

The Autonomous Nursing Staff in the Hospital

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Nurses have had an equity, that is, a stake in the health care endeavor since its inception. They have not, however, enjoyed parity. Parity, which connotes equality, is vital if nurses are to exert power and influence decision-making in the care process. Symmetry and balance, on the other hand, are organizational means by which parity can be built into the structure.

By employing the concepts of symmetry and balance, the three major departments controlling the care of hospitalized patients—hospital administration, medicine and nursing—can be aligned into an organizational system which facilitates the role expression of each and eases communication between and among them. Other professional departments such as dentistry, social work, and

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physical therapy are needed in the care of patients but they generally provide *ad hoc* services to the patient population as demands for their specialized services arise.

ACCOUNTABILITY

Symmetry and balance are not sufficient in themselves for the emergence of parity. Each of the three major departments also must be organized in such a design that systematic accountability is assessed for each participant. The model for nursing care, for instance, must reflect the constancy of patient assignment, a 24-hour responsibility for the clients, scientifically ordered care plans, and a method for unerringly fixing responsibility for outcomes including the detection of errors of either omission or commission. A highly desirable concomitant of this model is the identification of excellence so that effective functioning may be rewarded. Using the notion of perfect accountability is one of the best means of placing each practitioner on his/her mettle. It is a practical form of supervision since primary accountability for patient outcomes is placed clearly on the practitioners themselves. It elicits the finest application of the knowledge that each practitioner possesses.

MODEL CONCEPT VS. PRACTICE

A brief comparison of this conceptual model with the manner generally employed by nurses to organize the nursing care patients

might be instructive. The behavior generated by team nursing, or care by proxy, can more accurately be labeled "reflex practice" than scientific care. The mechanical similarity of care that exemplifies the behavior of nursing staff members throughout the country can be orchestrated in the ritualized way that care is given. Patients are managed by "morning routines," "afternoon routines," procedure books, policies, and rules—none of which is based firmly on scientific or experimental data. Nurses have not yet shed the heritage of the matron system which originated with the earliest form of organized nursing. Nurses must recognize the problem, but not be dismayed or distraught over its existence. The growing number of nurses with baccalaureate and graduate training has strengthened and broadened the scientific base possessed by nurses. A shift in attitude is the main requirement for changing the posture of the profession. To make critical decisions about the form and nature of new practice is an awesome, but far from impossible, task. In the face of the great uncertainty caused by ambiguous data which surface continuously in this period of rapid technological and social change, it is the only recourse of the true professional. Knowledge and the responsibility to apply it are essential to development.

DEVELOPMENT

To develop and implement an autonomous nursing staff, the concept of

parity, with all its implications, must be in central focus. An autonomous nursing staff is essentially an organization designed explicitly to permit:

1. the expression of clinical self-direction among nurses;
2. the fulfillment of their responsibility to patients; and
3. the acceptance of after-the-event sanctions rather than before-the-event controls over their practice.

Instead of relying on the control of practice through such mechanisms as an appointed hierarchy of nurse supervisors and administrators, individual practitioners will have to submit to the same risks that physicians accept in the area of legal and professional malpractice. Thus, all the repressive "protective" measures such as prior administrative consultation, excessive supervision, and the rubrics of functional nursing, must be abandoned.

Autonomy is not anarchy. Nurses' autonomy will precipitate very heavy demands on practitioners for greatly increased competence and skill. Autonomy also requires the formation and maintenance of a primary nurse-patient relationship. Autonomy demands methods for determining the skills possessed by each member of the staff, for maintaining those skills, and for requiring certain preconditions for entry to any of the several departments of the staff. Autonomy means having the right to obtain consultation on request and the obligation to undergo periodic reviews of clinical consistency and results. The medical model can serve as a general

prototype even though the particular techniques of the process may be different.

IMPLEMENTATION

Staff autonomy places the responsibility for adequacy and safety in nursing care directly on the nurses themselves. The nurses are collectively accountable to their patients, *and* to the governing boards of hospitals and agencies.

To implement this responsibility, nurses must use a process similar to that employed by the medical staff. They must:

1. control access to staff and practice privileges,
2. confirm background education and certification,
3. review clinical work through appropriate committees,
4. see that shortfalls (less than adequate care) in practice are determined and remedied,
5. delimit practice privileges,
6. develop quality assurance mechanisms
7. delineate requirements for continuing education,
8. participate in the educational preparation of nursing students, and
9. engage in research to improve care.

Because specialization in nursing is increasing greatly, the departmental responsibility for peer review and quality of care is just as necessary as it is in the medical departments.

Through the committee structure

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and the directing body (usually an executive committee and an elected chief-of-staff), the autonomous staff will maintain consultative relationships:

1. with the board of trustees over qualifications for nursing staff membership and appointments and for standards of care,
2. with administration over logistical, material, and management related issues, and
3. with the medical staff and the departments of the other health professions, e.g., dietary, social work, physical therapy, occupational therapy, clinical psychology, and with whatever other departments may exist in order to share power and accountability (see Figure 1).

FUNCTION AND COORDINATION

The functions of an autonomous nursing staff would depart to a considerable degree from the principles stated in the *Accreditation Manual for Hospitals*, JCAH, as updated in 1973. The principles stated by JCAH clearly delineate the medical staff as a self-governing body responsible and accountable to the Board of Trustees for its professional practice, but the nursing staff bears its primary relationship to hospital administration. If nurses are to achieve full professional status, they must assume, with alacrity and zeal, all the obligations and accountability which accompany that privilege.

The work of all professional staff members must be coordinated to

insure the protection and amelioration of patients. The nursing and medical staff can best accomplish this objective by means of joint practice committees which examine the congruency of their role functions and interventions. A future development for hospital care process management might well be the formation of a hospital professional staff that would include the departments embraced by medicine, nursing, clinical pharmacy, psychology, dentistry, podiatry, and those other clinical departments which are organized and available for the care of patients. Hospital administration should have representation on this professional staff in order to aid the coordination effort and to allocate resources to attain the care objectives.

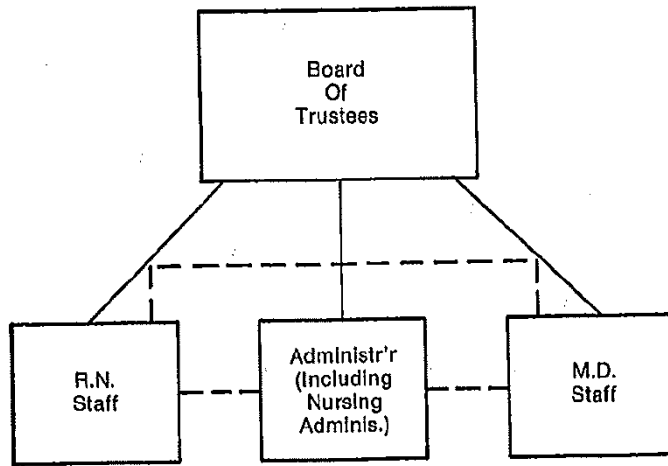
Administration

The functions and activities of the directors of nursing and other administrators will change in direct proportion to full autonomy. As is now evident in medical staffs, some full-time chiefs of services on salary will continue to exist, as well as other types of roles, such as educators and consultants. An autonomous staff will increase the options for career patterns rather than limit them, but the role expression of professional competence will have a different emphasis.

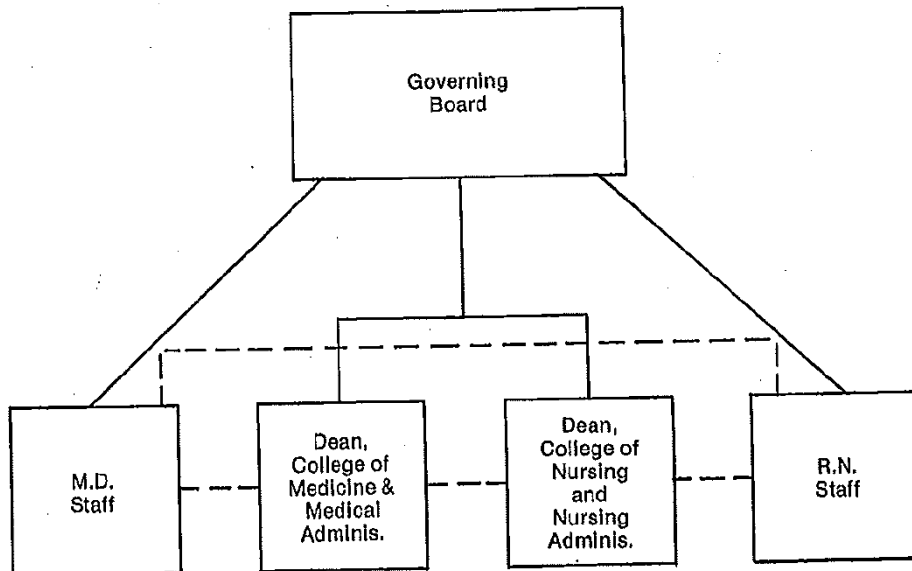
Patient Billing

The patient-nurse relationship in the accountability model being discussed virtually demands individual patient billing for nursing services rendered. The cost will be based on

FIGURE 1 AUTONOMOUS STAFF RELATIONSHIPS



Schema for Non-teaching Hospitals



Schema for Medical Center Hospitals

actual time requirements and actual forms of service needed to assist the patient. Such a billing arrangement is quite feasible; it presently is being used in at least one hospital. Whether the patient pays directly or not is beside the point: the patient can determine from the bill precisely those services which nurses have performed. All types of permutations and combinations on this theme of direct billing are possible. Nurses could contract with their respective hospital administrations under direct billing of nurses' service through the hospital to collect their compensation solely from such billings, knowing full well they would have the same bad debt problem that faces physicians. Another possibility is to have departmental contracts for each of the specialty departments. These contracts might vary in terms and conditions according to the desires of the participants and to the services generated, and the option to all nurses to remain on salaried reimbursement with variations according to levels of practice continues to be a possibility. At this point of conceptualization, it is unnecessary to cite a variety of types of reimbursement models. The few mentioned here are suggestive of the variations that can be implemented.

NEW LIFESTYLES

It appears that medical center hospitals and their affiliated hospitals and care networks have the nursing resources, as well as the skills and understandings of hospital adminis-

trators and physicians, to enable the creation of autonomous nursing departments as a viable model. Wholly new lifestyles for nurses must be experienced and learned before such a professional system can be transmitted to students and to colleagues working in less sophisticated settings. The full responsibility for standards of care is more than rhetoric. Standards must be empirical and based on scientific content. It will take time and energy to master the lifestyle embracing all the issues attendant to this process if the performance of an autonomous nursing staff is to have credibility with patients, governing boards, and colleagues among the other professions.

The many problems that are perceived at first as being almost unmanageable probably will disappear after the enterprise is underway. As one example, the staff may show a greater tendency to stabilize because of the intrinsic satisfaction derived from helping to control their own destiny. A system of a courtesy staff living side by side with a full active staff is one way of distinguishing between the comers and goers and the core professional staff. Status will abide in full staff membership as so much energy is devoted to becoming competent enough to earn full status. Nurses who have originally organized for collective bargaining have previously manifested this experience with beginning autonomy even though that autonomy is ordinarily limited to highly specific issues. This experience can be tempered and used

by nurses in an exciting professional adventure to develop fully the service of nurses to patients and to greater satisfaction for themselves. Collective bargaining may diminish in economic importance as direct billing provides a marketplace indicator for nursing services and is a provider of income for nurses, but it may portend the rise of other self-realizations. A word of caution: it would be unwise to allow the organization of the autonomous nursing staff to develop in the manner of a fad. If this occurs, more form than substance almost surely will result. The move toward an autonomous staff should proceed with deliberate staging and orderliness until a critical mass of hospital nursing staffs have successfully adopted the model. It cannot be implemented so swiftly that nurses fail to understand the endeavor.

SOCIAL CONTRACT

Professions are social monopolies. As with all monopolies, obligations as well as rights and privileges accrue to them. How well each profession carries out its social contract to society will determine its social worth and its apportionment of social rewards, esteem and other forms of extrinsic incentives. Nurses must begin seriously to put it all together in a paradigm of scientific excellence, precise measurement, and sustained improvement of competence if they expect to have a greater image among their fellow practitioners and the public. Nurses no longer can blame "them" (meaning

hospital administrators and physicians) for lack of development and for innovative change. The true professional looks to himself for the emergence of self-control and self-actualization.

OPEN DOORS

The National Joint Practice Commission has recommended the formation of autonomous nursing staffs as a basic prerequisite to effective collaboration between the nurses and physicians on the staffs of hospitals. Patients, physicians, and hospital administrators are expecting nurses to respond to new developments. The doors have been opened; it remains to be seen whether nurses will pass through and grapple with the future or remain comfortable, passive, and inert. There is risk, but the professional excitement of improving care to patients can become a marked stimulus to the growth of the profession and to the elimination of outmoded stereotypes. This air of excitement can be the catalyst that insures success—and it can be infectious.

The concept of an autonomous nursing staff is essentially a means of organizing so that the mutual expectations of nurses and physicians for each other can be met with regularity. Resultantly, the expectations of patients for both will be met with a fullness and richness never before present. To create an autonomous nursing staff requires a change of attitude, but not a new technology. It

- 44 can be achieved without a large capital outlay or the use of esoteric sciences. Autonomy has, as its basic components, personal accountability and shared power and influence. This accountability and influence are outcomes of the organizational format and the style of behavior whereby nurses organize for practice. An autonomous nursing staff is feasible. It is professionally exciting. It cannot be done *for* nurses; it must be done *by* them. Will nurses aspire to this level of professional development?