state, and there was no time for ego.

"The doctors relied on the nurses, totally," recalls Furillo, now governmental affairs director for the California Nurses Association. "We had the expertise. We had the training. We were there every day." Occasionally, a new doctor would come in — a "Mr. know-it-all," trying to lord it over the nurses, make sure they understood who was in charge. "He'd get quickly put in his place." Today, she says, "there still are physicians out there who believe that nurses are their handmaidens, that you're just taking a second job to help out the family."

Amazingly, in 1998, when increasing numbers of nurses are earning advanced degrees, practicing independently, delivering babies, providing complex home care for the escalating population of seriously ill people discharged from downsized hospitals by aggressively cost-conscious health maintenance organizations, their perceived role remains in many ways traditional: caregivers, handholders, nurturers.

In California, about 95 percent of RNs are female. "It is still perceived as a woman's profession," says Assemblywoman Helen Thomson (D-Davis), a registered nurse married to a psychiatrist. "When I went into nursing, there weren't many choices for women — nursing or teaching."

While no longer perceived as one of only a few professions where women are welcome, nursing is in a major state of flux. "In past decades, RNs entered the work force after kids were in school and left when they had to take care

Kit Costello

The fiery president of the powerful California Nurses Association stirs praise, criticism.

By Tippy Young

Wendy Wilson and Kit Costello at a nurses rally.

Flanked by framed posters depicting "Nurses of Yesterday," Kit Costello is talking with reporters in the legislative offices of the California Nurses Association (CNA) in downtown Sacramento. Periodically, she jumps up from her chair to retrieve a file from a bank of cabinets — in a profession of caregivers dominated by women, the divisions between management and support staff are unclear, nonexistent even. On the wall above her head is another poster that reads: "California Women - Courage - Compassion - Conviction." For the intense, overscheduled — some would say, driven — Costello, it is an appropriate backdrop.

Costello, 43, is in her third year as president of CNA, the state's largest union for registered nurses, representing about 30,000 members — a union alternately described as unconventional, unrelenting and militant. She shows no signs of slowing down. Despite her frenetic schedule — she looks tired on this cloudy, almost-spring day, the hint of shadows beneath her eyes — she is alert and engaged. "I consider this my privilege in life," she says firmly, "to represent nurses."

Often described by her peers as energetic, intelligent, a strong advocate for nurses — and by her critics, some also peers, as dogmatic and doctrinaire — Costello's combination of experience and fearlessness is hard to ignore. "She's good at representing the profession and telling it like it is," says Assemblywoman Helen Thomson (D-Davis), who also is a registered nurse.

A nurse for 20 years, Costello received an associate's degree in nursing from Sacramento City College in 1978 and a bachelor's in nursing with a public-health nurse certification from California State University, Sonoma, in 1983. Costello's journey to her present position as the tough-talking, sometimes unyielding head of a nurses union that many say brought the giant Kaiser health plan to its knees at

of aging parents," Catherine Dodd, a registered nurse who is the executive director of the American Nurses Association-California, testified at a March hearing of the state Senate Business and Professions Committee on California's critical nursing shortage. "Changing professions midlife while providing for a family is very difficult, so RNs stayed despite the unsatisfactory working conditions. ...Nursing today is even more demanding — physically, scientifically and emotionally. Where did the RNs who left go? Many retired. The early baby boomers were tired. The rest of us are not far behind."

Half the RNs in California are over 45, and 30 percent are over 50. Many say they are leaving the profession because of overwork and burnout. "Job satisfaction in nursing is very tied to how you feel about what you're doing," says Thomson. "I think it's more so than in many jobs and professions. And many nurses are dissatisfied."

As their dissatisfaction grows, their militance increases. CNA, which represents about 30,000 California nurses, has moved successfully on several fronts to force major hospital chains and HMOs to accede to demands for higher salaries and better working conditions. The long, contentious CNA battle with the giant Kaiser Permanente HMO — ironically among the first major health-care organizations to pay nurses higher salaries as well as to utilize independent nurse-practitioners — made nationwide headlines when the nurses eventually won most of their demands.

The CNA successes have not come, however, without great personal and professional cost — including a bitter

Costello

the bargaining table, began when she was a young mother attempting to juggle work and family — she is married with two children, a son, now 12, and daughter, 14.

Costello's longtime association with Kaiser is intensely personal as well as professional. "I worked for Kaiser for 12 years, had my two children in Kaiser hospitals, [and] saw my son go through two neurosurgeries in their system," she wrote in an article describing her experiences with the HMO for the CNA publication, *The California Nurse.*

While working as a registered nurse at Kaiser in 1984, following the birth of her second child, she found that her child-care costs were "about equal to my mortgage payment." Looking for some relief, she wrote a proposal for on-site child care. Based on a federal tax provision allowing employees to use pre-tax dollars for child care, she estimated that what Kaiser would save in Social Security payments for its employees participating in the plan could be used to build a child-care center.

She took the proposal to members of the CNA contract bargaining team to present to management. "I said, 'I've got this great idea, it's all written, somebody just has to take it and argue the point.' They said, 'Why don't you go?' So that was kind of how it started. I had this burning issue, and it was important for me to get it to the bargaining table." Kaiser agreed to the pre-tax program but not the on-site child care. Disappointed by the outcome, Costello accepted a position as an alternate on the collective bargaining committee of the CNA.

She steadily rose in the ranks of the union, joining the CNA's legislative and regulatory committee in 1991, the board of directors in 1993, and, in 1995, was voted CNA president. Costello's presidency marked a major shift for an organization formed in 1903 primarily as a professional association for nurses. Although still deeply involved in legislative and regulatory issues, the CNA is now known primarily as a labor union.

"What is so historically significant about the presidency of Kit Costello is that she was the first one who was bold enough to recognize the value of staff nurses in an organization," says Rose Ann DeMoro, executive director of CNA. "For many years, there were no direct-care nurses on the CNA board — this organization paralleled the hierarchy in the hospital. It was Kit and a few others who had enough self-respect and understanding to step out of the mold and say, 'Wait a minute, there's something wrong with this picture.' It challenged the whole history of the social role of nursing."

CNA Communications Director Chuck Idelson says Costello "played an absolutely pivotal role in the transformation of an organization that for years had been dominated by nurses aligned with management and administration [into] an organization whose emphasis is patient advocacy and safe staffing for nurses."

Others disagree, saying Costello's focus on collective bargaining is too narrow. For nearly a century, the CNA had been the state affiliate of the American Nurses Association (ANA). In 1995, the CNA officially broke from the ANA in order to emphasize its collective-bargaining function, creating tension between the two nurses' organizations. "I disagree with making CNA just a union," says Catherine Dodd, executive director of the ANA-California. "I admire Kit's continued advocacy [but] I believe [the CNA] needs to be part of a national professional organization."

Costello's term was just beginning as the union was preparing to renegotiate its contract with Kaiser Permanente, the nation's largest HMO. This was the start of what would become a "very intricate, complex, and contentious 18 months" for Kaiser and the CNA, says Lila Petersen, Kaiser communications director. The CNA filed charges with the National Labor Relations Board (NLRB), seeking access to information on the HMO's patient-care standards.

The next two years were characterized by bitter disputes between the nurses union and the HMO. The CNA began an intense campaign alleging inferior patient care by Kaiser — launching six strikes at Kaiser hospitals and clinics, costing the HMO an estimated $10 million a day. "The nurses were saying it's now or never," says Costello.

Finally, last March, the CNA made headlines when a federal administrative law judge ordered Kaiser to turn over extensive information about quality of patient care to the nurses, with a ruling that Kaiser had violated labor laws when the HMO refused the CNA's initial request for information on health-care standards. The decision was a huge win for the nurses. Costello says the CNA got "everything they wanted" out of the ruling. Kaiser takes a somewhat more inclusive view; Petersen describes the decision as a "triple header" win, for Kaiser, the HMO's members, and the nurses.

For Costello, it came down to a matter of self-respect and tenacity: "You're in the dwindling years of your career where you figure — I've done it all, I've seen it all, they can't touch me. And I'm standing up for myself."

1995 split between the CNA and its longtime national affiliate, the ANA, over collective-bargaining issues. And although the two unions officially cooperate on many legislative and workplace issues, there is no love lost between CNA and the Service Employees International Union (SEIU), one of the fastest-growing unions in the country, representing numerous classifications of health-care workers.

Nurses are increasingly flexing their newfound political and professional muscle in other ways. A recent episode of "60 Minutes" featured a group of independent nurse-practitioners, functioning pretty much like primary care physicians, but making house calls to judges in their chambers — to the distinct irritation of some New York physicians concerned about their own turf, and income, in the cut-and-slash era of managed care. Although nurse-practitioners are welcomed by physicians reluctant to establish practices in some impoverished rural outback or inner-city ghetto — where nurse-practitioners often provide the only immediately available medical care — they are not so welcome when they open offices downtown and see judges in their chambers.

When Oxford Health Plans, one of the country's leading HMOs, teamed up with Columbia Presbyterian Medical Center in New York to give doctors' wages to highly trained nurses who perform a wide array of primary-care responsibilities — the subject of the "60 Minutes" segment — physician reaction was predictable. "There are many physicians who work for me who see this as competition," Dr. Myron Weisfeldt, Columbia's chairman of medicine and a backer of the pilot program, told the *Wall Street Journal*. "Physicians who are already under stress, and who are finding it difficult to sustain their incomes while working longer hours, find this an unattractive possibility."

Advocates of increased levels of responsibility, and pay, for nurses with advanced, specialized training say the very nature of nursing, with its emphasis on prevention, counseling and hands-on care, fits ideally with the underlying concepts of managed care. And although organized medical associations generally oppose expanding independent nursing practice, individual physicians welcome them. "I don't know how I ever functioned without nurse-practitioners," Dr. Stephanie Seremetis, who directs the Women's Health Program at New York's Mount Sinai Medical Center, told the *New York Times*. "Probably in the future the best use will be nurse practitioners in independent practice, using a physician as backup."

In California as elsewhere around the nation, advanced-practice nurses such as nurse-practitioners, nurse-midwives and nurse-anesthetists are increasing in numbers and slowly broadening their "scope of practice." But they face rankling limitations from the physician lobby. "Most physician organizations work well with nursing," says California Medical Association Vice President Steve Thompson, "sometimes in disagreement, sometimes in expansion of scope and roles." Opposed to "totally independent" practice for RNs with advanced training, he said the CMA generally agrees with nurses' concerns about the excesses of managed care. "The challenges of managed care are fairly simple," he said. "In order to make it financially, physicians, nurse-practitioners, physicians assistants, are having to spend less time with patients, and there is increasing frustration among health workers." He admits that doctors facing their own financial demons under managed care may well balk at increasing demands from nurses for more independence. "If I was a physician scrambling to survive in managed care," he said, "I wouldn't be a happy camper either."

Despite California's reputation as a bellwether state in health-care innovation, it lags far behind other states in the independence and status accorded nurse-practitioners. In 1994, the *New England Journal of Medicine* reported that "favorable practice environments" for nurse-practitioners varied widely among the states, with California near the bottom in a ranking of states based on such factors as prescribing authority, legal status and reimbursement rates. "Practice-environment scores" for nurse-practitioners ranged from 100 in Oregon to 14 in Ohio and Illinois. California scored 30. Certified nurse-midwives scored considerably better, at 80, with six states having scores of 90 or higher (Minnesota scored 100), and 13 with scores of 50 or less. Physician assistants in California were somewhere in the middle of the states' rankings with a score of 58.

Of the 259,818 registered nurses in California, according to the state Board of Registered Nursing, 8,477 are certified nurse-practitioners — nearly double the number just a decade ago. And perhaps nothing rankles them more than the fact that they do not have full authority to write prescriptions, which they say also limits their ability to receive direct reimbursement from insurers. A pitched legislative battle in 1995-96 modified the law somewhat, removing some restrictions on the prescribing authority of nurse-practitioners and giving them the right to "furnish" prescriptions — an odd semantic quirk that prevents them from authorizing prescriptions for the many controlled substances monitored by the U.S. Drug Enforcement Agency (DEA). Because of the "furnishing" language in California law, they say the DEA has declined to assign California nurse-practitioners a "DEA number" permitting them to sign those prescriptions.

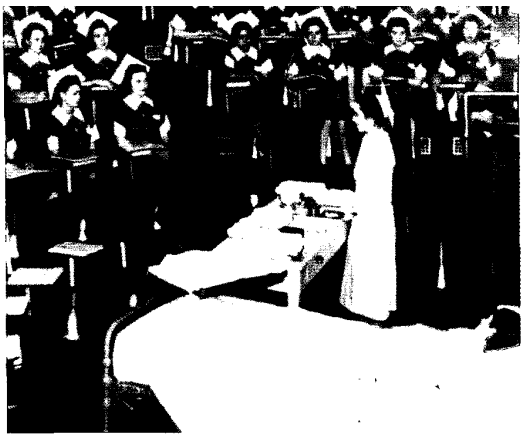
The ANA's Dodd, who was CNA's governmental affairs director from 1991-93 and actively pressed the 1995 prescriptive legislation for ANA, sarcastically calls the "furnishing" language in California law "the interior decorators' license" for nurse-practitioners. Because of intense opposition from physicians and pharmacists, Dodd says, "The first thing that came out [of the bill] was the 'P' word." As a result, although nurse-practitioners regularly prescribe medication, they must track down a physician to sign a prescription for a controlled substance before it can be given to a patient. The physician is listed as the prescribing authority, which nurses say can lead to confusion and skewed numbers when the DEA tracks those prescriptions — showing, for example, that a physician is writing far more prescriptions for controlled substances than he or she actually writes.

"All it really does is create a hassle for the patients, the pharmacy, the HMO, the physician and the nurse-practitioner," says Dodd. Nurse-practitioners in active practice remain furious about the law and are pressing for clarification of the "furnishing" language. "We have a lot of very restrictive laws that exclude us from doing our job," says Jeanette Morrow, state government relations director for the California Coalition of Nurse Practitioners (CCNP) and a nurse-practitioner in the emergency room at Mercy General Hospital in Sacramento. "I think most nurse-practitioners will tell

you that most doctors are supportive of their capabilities and regard it as a hassle when they have to sign things for us. They trust our judgment."

CMA lobbyist Scott Syphax said the physician's group is working "closely and cooperatively" with CCNP to try to resolve any "ambiguity" in the law as it applies to nurse-practitioners' prescribing controlled substances.

Susan Cook, a certified pediatric nurse-practitioner with Kaiser in Redwood City and a member of the CCNP board of directors, says physicians "struggling for their own economic survival" may see advanced-practice nurses as a threat, but many recognize that "there is plenty of health care out there for all of us." Nurse-practitioners can earn as much as $95,000 annually, although most working in competitive urban areas of California are in the $55,000-$75,000 range. At Kaiser in Northern California, spokeswoman Lisa Petersen says nurses' salaries, including nurse-practitioners, average $62,000. Recent media accounts place entry-level nurse-practitioner salaries at Kaiser at $56,000, about half that of entry-level physicians. According to the CNA, most RNs in California make considerably less, perhaps $40,000 to $50,000.



"Job satisfaction in nursing is very tied to how you feel .... And many nurses are dissatisfied."

— Assemblywoman Helen Thomson (D-Davis)

HMOs attending to the bottom line increasingly rely on lesser-salaried health-care workers — and, nurses say, dangerously growing numbers of "unlicensed assistive personnel," the UAPs of the health-care world — to share the workload. A Kaiser hospital in San Jose was recently cited by the state Department of Health Services for allowing unlicensed orthopedic technicians to "perform duties beyond their scope of practice [which] included, but were not limited to, suturing of tissue," after CNA filed a complaint that Kaiser was using unlicensed technicians to suture, inject anesthetics and perform other duties. Shannon Sutherland, an RN and attorney who is CNA's regulatory policy specialist, says the practice is "systemic" in other hospitals. Kaiser officials insist the incident at its Santa Teresa Community Hospital was an isolated one that was dealt with immediately and that the CNA is "exaggerating."

Cook, a nurse for three decades and one of the pioneers as a nurse-practitioner in the early 1970s, says the increased reliance of HMOs on advanced-practice nurses, while recognizing their value, also comes with enormous stress. "HMOs don't really acknowledge what we bring to the practice," she says. "They recognize that we are less expensive and provide high quality care. They have this great deal. But the time constraints are very difficult."

Hospital and HMO officials dispute that assesessment, saying staffing is determined by patient needs. "Demands for health care far exceed resources," says Maureen O'Haren, executive vice president of the California Association of Health Plans. "Ask yourself, do you need a nursing degree to bring food to people, to change bedpans?" Dorel Harms, an RN who is a vice president of the California Health Care Association, which represents hospitals, says staffing ratios are adjusted depending on the seriousness or "acuity" of patients' conditions. As patients are discharged earlier under managed care, she said nurses are particularly crucial in determining patient acuity. "I think managed care has probably enhanced the role of nurses," says O'Haren.

Nationally, according to the California Strategic Planning Committee for Nursing, established by legislation to address nursing education and staffing issues statewide, California ranks the lowest among the 50 states in the proportion of RNs per 100,000 population — from a high of 1,710 per 100,000 in the District of Columbia to a low of 566 in California. As the state population increases by an estimated 21 percent from 1997 to 2010, that shortage will become even more severe, particularly in critical-care, public health, home care and advanced-practice specialties. Dodd says California produces fewer nurses with baccalaureate degrees than any other state; educational standards for the degree may vary widely among the campuses of the CSU, and many programs are seriously impacted.

Several legislative proposals to increase training are moving through the Legislature, with little fanfare, very limited funding and varying success — notably SB 1816 by Senator Richard Polanco (D-Los Angeles), which would appropriate $145,000 to further assess the nursing work force in California; AB 2429 by Assemblyman Wally Knox (D-Los Angeles), making grants available to community colleges to provide additional training for RNs in understaffed specialty areas; AB 695 by Assembly Speaker pro Tempore Sheila Kuehl (D-Santa Monica), to require minimum nurse staffing ratios in acute-care facilities, strongly opposed by hospitals and HMOs; and AB 1439 by Thomson and Assemblyman Brett Granlund (R-Yucaipa), to require all health personnel to wear "plainly readable" badges with their names and credentials.

At the heart of the controversy over California's looming nursing shortage is the state's fragmented system of nursing education. Gone are the hospital "diploma schools" of early nursing, replaced by a complicated system of training in community colleges (a two- or three-year associate's degree), state universities (the increasingly touted bachelor's in nursing) and the University of California (mainly for graduate programs in specialty areas). A nurse with a community college degree — the majority of nurses practicing today in California hold such degrees — who wants to continue her education faces formidable challenges, particularly if she is working and raising a family.

"As an associate degree nurse, I was an excellent nurse," says Patricia McFarland, executive director of the Association of California Nurse Leaders (formerly the Organization of Nurse Executives) and a member of the Strategic Planning Committee for Nursing. McFarland, who has been with Mercy Healthcare in Sacramento for 21 years, now holds a master's in nursing. "When I earned my bachelor's degree, I had a much better understanding of the whole of health

care. Education is power, and the opportunity for nurses to pursue an advanced degree should be available. But nursing is still a woman's profession, for many single moms, single breadwinners. They need more help through CSU. We have made it too difficult. We have to knock down those barriers."


Catherine Dodd, ANA-Calif executive director

The debate over how much education a nurse needs has been around since the beginning of nursing — and remains the source of considerable friction among nurses. Much of the bitterness between CNA and ANA-California stems from a perception among "direct-care" nurses like fiery CNA President Kit Costello (see page 10), a longtime Kaiser RN in Sacramento, that nursing has been dominated by the so-called "nursing elite" — nurses with advanced degrees, nurse-educators and specialty nurses. "You had this anomaly in CNA that 90 percent of the members of the organization were direct-care staff, nurses doing bedside care, and yet the CNA was dominated by the elite," says CNA spokesman Chuck Idelson. "The direct-care nurses became increasingly irritated." And in 1995, with Costello at the helm, they took over the leadership of the CNA, splitting with ANA.

In 1996, CNA split with its sometime ally, sometime rival union, the SEIU, in part over the wording of HMO initiative reform proposals. The result was two separate but similarly worded initiatives (Propositions 214 and 216), terminal voter confusion, and the defeat of both. The expensive initiative battle further exacerbated already fragile coalitions within nursing and related health-care fields.


Rose Ann DeMoro, CNA executive director

Dodd and other nursing leaders outside the CNA say the latter has pressed an aggressive collective bargaining agenda to a fault, and that the hard-line views of the leadership make any cooperative discussion among the various elements of the health-care behemoth more difficult — a view disputed by CNA officials who point to their active legislative and regulatory agenda as well as their union organizing.

"The attitude is that you can agree with them 95 percent of the time," said one prominent SEIU official, who asked not to be named, about CNA leadership, "but disagree once, and you are an enemy forever." The SEIU also points to the predominantly white composition of RNs, while less skilled workers and licensed vocational nurses (LVNs) are heavily minority. "You walk into any hospital except in a couple of inner-city ones, and the nursing work force is all white, while the technical staff and the LVNs are [mostly minority]," says SEIU Local 250 President Sal Roselli, whose Northern California union, with 45 percent minority membership, represents 40,000 health-care workers. CNA hotly disputes that notion, pointing to statistics that — while not entirely reflective of the state's general population — show California RN's to be 66 percent white, 24 percent Asian and Filipino, 4 percent black and 5 percent Latino.

In a major political departure from years past, some of the disputes over educational and collective bargaining issues have turned increasingly bitter among nursing groups historically conditioned to "get along" with each other. CNA leaders are sanguine in the face of their critics, pointing to their victory over Kaiser as well as other successful hospital organizing drives throughout California. "This is a group of women who basically subsidized an industry with the cheapest labor available," says CNA Executive Director Rose Ann DeMoro, a collective bargaining specialist who is not an RN. "It was stunning how little they were paid. Then, with the women's movement, more options opened to women and the nursing profession became more undesirable" as a career goal for women.

Although they often disagree on strategy, nursing leaders uniformly equate the murky status of the profession with the fact that it is populated so heavily with women. "The hospital hierarchy is still basically male," says DeMoro, who has done doctoral work on women's rights issues. "There is a genuine, deep, profound institutional sexism in the health-care industry, and there is a long history of discrimination against direct-care nursing." Discrimination by hospitals, health plans, physicians, and even, she says, by other nurses "conflicted" by their training as caregivers and their own desire for status in a viciously competitive health-care bureaucracy. Ironically, she adds, as nurses advance educationally and professionally, "the genuine heartbreak occurs when they find they don't have power."