Accountable But Powerless

Unable to deliver high-quality care, a nurse calls it quits, but not before blowing the whistle.

by Barry Adams

Having grown up with both a mother and a cousin who were registered nurses, I was familiar with both the value and the inherent challenges of being a nurse. My own experience of being a patient who was hospitalized twice for open-heart surgery before the age of thirty also taught me the importance of competent nursing care. Yet nothing could have prepared me for my own sojourn in nursing.

The profession’s sharpest dilemma crystallized for me during a 3–11 evening shift in 1996, after a nurse supervisor assigned nine patients to my care. One of them was a man with terminal cancer who required frequent increases in pain medication as his disease progressed. Following the institution’s policy, which required a new prescription order for every increase in narcotic dose (rather than the more flexible range often allowed in care of the terminally ill), I phoned the ordering physician for the third afternoon in a row.

He informed me that he was very busy and I was not to call him again. Instead, he demanded that I get the order from his office helper. I attempted to explain that I, too, was very busy, being responsible for eight other very sick patients, and that I was required to follow hospital policy. I reminded him that it would be illegal for me to accept a medication order from an unlicensed assistant. Furious, he asked me to produce the law in writing. Embarrassed that I had never read the law, I agreed. I obtained a copy from the state nursing board; highlighted chapter 112, section 80B, which states that an RN can only receive medication orders from an “authorized” prescriber; and mailed it to him. (Only after I promised to mail the law did he provide the verbal prescription I needed.)

But after finding the law I needed, I kept reading. One particular line caught my attention: “Each individual licensed to practice nur-

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ing in the commonwealth shall be held directly accountable for the safety of nursing care he delivers..."

Hands Tied

At that moment I understood the contradiction that makes nurses flee a noble profession that should be a rewarding career. Although RNs are identified as the last safety net for the patient and are held to high standards of professional accountability, we have no authoritative voice in a health care system that often does not put patients' needs first.

I clearly recall a discussion at the family dinner table thirty years ago after my mother, who was a county public health nurse, was told by her employer not to discharge Medicare patients who, in fact, no longer required nursing care and thus no longer qualified for Medicare reimbursement. The object was to assure ongoing revenue for the county public health department. Indignant, she protested. But she was immediately reminded by her supervisor of the price of rocking the boat: She might lose her job.

Most nurses in this country are "at-will" employees who can be fired without reason unless the firing involves discrimination or other violations of the law. We are expected to take commands from employers, even when the orders may not be in a patient's best interest, yet it is we who are held directly accountable for patient care and outcomes.

When I graduated in 1992 from a university-based nursing program, U.S. health care financing was in the middle of a dramatic upheaval. Viewed by hospitals largely as labor costs rather than as cost-effective, licensed care providers, nursing staffs were cut across the nation for the sake of other budgetary priorities. Predictions for the future of the nursing profession were bleak. I began my career wondering if a nursing education had been a poor investment. I decided that a variety of clinical experiences in different practice settings would be the best way to build my knowledge base and increase my marketability. Per diem employment in nursing was becoming the industry trend, so finding shift work to supplement my first job (which required day, evening, and night rotations) was not difficult. But no matter where I worked, it became obvious that an honors degree in nursing was meaningless when trying to provide high-quality care for nine, twelve, twenty-four, or forty sick patients.

Administering two rounds of numerous medications (intrave-
nously, orally, or by injection) to a randomly assigned number of patients with complex medical and nursing needs was, more often than not, impossible in an eight-hour shift. Even the days when this risky drill was accomplished, everywhere I worked—two hospitals, one inpatient hospice, and several nursing homes and home care stints—nurses were voicing alarm that standard safety checks were becoming lost in the race against time. Commonsense error prevention measures, such as questioning the physician’s medication orders and determining if the right drug and the right dose were being given via the right route at the right time to the right patient, were being overlooked. Furthermore, an increasing number of minimally trained, unlicensed patient care “technicians” were quickly becoming the hands-on care providers to a patient population growing ever sicker as hospital admissions and length-of-stay decreased.

Aggravating registered nurses’ efforts to provide good care while being overworked was the need to comply with assorted institutional policies, individual insurer and HMO mandates, state and federal regulations, and an ever increasing crush of paperwork. Ironically, the purpose of many of the forms was to document that patients were receiving the cost-effective, high-quality care that Medicare and private insurers expected. Which, of course, they were not. After only two years of working as a nurse, I decided that the profession was not for me, and I joined the growing ranks of nurses who were leaving clinical practice.

I accepted a position as a liaison for a community-based nursing HIV program. But, uninspired after a year away from patient contact, I decided to try again. I took a thirty-two-hour-a-week position on a newly opened subacute unit caring for patients with cancer, AIDS, and a plethora of medical and postsurgical conditions that required close nurse observation and medication monitoring.

Increased Medical Errors

Within months, as the hospital restructured to meet an anticipated financial crisis, the numbers of patients being cared for by nurses increased. As more nurses left, the ratios continued to climb to nine, twelve, and sixteen
patients per nurse, even more on the night shift. To cover the gaps, nurses were working overtime and being floated to other units. During one particularly frenetic evening on an unfamiliar unit, I was given only a tape-recorded report and assigned ten patients with whom I was completely unfamiliar. I approached my supervisor and protested the deteriorating conditions. She supported my concerns but said that her hands were tied. The new staffing directives were coming from the hospital administration and nurse executives. I requested a meeting with the director of nursing. My supervisor told me, “There will be no meeting. She told me that if you want to keep your job, you will not do that [raise such concerns] again.”

Potentially dangerous medication errors happened often during the months that followed. Insufficient nursing coverage resulted in more patient falls, poor wound care, and patients’ going unmonitored or unexamined for hours. Despite minimal staffing, newly admitted patients continued to be sent to the floors. Patients’ and families’ complaints increased dramatically. Three patients were threatening to sue the hospital for lack of care and demanded transfer out of the facility. Adding to the growing alarm and indignation of the nursing staff was an employee newsletter in which the administration lauded, as an indicator of high-quality care within the facility, the recent three-year accreditation granted by the Joint Commission on Accreditation of Healthcare Organizations.

Blowing The Whistle

In 1996, bolstered by the language of the Massachusetts law on the accountability of nurses and my own observations of inadequate nurse-patient ratios, poor care, and medication errors, I sought out the director of the nursing department. “There are no unsafe work environments, only unsafe nursing practice,” she said in response to my protests. A series of meetings that included the director of human resources followed. Within the month, despite an unblemished employment history and a personnel record that called me a “role model for nursing,” I was issued a disciplinary action that accused me of having difficulty with problem solving and managing my time. When I refused to sign the disciplinary document, which would have signified my consent to the allegations and jeopardized my employment, I was fired for insubordination.

Together with another nurse who was disciplined one week later after reporting short staffing to the director of nursing, I sought out what seemed to be our only recourse. We jointly filed a complaint
with the National Labor Relations Board (NLRB) for unfair labor practices. Another complaint from a third nurse, accused of patient neglect after raising similar red flags, followed. Six months after I was fired, a two-day trial was held in Boston. In November 1997 a federal judge for the NLRB ruled that I was illegally dismissed by the nurse executives in an attempt to silence and retaliate against me for expressing differences with management. I was ordered reinstated with back pay and the other nurses compensated for any lost wages due to the mandatory shift rotations that were punitively instituted after they, too, documented poor staffing. I declined reinstatement at the hospital; by then I was working as an IV infusion nurse for the Boston Visiting Nurses Association.

No Support From The Nursing Board

What followed was a game of duck and cover involving state regulatory agencies after the high-profile accidental overdose death of a hospital patient in the same month I was fired. The Massachusetts Department of Public Health, which I had previously contacted about conditions at my hospital, investigated the death. Its findings included two counts of patient neglect, two counts of lack of professional and technical services in the department of nursing, and several violations of administrative policies. But questions remained, such as how the facility achieved an accreditation by a federal regulatory agency amid a swell of nurses' concerns.

Of great importance to me and my fellow nurses was that the state nursing board violated Massachusetts law and its own regulations by ignoring my complaints of unprofessional and unethical conduct involving my hospital's nurse executives. The Massachusetts Board of Registration in Nursing is, in theory, supposed to investigate all nurses' complaints, whether they be about superiors or subordinates. Not only did the board refuse to do this, but in a wry turnabout it later investigated me based on an “unprofessional conduct” charge against my nursing license by the hospital's director of nursing. After I hired an attorney, the charge was dropped.

This was the board that at about the same time held eighteen staff nurses at the Dana Farber Cancer Institute accountable for the widely publicized fatal chemotherapy overdose of a Boston Globe journalist. Accountability for this accident was complicated by the fact that the institute was restructuring at the time, no nurse was heading the nursing department, the drugs involved were experi-
mental, and internal policies about the treatment protocol were not available to nurses; yet the board refused to analyze the case in light of those special circumstances.

After I navigated my way through a labyrinth of several state offices, including that of the governor, the board of nursing requested that I meet with an executive committee to discuss my continuing concerns about the accountability of nurse managers. I was asked to bring materials or witnesses to assist them in the matter. I did so, but the board refused to hear from my witnesses or review the evidence, thus shirking its responsibility (state law defines the board’s purpose as overseeing nursing practice and examining ethical and professional conduct).

More than four years of growing national attention, combined with a legal action charging the board of nursing with violation of Massachusetts law, forced the board to hold a full hearing. With observers packed into a small hearing room and a thousand pages of evidence before them, the Massachusetts Board of Registration in Nursing found “no evidence” of wrongdoing on the part of the hospital nurse executives. The board has a reputation among nurses nationwide as being unresponsive to patient care nurses who file complaints about nurse supervisors and protective of higher-ranking nurses. But I hear nurses around the country describe their own state nursing boards similarly, if not quite as severely. And there has been an exodus of nurses from the profession. I left in 1999, no longer able to see nursing as a viable career option.

Epilogue: After continued media attention following my case, the hospital’s CEO and RN administrator resigned, the director of nursing left, and the hospital closed its subacute unit. The hospital has since created a new policy that seeks to protect employees from retaliation for “good-faith” reporting of concerns through internal procedures, including a toll-free “integrity help line” run by an outside firm. In May 2000 I attended the Massachusetts governor’s public signing of a law that protects licensed health care workers from retaliation if they blow the whistle on unsafe conditions. Other states have similar legislation, but nurses across the country need the same protection. The cost of silence is too high, both for patients' health and for the health of the nursing profession.
Mosaics And Misery

Corridors of anticipation we were,
Green scrubs, white coats and yellow gowns,
Prepared for the battle our Medi fathers waged
And won.

Our mosaic of color,
Stood and waited, Hopeful and proud.
Managed care and market share, irrelevant.
Healers again, ready to serve.

We hoped for a long night and day,
Aching fatigue and sleep deprivation
Fantasies of the worst of residency nights
So busy as to forget the images of the morning.

A curse to note the quiet,
We stood, Horrified by the silence,
As the fumes came North,
The sky grew as dim as our hopes.

Like the grey of Poland,
We feared incineration.
Ashes to ashes and dust to dust.
Our patients ethereal now, shadows in the sunlight.

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