

KEEPING THE TURF (WARS) TRIMMED

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The Ancient Greek philosopher, Diogenes (the one who lived in a barrel to get away from his nagging wife), was a rather cynical and arrogant skeptic. One bright and sunny day, he was seen carrying a lighted lantern. Bystanders asked him what he was hoping to find with this seemingly unnecessary illumination. His response was that he was looking for an honest man. One can only assume, from this seemingly witless act, that he was pessimistic at best.

Lip service is easily expended on the icons of the healthcare professions, and one of these is the goddess of collaborative practice. Collaborative practice cannot be dismissed with a wink and a nod, or the intimation that there are only 2 approaches to critical care disciplines: "My way or the highway!" The fundamental nature of collaboration is working together on a task. The aim of collaboration is to combine the skills and knowledge of more than one person to improve the outcome of a specific venture more than if the individuals were working on their own, ie, to make the whole greater than the sum of the parts. While collaboration does not deny the need for someone to be in charge, it does imply an overlapping of responsibility and accountability for actions that are within the scope of any of the team members if they are indeed working in a cooperative fashion.

The antithesis of collaboration is summed up in one short word, "turf." Turf allows individual groups to exclude others from their particular area of expertise or decrease the capacity of others to play a significant part or perform in a particular field. The rationales given by these groups for this behavior in the healthcare professions usually include some lofty ideals about how such exclusivity will improve patient safety. When there are precious little data, and frequently the data that exist are only anecdotal, the excluded parties

feel that they are barred from an area of practice because the exclusive group wants recognition or job security. There is nothing like a single untoward event occurring in a hospital to a high-profile patient, particularly when discovered by the media, to create expensive lobbying efforts and a politically motivated legislative frenzy. The increased regulations that result can significantly decrease the efficiency and amplify the frustration levels of staff and may exclude skilled people from an area of their expertise. When turf battles are won for the wrong reasons, the sum is less than the parts, as the ability to collaborate is diminished.

We have never needed collaboration more than we do now. The need to maximize the accessibility of our patients to the professional motivation, experience, and skills of the registered nurse has become painfully obvious. A recent study,¹ published in the *New England Journal of Medicine* (a full version of this report can be found on the Internet at: <http://bhpr.hrsa.gov/nursing/staffstudy.htm>), looked at various outcome measures from 1997 of more than 6 million patients from 799 hospitals in 11 states. With overwhelmingly significant data, this study showed that a higher proportion of registered nurse hours of care was associated in medical patients with a shorter length of stay in the hospital and a lower incidence of urinary tract infections, upper gastrointestinal tract bleeding, cardiac arrest, shock, and "failure to rescue." Failure to rescue was defined as "death from pneumonia, shock or cardiac arrest, upper gastrointestinal tract bleeding or deep venous thrombosis." In addition, surgical patients had a lower incidence of urinary tract infection and failure to rescue. Increased staffing with licensed practical nurses or nurses' aides did not reduce the number of adverse outcomes. Steinbrook² has pointed out that the downsizing of all hospital staff, including nursing, has been so encouraged by the desire and power of HMOs and insurance companies to cut their costs, that we have now gone below a safe floor (lower limit) for reasonable patient care both economically and outcome related.²

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Steinbrook² has also pointed out that there is no emergency infusion of registered nursing staff available to resuscitate the hospitals to a better level of patient care. Hospitals are hiring more registered nurses than ever before, and nationwide there is a 13% vacancy rate. In 2000, more than 1.3 million registered nurses were employed in hospitals, and the profession is aging: 22 years ago, the most common age group was 25 to 29 years old, and in 2000, it was 45 to 49. There is about a 1% unemployment rate, and enrollment in nursing schools has gradually declined over the past 2 decades. (A hopeful slight increase in enrollment in baccalaureate programs did occur last year.) One of the disincentives may be that the inflation-adjusted salaries for registered nurses has had a very sluggish rise in the last 20 years, despite a considerable increase in the number who have obtained a higher level of education. About 7% of registered nurses currently have advanced practice credentials. (Most of this statistical data come from the National Sample Survey of Registered Nurses³ and are available at: <http://bhpr.hrsa.gov/healthworkforce/rnsurvey/>.)

There is an international shortage of qualified nursing personnel, so the remedy of the old days to recruit from abroad is a somewhat limited option. The situation will be further stressed by states enacting laws that will develop hospital codes mandating nurse-to-patient ratios. An example is the California Assembly Bill 394, enacted in 1999, which gave the California Department of Health Services the mandate to set up minimal nurse-staffing ratios. The proposals, announced by the governor in January of this year, will be implemented in January 2003. For nurses working in the intensive care unit (ICU), the nurse-to-patient ratio will be 1:2, which is probably reasonable, while medical-surgical units will be 1:5. California has almost the lowest per capita registered nurse population (544 per 100 000 population³), so where the nurses will come from to meet the new requirements is hard to envision. Many institutions could be driven out of business by the expense of hiring increased numbers of nursing staff at a time when a bidding war is already in progress with such incentives as signing bonuses. In the longer term, the governor's proposal² to expend \$60 million on the development of larger and increased training programs may help, but will do little to augment the workforce by next year or to address the problems in the hospital work environment that have put nurses under such stress today.

A factor not taken into account in assigning staffing ratios is the effectiveness of a collaborative workplace in expanding the coverage of nursing staff. As already pointed out, the outcomes in patient care

did not seem to be changed by higher numbers of ancillary nursing staff.¹ In ICUs, it is amazing to realize how many clinical responsibilities were handled by critical care nurses over 20 years ago,⁴ and how much has been whittled away when other healthcare professionals have demanded a piece of the territory, sometimes as an exclusive domain. The CCRN certification examination covers all the major aspects of critical care.

The Editors have been taken to task⁵ when lamenting the loss of respiratory skills among many critical care nurses who, either because of lack of practice or local regulation, are constrained from becoming involved in the care of patients receiving mechanical ventilation.⁶ Our colleagues from abroad look at this situation with amazement. Respiratory failure is arguably the largest part of critical care management and correctly a part of critical care nursing. Respiratory therapy departments have not escaped the financial cutting that the rest of us have had to endure, so the availability of therapists has declined. If a patient's life depends on a mechanical device, be it ventilator, balloon pump, or dialysis machine, it is surely not too much to ask that whichever member of the team is at the patient's bedside should be in a position to make necessary adjustments without the delay or anxiety of waiting for a designated expert to appear from elsewhere. This is where a collaborative team can win.

Anyone who has worked in an ICU as part of a truly collaborative team knows what a gratifying and rewarding job it becomes when there is a high level of mutual professional respect between colleagues of all specialties. Furthermore, the frustrations and delays are fewer, and efficiency and satisfaction run high. Some degree of cross-training inevitably develops, broadening the scope of the professional practice of all participants. A credentialing process also should be in place to document that people have been adequately trained and to maintain an appropriate degree of comfort among outsiders looking in on how the operation is being managed.

Part of the success of collaborative practice depends on sound, efficient, and speedy communication. This can be greatly facilitated by computerized systems, so that when alterations are made in a patient's care plan or new therapy is initiated, all members of the team can find out who initiated the changes, when, and why. To give an example from a multidisciplinary ICU, if, during the planned weaning of a patient, a physician or a nurse makes a change in ventilator settings at a time when the respiratory therapist is not available, the new settings are entered in the medical information system. When the respiratory therapist returns, the healthcare professional at the patient's bedside will

then inform him or her of the changes and possibly of the new blood gas levels. The respiratory therapist can easily confirm the order and who made the changes, in case there are any doubts about what was done. By obsessively keeping all members of the team in the loop, the efficiency of the weaning process has been optimized. As part of the team, the respiratory therapy department takes on the responsibility of providing in-service orientation when new ventilators are introduced into the ICU; the expertise of the respiratory therapist is both admired and respected, and a basic degree of skill is maintained in other team members.

Therefore, it is difficult to countenance the efforts of some of our colleagues when they start to define their turf by legislation to the exclusion of others who may well have considerable expertise in a particular field. For instance, the Assembly of South Carolina has enacted legislation that has effectively excluded a qualified critical care nurse from certain areas of the management of patients undergoing mechanical ventilation. In that state, it is now illegal for a nurse to adjust the dial of a respirator. The usual anecdotes about disasters and desire for greater patient safety were trotted out as justification, but the results may well prove destructive to the development of meaningful collaboration.

The development of a close-knit team seems more important to outcome than who is in charge. Dedicated physician- and nurse-coordinated teams have both been shown to be effective.⁷⁻⁹ The resource we need to safeguard most is nursing care, and collaboration should help get the most out of what we have available. In the ICU, we need to define and separate high-dependency patients, who can be managed along some preordained pathway or trajectory with reasonably predictable outcomes, from critically ill, unstable patients who cannot. Then we shall be in a much sounder position to discuss minimal staffing ratios. If the nursing study on the effect of registered nurse staffing on patient outcome¹ is correct in its data, we should be finding ways to cut out the parts of the job that take the nurse from the patient's side and finding another member of the team to do those tasks. It is time to mow the lawn and keep the turf as close-cropped as possible!

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