A Provocative Conversation
With Peter I. Buerhaus, PhD, RN, FAAN

IN SEPTEMBER 2010, PETER I. Buerhaus, PhD, RN, FAAN, was named chair of the National Health Care Workforce Commission, a 15-member panel composed of distinguished leaders from academia and the health care industry created under The Patient Protection and Affordable Care Act.

Reporting to the U.S. Government Accountability Office, the Commission’s role is to:

- Serve as a national resource for Congress, the President, and states and localities.
- Communicate and coordinate with federal departments.
- Develop and commission evaluations of education and training activities.
- Identify barriers to improved coordination at the federal, state, and local levels, and recommend ways to address them.
- Encourage innovations that address population needs, changing technology, and other environmental factors.

He is also director, Center for Interdisciplinary Health Workforce Studies, Institute for Medicine and Public Health, Vanderbilt University Medical Center, Nashville, TN.

In this interview, Dr. Buerhaus, a frequent contributor to Nursing Economic$ and former journal editorial board member and columnist, discusses the future of hospital nurse staffing, nursing economic accountability, and how all nurses should not only be prepared for the impending changes affecting health care but take action to help implement those changes to strengthen the nursing profession.

Implementing Evidence Into Practice

Kathy Douglas (KD): There is a large body of evidence that could be used to assist hospitals in implementing staffing programs which are based on evidence. Why do you think we’re having so much trouble getting evidence into practice?

Peter Buerhaus (PB): It’s slow and difficult because changing staffing practices can be very expensive. Providing health care in hospitals is labor-intensive, and nurses account for a high proportion of those labor costs. It is understandable there would be resistance and inertia by hospital decision makers to get behind changes that might substantially affect their labor costs.

Because nursing is provided 7 days, 24 hours a day, it is difficult to incorporate care delivery processes and variations in the activities a patient experiences across two or three nursing shifts each day during the week and over the weekend. In addition, nurses are not the same in that they vary by education, experience, skills and competency, knowledge, attitudes about their work, and their beliefs of what it means to be a nurse and how they contribute to an organization’s...
mission. These factors and more add further complication and opportunity to resist change.

Cultural and organizational barriers often slow down changing staffing levels and care delivery practices. The presence of unions and collective bargaining can also be barriers to change or make it more difficult. People are comfortable with what is familiar, and that is an important barrier. I also think many nurses and managers are not reading the literature or are not aware of the evidence linking nurse staffing with patient outcomes, and thus, may not fully realize or know that changing staffing practices might be important.

Then there is uncertainty about how changing staffing will affect the organization’s performance in terms of lowering costs or improving reimbursement. I suspect many CNOs and financial and other operations people question whether and how changes in staffing will impact patient outcomes or benefit hospital operations.

Finally, I am somewhat frustrated in that studies we and others have published that show relationships of staffing and adverse patient outcomes have not led to nurses taking more responsibility for these outcomes. Instead, they are blaming hospitals, saying in essence, “Our hospital doesn’t treat us well; therefore, adverse outcomes continue to be experienced. If they would just listen to us and improve our life, we could do better to decrease adverse outcomes.” Many RNs are not stepping up and taking responsibility and saying, “These outcomes are occurring, and they are associated with nurse staffing. What can we do as nurses to improve and assure they are not occurring in our institution, and on my nursing unit?”

KD: In today’s economic environment, it is not uncommon to see cuts in staffing, which could have more far-reaching implications than managing labor costs. How do we get CFOs and COOs to take evidence in staffing more seriously?

PB: Let me be direct: nothing short of strong, clear, and meaningful economic incentives will motivate a change in their behavior. Their financial interests need to be tied directly to making sure their hospital has adequate staffing and other resources so nurses can do better to avoid poor patient outcomes—that is the fastest, quickest, and most direct way to get those who control resources to change. When CFOs and COOs realize achieving their economic interests is tied directly and more consequentially to nurse-sensitive patient outcomes, then all the barriers and resistance to change I mentioned previously are likely to diminish. We don’t have those incentives right now.

Nurse Credibility Reflected through Evidence

Karlene Kerfoot (KK): Do you think not paying for adverse events is going to help at all?

PB: It has already started by getting long-overdue conversations underway, conversations that are occurring at a deeper level than some readers might appreciate. But they are not yet at the breadth and intensity needed to offset the uncertainties and other changes in the political, economic, and regulatory environment that hospital executive decision-makers face.

KK: We do have these studies available, but then some start poking holes, critiquing, and discrediting them. I don’t know what that’s all about. So, are the studies not valid, or do we need more rigor in how we do the studies?

PB: Over the years, a strong motivation of mine has been to address exactly that question, and this was a primary reason for conducting the study published recently in the New England Journal of Medicine (Needleman et al., 2011) about hospital mortality and nurse staffing. When Jack Needleman, myself, and our colleagues published the first paper in 2002 in the NEJM, a relationship between nurse staffing and five patient outcomes was established, and it changed the policy focus. It catalyzed concern about nurse staffing and quality of patient care at a time when the quality movement was taking hold. It established that nursing matters.

Until that publication in the NEJM and Linda Aiken’s in JAMA (2002), I did not perceive thought leaders in the quality movement were giving nursing enough serious attention. They did not seem to realize how critical nurses were to achieving their quality and safety improvement goals and agenda. So these initial publications and others elevated the credibility of nurses’ contribution and helped facilitate the role of nursing to be more meaningfully included in both national and hospital-level quality discussions. But these articles also led to a series of valid and important criticisms, particularly because some researchers thought we were assuming or trying to prove causality in our studies and in Linda’s studies. That was not the case. We were showing evidence of strong associations given the limits of our data and the analytic methods used at the time. Over the past decade, Jack and I observed expressions of doubt over the results of nurse staffing studies, and we realized that these concerns needed to be addressed.

Therefore, our most recent NEJM study focused on addressing key methodological challenges and criticisms that had been raised, and hopefully, moving the discussion about staffing into more productive and forward thinking ways. We hope this study communicates directly to policy makers involved in shaping hospital payment policy; they must be very careful to consider the effects of payment changes on hospitals.
and ensure policies will reward hospitals to invest in nursing and in the resources needed by nurses.

**The Caring Attribute**

**KK:** Can you imagine a future where we actually have enough evidence that we have a way to set standards or create something that people have to live up to?

**PB:** I disagree with the notion of compliance with respect to staffing standards. To me, such standards imply that we have the necessary knowledge and the necessary ability to comply with staffing standards every single shift, every day, etc. Also there is no certainty that compliance will result in obtaining the desired patient outcomes every single time, regardless of anything else that might be going on in the environment and with the patient. Rigid adherence to standards that govern the inputs of production can (and should) be done in some industries. This is largely how many producers achieve reliability and uniformity in product quality and lower cost. But the world of nurse staffing is far more complicated because of uncertainty about treatments, multiple levels of decision making, and great variation in the quality of physicians and nurses. Plus, no two patients are alike just like no two nursing units are alike, not to mention the constant evolution in the use of new technology to diagnose, treat, and monitor patients, and on and on. So applying standards to nurse staffing doesn’t make sense. Rather than compliance to staffing standards, I believe the future would be one where nurses are more focused on assessing patient needs, working with their organizations to accommodate care delivery processes and nursing practices to meet these needs, adjusting resources, flexing and adapting, and pursuing change and innovation to find better ways to achieve the goal of patient care and excellent nursing, all along bringing forward the humanistic aspects of nursing to patients and families. More nurses would be asking, “How do I pull all these unique factors together in ways that improve care and more effectively benefit the patient?” versus coming to work wondering, “Is the hospital complying with the staffing ratio on my shift?” The latter mindset leads to nurses becoming focused on the ratio versus focused on understanding the patient’s needs and how nursing can improve to provide the right care needed.

**A Wake-Up Call for Nurses and Nurse Educators**

**KD:** This speaks to a big concern. It takes away the decision-making authority and responsibility of the nurse. If we give that away, we give away the essence of the role of the registered nurse.

**PB:** I am disappointed over efforts to put patient-to-nurse ratios into practice and do not understand why nurse researchers use their precious time and abilities to conduct studies aimed at determining the affect of ratios. I wonder if they have stopped and thought hard about the concept of a ratio; their usefulness; purpose; applicability to care delivery in a highly complex interpersonal, technical, and information-dominated system; intended and unintended consequences; whether and how they might contribute to organizational resilience; the affect on core professional values and on nursing’s social responsibility; or thought about ratios from other disciplinary perspectives, especially economics, policy (public and private), sociology, clinical practice, organizational, systems, and safety, to name a few.

Rather, to me it seems researchers have been caught up by the lure of the introduction of ratios in California as constituting a “natural experiment,” and thus, a rare opportunity for analysis that must be acted upon. I have read the staffing literature, and it is devoid of critical thought, lacks a theoretical perspective, fails to raise important questions, and has not provided constructive insights. I have tried to raise concerns by publishing four manuscripts that focused on a few underlying conceptual issues connected to ratios, and I am struck by the deafening silence they have generated. There have been no rejoinders, no thoughtful counterpoint of views that I am aware of. Where is the argument and debate over a development that could unwittingly undermine the value and relevance of the entire nursing profession at a time when the profession is being called upon in ways that will require innovation, change, flexibility – the attributes that are exactly opposite of a ratio mentality? I do not see evidence that my colleagues in nursing research are taking the time to think deeply about this subject. Instead, in their rush to do studies, they have added to the visibility of the issue and perpetuated a notion that ratios are even worth studying. Not all ideas or developments make for good research or important research. The idea of applying ratios is absurd, counterproductive, and backward thinking. I believe some people think there is an “optimal ratio,” an idea that has no merit whatsoever. Ratios are a bankrupt idea, and their widespread implementation could slowly bankrupt the profession. I would not want to be associated with a profession that allowed itself to be dumbed down to the point where it self-inflicted onto the profession the very notion it abhors: “a nurse is a nurse is a nurse.”

I would love to see a 2 to 4-day conference of thought leaders in and outside of nursing who would come together and argue, think, debate, and seriously ask, “What are the most important questions facing the nursing workforce?” They could then spend time developing a specific strategy for how these questions could be addressed conceptually, empiri-
ically, and with attention to the needs of public and private policy makers. Bring the top doctoral stu-
dents in the country to the conference and engage them in great questions. We need deep thinking now to guide the profession over the decade. Implementing the Institute of Medicine’s (IOM, 2010) 8 recommendations is a timely and worthwhile agenda over the next 10 years, but there are deep issues that need to be thought through and acted upon if nurses are to do well for society, thrive as a profession in the emerging delivery system, and take full advantage of the efforts to implement the IOM 8.

**Economic Accountability**

The other challenge developing now that will grow larger over the decade is, “How do we get staff to see themselves as increasingly critical to the survival of the institutions that employ them?” Because of the accumulation of so much national debt that will constrain spending for years to come, I anticipate it will be increasingly difficult for many institutions to have the financial resources they would like, and so the contributions of nurses are going to be more critical to the economic survival of organizations. Nurses need to begin to anticipate such a future and start to practice with more economic accountability.

I don’t mean that nurses should be going around and reducing costs all the time. Yes, you want nurses to be more visible in actively reducing costs by reducing waste, but by economic accountability, I think more about nurses who are focused on testing innovations and generating ideas to help nurses do their work more effectively with less hassle and ways that save time. Nurses should be asking how they can innovate to become more sensitive to patient satisfaction and achieve desired clinical outcomes – to see themselves as innovators and improvers. There are challenges for nursing’s leadership to get the profession to practice with greater economic accountability. The change can’t be accomplished in health care delivery organizations alone, but it has to involve nursing education programs. However, I am not confident the schools are emphasizing the economic dimensions of nursing practice to the degree needed.

So there is a big wake-up call for nursing educators to build more content into the nursing curriculum about the financing of health care, underlying economic incentives facing providers, and how nurses can shape their practice to leverage these incentives in ways that are more efficient and accountable. Once a significant portion of the nursing profession embraces such a world, they will help other nurses realize how profoundly valuable the nursing profession is to an organization’s survival and to the welfare of the entire health care delivery system.

**The Nucleus of Health Care**

It’s all within nursing’s power; we’re just not seeing it. Nurses need to become motivated and realize how much power this could bring to our profession. It will be the nurse executive with vision and leadership that has to convey the power of accepting greater economic accountability. One way I would suggest is to take advantage of this time in our lives where everyone is focused on the economy. Everyone knows the recession is “technically over,” but in most parts of the country, it doesn’t feel like it. Unemployment rates are still high, and consumer confidence is low. Why not take this natural interest and concern over the economy and spend time with staff educating them about the nursing workforce, the economic conditions of the health care industry, how health care delivery and the nursing profession might evolve over the next few years. Together, we can begin to see the profession in a larger way, and how nurses can contribute to society and to the economic performance of health care delivery systems so we decrease wastes and costs, thus allowing more people to have greater access to health care. There is a rainbow forming around the economic and social worth of nurses, and more nurses need to see and act on that rainbow of opportunity. Nurses are the nucleus of the health care delivery system. However, in this decade, nurses need to practice with greater economic accountability to fully realize the profession’s potential.

**The Influence of Nurse Practitioners**

**KK:** Any other final thoughts you have to share?

**PB:** Most thought leaders and policymakers understand the influence of nurse practitioners (NP), or more generally, advanced practice registered nurses (APRN), will grow substantially. There is a realization that NPs are high-quality providers whose costs are not as high as physicians. Given what is currently known about their practice, thought leaders are seriously questioning why barriers exist that prevent APRNs from practicing to their potential.

We would not permit barriers to the adoption of cars that got 100 miles per gallon of gasoline and performed just as safely— that would not be accepted in society, particularly as the price of a gallon of gasoline increases. Similarly, I think policymakers are coming to realize that it makes little sense to prevent primary care delivery by NPs. We are in the process of seeing barriers fall away, and as they do, lead to changes that will open up limitless opportunities for APRNs to materially shape the health care delivery system in the next 15 to 20 years. However, I worry that some in the advanced practice nursing world have spent so long trying to get these issues in

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front of the public that understandably, they are not giving enough attention to pressing the education community to increase the quality of the advanced practice nursing workforce being produced.

Will Nurse Practitioners Be Ready?

To be sure, many education programs are producing very good APRNs, but others are not, and that worries me. The door is swinging open for APRNs, and it will open more and more and in new and unexpected ways, and it is all there for APRNs to walk through. But as APRNs walk into the delivery system of the future, will they be ready? Educators should pause and ask, “Are we producing strong, high-quality APRNs up to our potential so this workforce can live up to its promise?” APRN educators should do all they can to increase the quality of the APRN workforce.

REFERENCES


