

BALANCING THE RED CROSS: AN EXAMINATION OF HOSPITAL MALPRACTICE AND THE NURSING SHORTAGE

INTRODUCTION

I first started working as [a Registered Nurse] in the early 80s. I worked at the bedside for about seven years. Sure, there were times when I would tell my children, wait at the corner, I will pick you up in an hour and it did not happen. Women have been doing things like that forever. It's hard to get off work when there is a shortage. When I worked as an ambulate nurse, each person's life was dependent on me. It was just me and them. If I stopped, that person could die. It was that simple.¹

Hospital malpractice appears to have reached a peak in the United States.² Studies suggest that this trend has been in the works for well over a decade.³ A reporting of hospital deficiencies suggests a link between poor working conditions for hospital employees and an increased risk to patient safety.⁴ Specifically, "the long and unpredictable hours" that nurses work contribute to adverse effects on

1. Telephone Interview with Gingly Harshey-Meade, MSN, RN, CNAA, BC, CEO, Ohio Nurses Association ("ONA") (Jan. 6, 2007) [hereinafter Harshey-Meade Interview] (on file with author).

2. *See generally* INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1 (Florence Poillon ed., Nat'l Acad. of Scis. 2000) (1999) (discussing the factors contributing to the nation's hospital malpractice rates, and methods for improving patient safety).

3. *See generally id.* at 3 ("[h]ealthcare is a decade or more behind many other high-risk industries in its attention to ensuring basic safety."); Anne E. Rogers et al., *The Working Hours of Hospital Staff Nurses and Patient Safety*, 23 HEALTH AFFAIRS 202, 202-03, 208 (2004) (discussing the risks posed by overworked nurses; noting that the risks posed to patients begin to increase when nurses work shifts longer than 8.5 hours, and that risks increased significantly when nurses' shift durations exceeded 12.5 hours per day); Anne C. O'Neil et al., *Physician Reporting Compared with Medical-Record Review to Identify Adverse Medical Events*, 119 ANNALS INTERNAL MED. 370, 370, 375-76 (1993) (studying the problems associated with traditional quality-assurance devices in hospitals, and recommending that the current system be revised to more actively include physicians in care improvement efforts).

4. *See* Rogers et al., *supra* note 3, at 210.

patient care.⁵

In Part I of this note, we explore the cause of the current surfacing of adverse medical care: a universal nursing shortage. The nursing shortage stems from problems on two fronts: there is (1) a decrease in those entering the profession, and (2) an increase in turn-over rates. The shortage's common catalyst—*mandatory overtime*⁶—is addressed and discussed.⁷ The effects of this common catalyst on nurses are surveyed: fatigue, job dissatisfaction and lower-quality nurse health.⁸ Part I illustrates the cyclical relationship between high rates of hospital error and the nursing shortage, which has contributed to the rise of hospital malpractice and resulted in the neglect of patient and nurse health.⁹ Thus, in order to resolve the adverse effects of poor patient care, the

5. See *id.*; see also Mary Etta Mills et al., *Core-12: A Controlled Study of the Impact of 12-Hour Scheduling*, 32 NURSING RES., 356, 357, 360 (1983) (discussing the frequency of errors on a variety of fatigue-detecting tests.); Roger R. Rosa, *Extended Workshifts and Excessive Fatigue*, 4 J. SLEEP RES. 51, 53, 55 (1995) (discussing that the trend in hospitals toward increasing error rates with respect to patient care reflects the association between extended work periods and the poorer work performance of nurses).

6. See Rogers et al., *supra* note 3, at 209 (citing *Prohibition of Excess Overtime for Nurses Act: Hearing Before the H. Labor Rel. Comm. on Mandatory Overtime*, 108th Cong. (2003) [hereinafter Campbell Statement] (testimony of Michele P. Campbell, Executive Administrator, Pennsylvania Nurses Association), available at http://www.panurses.org/documents/hotissues/c_hotissues_testimony_10.20.03.htm (defining mandatory overtime as “nurses’ being told that they could be fired, be subjected to disciplinary proceedings, or lose their nursing license[s] if they refuse[] to stay beyond their regularly scheduled shift[s] or come in to work on their day[s] off”); *Health Quality and Medical Errors: Hearing Before the Subcomm. on Health of the H. Comm. on Ways & Means*, 107th Cong. (2002) (statement of Mary Foley, President, American Nurses Association), available at <http://waysandmeans.house.gov/legacy.asp?file=legacy/health/107cong/3-7-02/3-7fole.htm> (“ANA hears that employers are insisting that a nurse work an extra shift (or more) or face dismissal for insubordination, as well as being reported to the state board of nursing for patient abandonment.”).

7. Hospital use of mandatory overtime to compensate for the nursing shortage has both discouraged individuals from entering the profession and encouraged nurses to leave the profession. See generally JANET HEINRICH, U.S. GEN. ACCOUNTING OFFICE, GAO-01944, NURSING WORKFORCE: EMERGING NURSE SHORTAGES DUE TO MULTIPLE FACTORS 3-5, 8-9 (2001) (concluding that factors such as mandatory overtime and job dissatisfaction have contributed to the shortage of nurses in the health care industry). See also Rogers et al., *supra* note 3, at 208.

There are already hints that the fatigue associated with working twelve-hour shifts is contributing to absenteeism and job dissatisfaction among RNs. Fatigue related to length of shift or the potential of overtime at end of shift, or both, was identified as the cause of approximately 12 percent of the absences reported [N]urses working twelve-hour shifts reported significantly higher absenteeism rates than nurses working traditional eight-hour shifts.

Id.

8. See Rogers et al., *supra* note 3, at 208.

9. Ironically, the widespread implementation of mandatory overtime to resolve the nursing shortage has itself contributed to the resulting shortage. See *supra* note 7 and accompanying text.

needs of patients and nurses must be addressed.

In Part II of this note, we investigate state and federal legislative initiatives to resolve the adverse effects of the nursing shortage on patient care. We investigate these initiatives' strengths and weaknesses in addressing the public health crisis, and provide a close analysis of enacted state and pending federal initiatives. These proposals address solutions to the nursing shortage and problems associated with mandatory overtime, in context of their most severe consequence, adverse medical care. While several of these state initiatives have succeeded, no such federal legislation has been enacted. Further, in Part II, we examine the rationale behind the absence of federal legislation, and argue that pending federal initiatives fail to address the complexity of the public health issue—a product of two neglected vital elements: patient *and* nurse needs.

Part III sheds light on the positive impact that the passage of federal legislation, providing for limitations on mandatory overtime, would have on patient care. Specifically, in this section we address the likelihood of a reduction in hospital tort liability and the bolstering of a strong union presence among nurses, following the passage of such federal legislation.

Finally, Part IV concludes the note with a synthesis of the strengths of the state and federal legislative initiatives set forth in Part II, proposing a new federal initiative. In this part, we also discuss the positive and negative effects of such a proposal, suggesting strategies to promote its passage.

I. CAUSE OF INCREASED HOSPITAL MALPRACTICE

A. *Breadth of Overtime in Nursing Industry*

The increase of hospital malpractice has long been blamed on the health care industry's widespread use of overtime.¹⁰ The implications of proposed federal legislation limiting mandatory overtime for nurses cannot be grasped without understanding the reality of nurses' current overtime situation.¹¹ Despite longstanding concerns about the link

10. See Rogers et al., *supra* note 3, at 206.

11. See *generally* Safe Nursing and Patient Care Act of 2005, H.R. 791, 109th Cong. pmbll., § 2 (2005) (aiming to increase the quality of patient care by limiting nurses' mandatory overtime hours).

between nurses' overtime and hospital malpractice, researchers have not undertaken studies focusing on the correlation between the two until recently. These studies have revealed alarmingly high rates of overtime in the nursing industry.¹² By failing to distinguish mandatory overtime from voluntary overtime, researchers may be missing out on the vital distinction between the two and their respective effects on work performance.¹³

According to a report by the American Nurses Association ("ANA"), "[n]urses report a dramatic increase in the use of mandatory overtime as a staffing tool and fear potential consequences for the safety and quality of care provided to their patients."¹⁴ Nurses average about eight and a half weeks of overtime a year.¹⁵ In 2002, the amount of overtime worked averaged almost six percent of the total hours worked.¹⁶ One study found that fourteen percent of nurses studied worked mandatory overtime hours every day.¹⁷ The use of mandatory overtime is so widespread that many hospitals have official policies that require it.¹⁸ Also, as noted by the ANA, "[m]any nurses contend employers insist they work an extra shift (or more) or face dismissal for insubordination and being reported to the state board of nursing for patient abandonment."¹⁹ According to a 2000 ANA survey, over sixty-seven percent of nurses in their sample worked unplanned overtime each

12. See, e.g., Barbara Berney & Jack Needleman, *Trends in Nurse Overtime, 1995-2002*, 6 POL'Y, POL., & NURSING PRAC. 183, 189 (2005); Rogers et al., *supra* note 3, at 205-06.

13. Berney & Needleman, *supra* note 12, at 184 (citing Rogers et al., *supra* note 3, at 209); Linda D. Scott et al., *Effects of Critical Care Nurses' Work Hours on Vigilance and Patients' Safety*, 15 AM. J. CRITICAL CARE 30, 33 (2006) ("Although the nurses worked longer than scheduled on 5201 occasions, only 1443 (28%) of these were identified as overtime shifts. Of these shifts, 236 were reported as mandatory overtime shifts (16.4%), and 152 shifts were reported as 'coerced' voluntary overtime (10.5%)").

14. AM. NURSES ASS'N, DEP'T OF GOV'T AFFAIRS, NURSING'S LEGISLATIVE AND REGULATORY INITIATIVES FOR THE 110TH CONGRESS: APPROPRIATE STAFFING 9 (2007), available at <http://www.nursingworld.org/MainMenuCategories/ANAPoliticalPower/Federal/legis/CompleteInitiatives.aspx>.

15. Susan B. Hassmiller & Maureen Cozine, *Addressing the Nurse Shortage to Improve the Quality of Patient Care*, 25 HEALTH AFF. 268, 269 (Jan.-Feb. 2006) (citing NURSE ALLIANCE, SERV. EMPLOYEES INT'L UNION, THE SHORTAGE OF CARE: A STUDY BY THE SEIU NURSE ALLIANCE 3 (2001), <http://www.seiu.org/a/search.php> (search "the shortage of care," then follow "Contents: View as HTML" hyperlink) (last visited Apr. 5, 2008)).

16. Berney & Needleman, *supra* note 12, at 186-87.

17. LONNIE GOLDEN & HELENE JORGENSEN, ECON. POLICY INST., TIME AFTER TIME: MANDATORY OVERTIME IN THE U.S. ECONOMY, 9 (2002), available at <http://www.epi.org/briefingpapers/120/bp120.pdf>.

18. See *id.*

19. AM. NURSES ASS'N, *supra* note 14, at 9.

month.²⁰

Members of the hospital staff often intimidate or coerce nurses into working mandatory overtime by threatening them with charges of patient abandonment, or even with termination of their employment.²¹ Since charges of patient abandonment can result in the loss of nurses' licenses, many nurses are fearful that such charges will be brought, even if they are not actually guilty of any misconduct.²² As such, nurses are essentially not free to decline overtime "requests."²³

Trend Toward Increase

Even more alarming than these numbers is the fact that they are rapidly increasing. From 1995 to 2002, the amount of overtime a sample of New York nurses worked increased by more than fifty percent.²⁴ While some hospitals in that seven year period decreased their overall use of overtime, more than twice as many increased their use of it.²⁵

It is important to note that this increase in hospital nurse overtime has occurred in tandem with an increase in patient turnover rates.²⁶ Specifically, the average length of an acute care patient's stay decreased from 6.7 to 5.2 days.²⁷

This higher turnover rate translates to more work for individual nurses because patients generally demand more attention on admittance than during the duration of their hospital stay.²⁸ In addition, nurses are responsible for "patient education and planning upon a patient's discharge."²⁹ Thus, increased patient turnover rates mean nurses have more demanded of them.³⁰

20. *Id.*

21. Am. Nurses Ass'n, *ANA Government Affairs on Mandatory Overtime*, NURSING WORLD, <http://nursingworld.org/MainMenuCategories/ANAPoliticalPower/Federal/Issues/MandatoryOvertime.aspx> (last visited Apr. 8 2008).

22. *Id.*

23. *Id.*

24. Berney & Needleman, *supra* note 12, at 186.

25. *Id.*

26. See HEINRICH, *supra* note 7, at 2-3.

27. Berney & Needleman, *supra* note 12, at 186. Acute care is defined as "[s]hort term care for serious diseases or trauma." STEDMAN'S MEDICAL DICTIONARY FOR THE HEALTH PROFESSIONS AND NURSING 23 (5th ed. 2005). See also COMM. ON THE WORK ENV'T FOR NURSES & PATIENT SAFETY, INST. OF MED. OF THE NAT'L ACADS., KEEPING PATIENTS SAFE: TRANSFORMING THE WORK ENVIRONMENT OF NURSES 42 (Ann Page ed., 2004) [hereinafter KEEPING PATIENTS SAFE].

28. See KEEPING PATIENTS SAFE, *supra* note 27, at 42.

29. See *id.*

30. *Id.*

Union vs. Non-Union Hospitals

Surprisingly, researchers have found that union hospitals use more overtime than non-union hospitals.³¹ This result is best explained by the greater incentive of unionized nurses to report the overtime hours they work.³² Union contracts are likely to have firm definitions of what constitutes overtime, encouraging unionized nurses to report and be paid for all overtime hours worked.³³ Non-unionized workers with work weeks comprising fewer than forty hours might not be paid overtime unless they work in excess of forty hours.³⁴ Thus, unionized nurses are likely not working more hours than nurses in non-unionized hospitals, but they are likely reporting their overtime more accurately because they have an incentive to do so.

For example, the Massachusetts Nurses Association emphasizes the importance of including clauses about mandatory overtime in contracts it has negotiated for nurses.³⁵ Such clauses define when mandatory overtime can be used, set forth procedures that must be followed in assigning overtime, and place limits on the number of hours hospitals can require nurses to work overtime.³⁶ At Boston Medical Center, whose nurses are represented by the Massachusetts Nurses Association, nurse supervisors can only mandate overtime in the case of a serious emergency, and cannot mandate more than four hours of overtime for an individual nurse at once.³⁷

31. Barbara Berney et al., *Factors Influencing the Use of Registered Nurse Overtime in Hospitals, 1995-2000*, 37 J. OF NURSING SCHOLARSHIP 165, 169-70 (2005).

32. *See id.* at 170-71.

33. *Id.* at 170.

34. *Id.* at 171.

35. *See* Mass. Nurses Ass'n, *St. Vincent's Strike: Backgrounder on St. Vincent's Hospital Nurses Strike Regarding Mandatory Overtime Issue*, MNA NEWS, <http://www.massnurses.org/News/2000/000003/strike/backgrnd.htm> (last visited Apr. 9, 2008).

36. *Id.*

37. *Id.* Several other hospitals have negotiated contracts with the assistance of the Massachusetts Nurses Association, with concrete definitions of what is considered mandatory overtime. *Id.* An examination of these contracts shows the union's efforts to provide a clear explanation both as to when overtime can be mandated and as to what qualifies as overtime and will therefore affect nurse compensation. *Id.* For example, Cambridge Hospital only allows mandatory overtime in the case of unforeseen emergencies, and specifies that no nurse may work more than 13 hours at a time. *Id.* Quincy Hospital enforces strict guidelines governing when mandatory overtime can be assigned. *Id.* *See also* discussion *infra* Part IV (further discussion and analysis on unions' impact on mandatory overtime conditions).

Cross-Industry Comparison

Unlike the nursing profession, some industries are federally regulated to govern their work hours.³⁸ The hours of medical residents nationwide are restricted by the Accreditation Council for Graduate Medical Education (“ACGME”) to eighty hours per week, and on-call shifts are limited to once every third night.³⁹ Similarly, some medical students have been subject to restrictions implemented by the Liaison Committee on Medical Education (“LCME”)—the agency responsible for accrediting U.S. medical schools.⁴⁰ The LCME has revised its standards on student work hours, emphasizing that medical schools should limit the amount of time students spend in required activities in light of “the effects of fatigue and sleep deprivation on learning, clinical activities, and student health and safety.”⁴¹ Motivated by public health concerns, restrictions on the work hours of medical residents and medical students support the assertion that similar restrictions should govern nurses.

Likewise, Federal Aviation Administration regulations specify that pilots cannot fly for more than eight hours in a twenty-four hour period.⁴² Rest periods are also mandated: a pilot must have “at least eight continuous hours of rest,” or he will not be permitted to fly for

38. See, e.g., Karen Heaton, *Truck Driver Hours of Service Regulations: The Collision of Policy and Public Health*, 6 POL’Y, POL., & NURSING PRAC. 277, 277-79 (2005) (discussing longstanding federal regulations on truck driver work hours); Am. Fed’n of State, County & Mun. Employees, *Legislative Efforts to Control Mandatory Overtime*, AFSCME PUBLICATIONS, <http://www.afscme.org/publications/2247.cfm> (last visited Oct. 18, 2006). See generally Clark J. Lee, Comment, *Federal Regulation of Hospital Resident Work Hours: Enforcement with Real Teeth*, 9 J. HEALTH CARE L. & POL’Y 162-63, 206 (2006) (discussing the controversial nature of the adoption of federal regulations governing medical resident work hours, and arguing that such federal regulations should be adopted).

39. Lee, *supra* note 38, at 163, 202; see Med. Alumni Ass’n of the Univ. of Md., *Cutting Back: The 80-hour Residency Work Week*, MEDICALALUMN.ORG, http://www.medicalalumni.org/bulletin/fall_2003/lead2.html (last visited Apr. 11, 2008). The Accreditation Council for Graduate Medical Education (ACGME) is a “private, non-profit council that evaluates and accredits medical residency programs in the United States.” Accreditation Council for Graduate Med. Educ., *The ACGME at a Glance*, ACGME.ORG, <http://www.acgme.org/acWebsite/newsRoom/ataglance.pdf> (last visited Apr. 11, 2008). See also Clarinda Mac Low, *Long Hours = Impaired Students?*, MEDSCAPE TODAY, Jan. 12, 2006, available at <http://www.medscape.com/viewarticle/519741>.

40. Mac Low, *supra* note 39.

41. *Id.* (citing LIAISON COMM. ON MED. EDUC., FUNCTIONS AND STRUCTURE OF A MEDICAL SCHOOL: STANDARDS FOR ACCREDITATION OF MEDICAL EDUCATION PROGRAMS LEADING TO THE M.D. DEGREE, 20 (2007), available at <http://www.lcme.org/functions2007jun.pdf>).

42. Press Release, FAA, Fact Sheet: Pilot Flight Time and Rest (Jan. 24, 2006) (on file with author), available at http://www.faa.gov/news/fact_sheets/news_story.cfm?newsId=6762&print=go.

more than eight hours in that twenty-four hour period.⁴³ In addition, if a pilot gets fewer than nine hours of rest in a twenty-four hour period, his or her next rest period is extended.⁴⁴ Flight crewmembers are also governed by such regulations.⁴⁵

Similarly, the trucking industry is regulated such that the drivers of passenger-carrying commercial vehicles are prohibited from driving for more than ten consecutive hours, following eight hours off duty.⁴⁶ Such drivers may not work more than seventy hours in an eight day period if the employer's hours of operation include weekends.⁴⁷ Public safety concerns dictate that such stringent rules be imposed, particularly on drivers carrying passengers.⁴⁸ Railway workers' shifts are capped at twelve hours, and certain railway workers who work this maximum amount are required to rest for at least ten hours prior to commencing his or her next shift.⁴⁹

The comprehensive regulation of these industries has been motivated by concerns about public health.⁵⁰ These regulations recognize the nexus between worker fatigue and public safety that has been emphasized by advocates of extending similar regulations to the nursing industry.⁵¹ The pressing question is why nurses, despite being the largest group of health-care providers in the country, are treated differently than professionals in other industries with arguably less of an impact on public health.⁵² With respect to the lack of similar regulation in the nursing field, Congressman Pete Stark noted, "no similar limitation currently exists for our nation's nurses who are caring for us at often the most vulnerable times in our lives."⁵³

43. *Id.*

44. *Id.*

45. *Id.*

46. 49 C.F.R. § 395.5 (2007).

47. *Id.*; Heaton, *supra* note 37, at 280.

48. *Compare id.*, with 49 C.F.R. § 395.3. See Heaton, *supra* note 37, at 277-78.

49. 49 C.F.R. §§ 228.7, 228.19; see also Am. Fed'n of State, County & Mun. Employees, *supra* note 37.

50. Heaton, *supra* note 37, at 277.

51. *Id.* at 277-78; Am. Fed'n of State, County & Mun. Employees, *supra* note 37 (noting a Rhode Island representative's statement that "[i]t's ironic that . . . bus and cab drivers can only work 12 hours in a 24-hour span, but we force health care employees to work as much as 16 hours a day. I'm no rocket scientist, but I can't believe that people can administer the same services in hour 15 as they did during hour six.").

52. Jeanie Croasmun, *Error Rates for Nurses Increase With Length of Shifts*, ERGONOMICS TODAY, July 12, 2004, <http://www.ergoweb.com/news/detail.cfm?id=959>.

53. 151 CONG. REC. E212 (daily ed. Feb. 10, 2005) (statement of Rep. Stark).

B. Current Nursing Shortage Crisis

Any proposed legislation related to the health-care industry must take into account the current nursing shortage. The impact of proposed legislation attempting to regulate the nursing profession must be examined in light of the dire industry-wide nursing shortage. In 2000, there were approximately 126,000 vacant hospital nursing positions.⁵⁴ As reported by the U.S. General Accounting Office, “[t]he national unemployment rate for RNs is at its lowest level in more than a decade, continuing to decline from 1.5[%] in 1997 to 1.0[%] in 2000.”⁵⁵ In 2000, approximately eighty-two percent of licensed registered nurses in the U.S. were actually employed in the field of nursing.⁵⁶ The current shortage coincided with an increase in patient hospital admissions from 1995 to 1999.⁵⁷

In turn, hospitals seem to be suffering from the highest rates of unfilled nursing positions, with vacancy rates dramatically spiking to their highest levels since the late 1980s.⁵⁸ While states’ vacancy rates vary, most have increased in recent years.⁵⁹ In Maryland, for example, vacancy rates increased by more than ten percent in the span of just three years, between 1997 and 2000.⁶⁰ The nursing shortage has also significantly affected other areas of the healthcare industry—nursing homes and home health care agencies are currently experiencing high rates of unfilled nurse positions.⁶¹

The industry’s low retention rate is another factor contributing to the shortage.⁶² Turnover rates for hospital nurses more than doubled,

54. Hassmiller & Cozine, *supra* note 15, at 268 (citing Peter I. Buerhaus et al., *Implications of an Aging Registered Nurse Workforce*, 283 J. AM. MED. ASS’N 2948-2948-54 (2000) (discussing the increasing average age of the nurse workforce and the decline in the popularity of nursing as a career in the younger generations, and how this will interfere with long-term nursing workforce requirements)).

55. HEINRICH, *supra* note 7, at 3-4.

56. *Id.* at 6. This level varies among the states, “from a high of 92 percent in North Dakota and Louisiana to a low of 75 percent in Pennsylvania and 76 percent in Virginia, Indiana, and Arizona.” *Id.* n.9.

57. *Id.* at 3.

58. *Id.* at 4.

59. *Id.*

60. *Id.* “A survey of providers in Vermont found that hospitals had an RN vacancy rate of 7.8 percent in 2001, up from 4.8 percent in 2000 and 1.2 percent in 1996. For 2000, California reported an average RN vacancy rate of 20 percent, and for 2001, Florida reported nearly 16 percent and Nevada reported an average rate of 13 percent.” *Id.*

61. *Id.* at 5 (indicating that nursing homes had a fifty-one percent nurse turnover rate in 1997, and home healthcare agencies had a twenty-one percent nurse turnover rate in 2000).

62. *Id.* at 4; PETER D. HART, THE FED’N OF NURSES AND HEALTH PROF’LS, THE NURSE

reaching approximately twenty-six percent in 2000.⁶³ High turnover among nurses illustrates that even when the industry is successful in recruitment, it fails to retain those already working as nurses. Unfortunately, this retention rate is expected to drop to a new low, as one in five current direct care nurses plan to leave the profession in the next five years for reasons other than retirement.⁶⁴ The underlying factor behind this low retention rate is “undoubtedly a result of [the nurses’] lower levels of satisfaction with every aspect of their job.”⁶⁵

Anticipation of Worsening Shortage

As the growing rate of unfilled nursing positions demonstrates, the nursing shortage is getting worse.⁶⁶ The shortage is expected to intensify as the demand for nurses escalates concurrently with the aging of the baby boomers.⁶⁷ The baby boomer generation will precipitate a doubling of the sixty-five and over population between the years 2000 and 2030.⁶⁸ If the nursing shortage continues steadily growing at its current rate, there will be almost twenty percent fewer nurses than needed by the year 2020.⁶⁹ With over forty percent of nurses planning to retire within the next three years, it is inevitable that the shortage will become more severe without meaningful changes in the industry.⁷⁰

C. Causes of Shortage

Several factors have contributed to the nursing shortage, including an aging workforce, nurses’ dissatisfaction with their jobs, and hospital administrations’ failure to hire enough nurses.⁷¹ These factors are difficult to determine merely by examining statistical evidence, and have been mostly ascertained through studies, and anecdotal, first-hand accounts. They have established that the nursing shortage is cyclical due

SHORTAGE: PERSPECTIVES FROM CURRENT DIRECT CARE NURSES AND FORMER DIRECT CARE NURSES 4-5 (2001), available at http://www.aft.org/pubs-reports/healthcare/Hart_Report.pdf.

63. HEINRICH, *supra* note 7, at 4-5.

64. HART, *supra* note 62, at 6.

65. *Id.*

66. *See id.* at 5.

67. HEINRICH, *supra* note 7, at 2, 11.

68. *Id.* at 11.

69. Buerhaus et al., *supra* note 54, at 2952.

70. Hassmiller & Cozine, *supra* note 15, at 269.

71. *Id.* at 268-69; HART, *supra* note 62, at 11, 18.

to the undesirable factors affecting the nursing profession.⁷² Many individuals have abandoned the field of nursing, which has added to the burden of the remaining nurses, who are then forced to labor under increasingly difficult working conditions.⁷³ These difficult working conditions, including increased mandatory overtime, have precipitated even higher nurse turnover rates, further compounding the effects of the shortage, and making the recruitment of new nurses more difficult.⁷⁴

Despite the direct correlation between increased mandatory overtime and a worsening shortage, cost concerns have compelled hospitals to rely on mandatory overtime in lieu of effectively recruiting more nurses.⁷⁵ One such concern is the cost of employee benefits. Using overtime to avoid hiring new employees allows the employer to avoid paying the medical benefits accompanying additional employees.⁷⁶ Certainly, the fact that benefit costs have been rising significantly faster than salary costs has made reliance on mandatory overtime an attractive solution for hospitals.⁷⁷

Also, the high cost of recruitment and training nurses underlies hospitals' increasing use of overtime.⁷⁸ Recruitment and training costs for an individual nurse are generally equal to a trained nurse's annual salary, which typically falls between \$42,000 to \$60,000.⁷⁹ These costs are even greater for specialty nurses, such as intensive care or emergency department nurses.⁸⁰ Accordingly, using overtime allows a hospital to save money by minimizing the investment associated with recruiting and training new hires.

Additionally, the unpredictable nature of day-to-day hospital occupancy provides an incentive for hospitals to use overtime as a cost saving measure.⁸¹ Since hospital administrators cannot foresee how many patients the hospital will serve in advance of any particular day, many administrators employ a regular staff that is only able to handle a low patient load, and then insist that these staff members stay beyond

72. Hassmiller & Cozine, *supra* note 15, at 269.

73. *Id.*

74. *Id.*

75. *See id.*; Barbara Berney & Jack Needleman, *Impact of Nursing Overtime on Nurse-Sensitive Patient Outcomes in New York Hospitals, 1995-2002*, 7 POL'Y, POL., & NURSING PRAC. 87, 87 (2006).

76. *See* Berney & Needleman, *supra* note 75, at 87.

77. *Id.*

78. *See* Hassmiller & Cozine, *supra* note 15, at 269.

79. *Id.*

80. *Id.*

81. Berney & Needleman, *supra* note 75, at 87.

their scheduled work hours when the hospital is more crowded.⁸² Thus, the hospital can operate at lower labor costs by retaining only the exact number of staff members necessary to accommodate the demand. Money saving concerns aside, the practice of understaffing leads to public safety concerns.⁸³

Aging Workforce

The average age of the nurse workforce has steadily increased over the past twenty years, with over half of the nursing workforce under age forty in 1980, as compared to less than one-third in 2000.⁸⁴ While the number of nurses under age thirty dropped by over forty percent between 1983 and 1998, there was only a one percent drop in workers under thirty, employed in other professions.⁸⁵ Chart 1, below, illustrates the problem of the aging nurse population. The graph shows the distribution of working nurses among age groups, emphasizing the difference between age distributions in the year 1980 and the year 2000.

More career options for women have translated to a sharp decrease in the amount of young women entering the nursing profession.⁸⁶ According to one study, female high school graduates in the 1990s were thirty-five percent less likely to enter the nursing profession than their 1970s counterparts.⁸⁷ The lack of replacements for the nurses entering the field in the 1970s has significant implications for the nursing shortage.⁸⁸ Since the demand for nurses will only grow as the population increases, the fact that the majority of the nursing workforce is aging out without replacements to fill their positions means that the impact of the aging workforce on the nursing shortage will be amplified

82. *Id.*

83. See discussion *supra* Part I for a more detailed account of hospital malpractice and related public safety issues.

84. HEINRICH, *supra* note 7, at 7.

85. *Id.*; Buerhaus et al., *supra* note 52, at 2948.

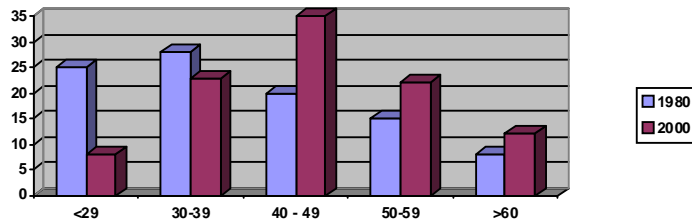
86. HEINRICH, *supra* note 7, at 6; Buerhaus et al., *supra* note 52, at 2948; Hassmiller & Cozine, *supra* note 15, at 269-70.

87. HEINRICH, *supra* note 7, at 6 (citing Buerhaus et al., *Policy Responses to an Aging Registered Nurse Workforce*, 18 NURSING ECONOMIC\$ 278, 279 (2000)). In addition, enrollment in nursing diploma programs dropped forty-two percent in just a three year span, between 1993 and 1996. *Id.* at 6-7.

88. See K. Reid & D. Dawson, *Comparing Performance on a Simulated 12 Hour Shift Rotation in Young and Older Subjects*, 58 OCCUPATIONAL & ENVTL. MED. 58, 59, 61 (2001) (studying the effects of working twelve-hour shifts on two different groups—one with an average age of about 21, the other an average age of about 44, and finding that “the older subjects [were] less able to maintain performance across a 12 hour shift than the younger subjects.”).

in coming years.

Chart 1: Age Distribution of RN Population – 1980 and 2000⁸⁹



Nurses' Dissatisfaction with Working Conditions

The large number of nurses abandoning the profession has seriously impacted the industry-wide shortage. In addition to the decrease in the volume of nurses entering the workforce, large numbers of nurses are leaving the industry for reasons other than retirement, contributing to the current shortage.⁹⁰ Nurses leaving the profession express dissatisfaction with their jobs based on increased use of overtime, heavy workloads, “stress-related burnout,” and insufficient staffing.⁹¹ Again, the cyclical nature of the problem is evident: mandatory overtime gives individual nurses heavier workloads, driving some to leave the profession.⁹² In turn, this reduces nursing staff levels and leads to more overtime for remaining nurses.⁹³

Difficult working conditions have played a significant role in influencing nurses to leave the profession. Whereas only eighteen percent were motivated to leave in pursuit of higher wages, over half of nurses responding to a survey by the Federation of Nurses and Health Professionals (“FNHP”) reported that their concerns about the stressful work environment and physical demands associated with nursing

89. HEINRICH, *supra* note 7, at 8 fig.1 (citations omitted).

90. See HEINRICH, *supra* note 7, at 8. In addition, “[a] recent survey reported the national turnover rate among hospital staff nurses was 15 percent in 1999, up from 12 percent in 1996. Another industry survey showed turnover rates for overall hospital nursing department staff rising from 11.7 percent in 1998 to 26.2 percent in 2000.” *Id.* at 4-5 (footnotes omitted).

91. *Id.* at 6; Hassmiller & Cozine, *supra* note 15, at 269.

92. See Hassmiller & Cozine, *supra* note 15, at 269.

93. See *id.*; HEINRICH, *supra* note 7, at 6.

encouraged them to leave the profession.⁹⁴ These results are not surprising, when one considers the variety of negative effects mandatory overtime has on nurses. Mandatory overtime has also been linked to poorer physical and mental health, unhealthy weight gain, and increased alcohol consumption.⁹⁵ Specifically, a recent study has established that overtime among nurses is significantly related to an increase in injuries such as back pain, and diseases such as heart disease.⁹⁶

Not only does mandatory overtime interfere with the emotional well-being of nurses, but it has also been shown to affect their families.⁹⁷ One can also infer that it negatively impacts nurses' relationships with their significant others and friends.⁹⁸ While such effects are more difficult to quantify, they are no less disconcerting than other problems precipitated by mandatory overtime. In her testimony before the House of Representatives on the issue of mandatory overtime, Registered Nurse ("RN") Michele P. Campbell described the negative effects of overtime on nurses' personal lives, and the interplay between those effects and patient concerns:

[O]vertime work in nursing, while helping to cover vacancies and sick leave for nursing personnel, has unhealthy social costs. It is taking its toll not only on the nurses but also on their families, communities and ultimately in many cases, patients. More hours spent at work means less time with family, less time to help a child with homework, less time for play, and less time for sleep. These sacrifices can translate into increased risk for accidents and injuries; greater chronic fatigue, stress and related diseases; reduced parenting and family time and diminished quality of services – a serious public concern particularly in healthcare.⁹⁹

In a phone interview with Gingy Harshey-Meade of the Ohio Nurses Association,¹⁰⁰ attributed the decline in nurse health, in part, to

94. HEINRICH, *supra* note 7, at 8, 10.

95. Loren Stein, *Mandatory Overtime*, CONSUMER HEALTH INTERACTIVE, Nov. 6, 2000, <http://healthresources.caremark.com/topic/overtime>.

96. *Id.*

97. Campbell Statement, *supra* note 6.

98. *See id.*

99. *Id.*

100. *See* Harshey-Meade Interview, *supra* note 1. The Ohio Nurses Association is "a member-driven, full-service professional association for Registered Nurses." *See* Ohio Nurses Association ("ONA"), <http://www.ohnurses.org/AM/Template.cfm?Section=About> (last visited Apr. 15, 2008). It was "[o]rganized in 1904 to secure a Nurse Practice Act to protect the citizens of Ohio, [and it] has been promoting and protecting nurses, the nursing profession, and those who receive nursing care for over one hundred years." *Id.* In addition, "[e]very member of the ONA is also a member of

mandatory overtime, and argued that it is a major contributor to the nursing shortage.¹⁰¹ First, Ms. Harshey-Meade referenced the impact of mandatory overtime on familial relations.¹⁰² She characterized mandatory overtime as “people being held hostage and not being able to come home to their families.”¹⁰³ Harshey-Meade discussed her own experiences, rife with the evils of mandatory overtime, when working as an RN.¹⁰⁴ Specifically, she noted that when hospital administrators spring overtime on employees at the last minute, those employees may be unable to make alternative childcare arrangements, and their children may be kept waiting at schools and “on corners, and hav[e] to stay there . . . [for] hours.”¹⁰⁵ Second, Harshey-Meade referred to the negative impact of overtime on the quality of patient care. Put simply, “the more hours you work, the less effective you are.”¹⁰⁶ She continued “when [your] energy is gone, [your] thinking capacity goes, too.”¹⁰⁷ Harshey-Meade’s anecdotes shed even greater light on the severely counter-productive nature of mandatory overtime.

The ANA has conducted research on the subject of mandatory overtime,¹⁰⁸ and its results support Harshey-Meade’s assertions about the negative impact mandatory overtime has on patient safety. In 2003, the Institute of Medicine (“IOM”) reported that one of the largest threats to patient safety is forcing nurses to work inordinately long shifts.¹⁰⁹ The IOM also noted the harmful impact fatigue can have on work performance by slowing one’s reaction time interfering with one’s ability to maintain focus.¹¹⁰ The researchers concluded that the practice of forcing nurses to work overtime is harmful to both nurse health and patient safety, and should therefore be eliminated.¹¹¹ Moreover, the

a local district nurses association and is represented in the American Nurses Association located in Washington, D.C., and the International Council of Nurses, with headquarters in Geneva, Switzerland.” *Id.*

101. Harshey-Meade Interview, *supra* note 1.

102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.*

106. *Id.*

107. *Id.*

108. *See, e.g.*, AM. NURSES ASS’N, *supra* note 14, at 9-10. “ANA is concerned about the impact of mandatory overtime on the ability of our nation’s acute care nurses to provide high-quality health care services. ANA believes that the elimination of mandatory overtime for the nation’s nurses is a critical step in efforts to improve the quality of health care, and reduce medical errors.” *Id.* at 10.

109. *Id.* at 9.

110. *Id.*

111. *Id.*

ANA reports a study commissioned by the Agency for Health Care Research and Quality, which further supports the notion that mandatory overtime leads to increased error rates in patient treatment.¹¹² According to this report, “The Working Hours of Hospital Staff Nurses and Patient Safety,” the risk of making an error increased significantly when nurses worked shifts that were longer than twelve hours, as well as when they worked more than forty hours per week.¹¹³ The researchers conducting this study found that nurses were three times more likely to make errors when working shifts lasting 12.5 hours or longer.¹¹⁴ Disturbingly, in nearly forty percent of the shifts studied, nurses worked at least 12.5 consecutive hours.¹¹⁵ Additionally, more than twenty-five percent of the participants in the study reported working mandatory overtime at least once during a one-month period.¹¹⁶ Over the course of this study, nurses reported staying beyond their scheduled shifts more than eighty percent of the time.¹¹⁷

II. STATE AND FEDERAL RESPONSES TO ADVERSE PATIENT CARE

A. State Initiatives

Several states have implemented legislative initiatives in response to increased hospital malpractice.¹¹⁸ As established, this public health crisis is the product of neglected patient and nurse health. Thus, in order to resolve the adverse effects of patient care, patient and nurse needs must be addressed. Although some states tackle both aspects of adverse patient health care, most fail to address nurse needs. Accordingly, because the failure to address these needs continues to contribute to the nursing shortage, both deterring those from entering and encouraging nurses to leave the profession, the public health crisis has yet to be resolved among the states.

112. *Id.*; Rogers et al., *supra* note 3, at 210.

113. Rogers et al., *supra* note 3, at 206-07; AM. NURSES ASS'N, *supra* note 14, at 9.

114. Rogers et al., *supra* note 3, at 206.

115. *Id.* at 205.

116. *Id.* at 203, 209.

117. *Id.* at 206.

118. HEINRICH, *supra* note 7, at 5; *see also* Theresamarie Mantese et al., *Nurse Staffing, Legislative Alternatives and Health Care Policy*, 9 DEPAUL J. HEALTH CARE L. 1171, 1174-78 (2006) (noting that while some state's legislators have focused on improving nurse-to-patient ratios to ensure higher quality patient care, other state's legislators have enacted legislation that limits the amount of mandatory overtime a nurse can be forced to work in furtherance of that goal).

Adequate Responses to Nurse Needs

Those states that sufficiently respond to nurse needs specify the steps that an employer must take when requiring mandatory overtime of nurses,¹¹⁹ address nurses' collective bargaining rights,¹²⁰ define "work time,"¹²¹ and establish a "complaint system"¹²² to enforce these rules. These initiatives are essential steps toward both securing and maximizing adequate nursing staffs, and therefore improving the quality of patient care. That is, each initiative addresses neglected aspects of nurse needs, furthered through mandatory overtime. Such needs include the need to provide for family and nurse health.

For example, New Jersey's detailed defining of these "reasonable

119. N.J. STAT. ANN. §§ 34:11-56a31, -56a32 (West Supp. 2007); WASH. REV. CODE ANN. §§ 49.28.140 to .150 (West 2002).

120. See § 34:11-56a36 (stating that "[t]he provisions of this act shall not be construed to impair or negate any employer-employee collective bargaining agreement or any other employer-employee contract in effect on the effective date of this act.>").

121. See OR. REV. STAT. ANN. § 441.166(3)(a)-(c) (West 2007). The Oregon statute contends that

[t]ime spent in required meetings or receiving education or training shall be included as hours worked, . . . time spent on call but away from premises of the employer may not be included as hours worked, . . . [and] time spent on call or on standby when the registered nurse, licensed practical nurse or certified nursing assistant is required to be at the premises of the employer shall be included as hours worked.

Id.

122. N.J. ADMIN. CODE § 8:43E-8.10 (2007). This code provides the employee with the right to file a complaint up to two years following the date of the assigned mandatory overtime if he or she believes the overtime was not in response to an unforeseen emergent circumstance . . . , reasonable efforts were not exhausted, and/or he or she was not provided the allowed time to make arrangements for the care of family members.

Id.

See also *id.* at § 8:43E-8.9 (providing that "[a]n employer shall not discharge or in any other matter discriminate against an employee because such an employee has made any complaint" about working statutorily prohibited overtime "to his or her employer, including the employer's representative; to the Commissioner of Labor; or to the State that licenses the facility where the employee works."); 210 ILL. COMP. STAT. ANN. 85/10.9 (West 2007).

No hospital may discipline, discharge, or take any other adverse employment action against a nurse solely because the nurse refused to work mandated overtime [Additionally,] [a]ny employee of a hospital that is subject to this Act may file a complaint with the Department of Public Health regarding an alleged violation of this Section. The Complaint must be filed within 45 days following the occurrence of the incident giving rise to the alleged violation. The Department must forward notification of the alleged violation to the hospital in question within 3 business days after the complaint is filed. Upon receiving the complaint of a violation of this Section, the Department may take any [authorized] action

Id.

efforts” encompasses the aforementioned initiatives.¹²³ Specifically, the state’s legislation mandates that before requiring mandatory overtime of nurses, an employer hospital must make “reasonable efforts”¹²⁴ to obtain voluntary workers during an “unforeseeable emergent circumstance.”¹²⁵ These efforts require the hospital employer to: (1) “seek persons who volunteer to work extra time from all available qualified staff who are working at the time of the unforeseeable emergent circumstance;” (2) “contact all qualified employees who have made themselves available to work extra time;” (3) “seek the use of qualified per diem staff;” and (4) “seek qualified personnel from a contracted temporary agency when such staff is permitted by law or regulation.”¹²⁶ Additionally, New Jersey’s legislation mandates that “the employer shall provide the employee with necessary time, up to a maximum of one hour, to arrange for the care of the employee’s minor children or elderly disabled family members.”¹²⁷ Further, New Jersey’s implementation of a “complaint system” enforces these steps, including their right to collective bargaining,¹²⁸ setting forth a nurse’s right to file a complaint for up to two years following the date of assigned mandatory overtime if he or she believes that the overtime was not a response to an “unforeseen emergent circumstance,” “reasonable efforts” were not exhausted, or time to make family arrangements was not provided for.¹²⁹

The enforcement of mandatory overtime under the standards above contributes to the fatigue that plagues the aging nurse workforce.¹³⁰ State implementation of a “time-off” period, following mandatory overtime, also addresses neglected nurse needs, specifically nurse health concerns.¹³¹ Specifically, the enforcement of mandatory overtime

123. See § 34:11-56a32 (defining “reasonable efforts” and “on call time”); see also *id.* §§ 34:22-56a34(c), -56a36; N.J. ADMIN. CODE § 8:43E-8.10.

124. See also § 34:11-56a32 (defining “reasonable efforts”).

125. See § 34:11-56a32 (defining “unforeseeable emergent circumstance” as “an unpredictable unavoidable occurrence at unscheduled intervals relating to health care delivery that requires immediate action.”); see also *id.* § 34:11-56a34.

126. *Id.* § 34:11-56a32.

127. § 34:11-56a34.

128. *Id.* § 34:11-56a36.

129. N.J. ADMIN. CODE § 8:43E-8.10.

130. See Rogers *supra* note 3, at 207-08.

131. See ME. REV. STAT. ANN. tit. 26 § 603(5) (2007) (stating that “[a]ny nurse who is mandated to work more than 12 consecutive hours . . . must be allowed at least 10 consecutive hours of off-duty time immediately following the worked overtime.”); see also 210 ILL. COMP. STAT. ANN. § 85/10.9(c) (West Supp. 2007) (finding that “When a nurse is mandated to work up to 12 consecutive hours, the nurse must be allowed at least 8 consecutive hours of off-duty time immediately following the completion of a shift.”).

contributes to the fatigue that plagues the aging nurse workforce.¹³² Further, legislative implementation of a mandatory “time-off” period helps mitigate the adverse effects of mandatory overtime on nurse health. Consequently, in doing so, these legislative initiatives have the ability to improve the quality of patient care, potentially decreasing instances of hospital malpractice.

The Illinois Nurses Association was instrumental in the enactment of legislation in the state, allowing hospitals to mandate overtime only in unforeseen emergency circumstances.¹³³ In the event of this mandate, no nurse may work more than four hours beyond her regularly scheduled work shift.¹³⁴ Further, a nurse may not be punished for refusing to work overtime, and if a nurse works for more than twelve hours, there must be an eight hour rest period before working again.¹³⁵ Similarly, the Oregon Nurses Association promoted the amendment of a mandatory overtime law by prohibiting a hospital from requiring a nurse to work more than twelve consecutive hours in a twenty-four hour period.¹³⁶ In 2004, West Virginia enacted legislation prohibiting hospitals from requiring nurses to accept an assignment of overtime.¹³⁷ Connecticut enacted legislation, prohibiting a hospital from requiring a nurse to work in excess of a predetermined work shift, except in certain circumstances, such as participating in a surgical procedure through its completion or in a public health emergency.¹³⁸ In 2003, Louisiana, Nevada, and West Virginia enacted legislation requiring the creation of study committees to explore the effects of overtime on nurses.¹³⁹ In 2002, Maryland passed a law stating that an employer may not require an employee to work more than regularly scheduled hours according to a predetermined work schedule.¹⁴⁰ However, there are some exceptions, including a need for a nurse who has critical skills and expertise to respond to an

132. See Rogers *supra* note 3, at 207-08 ; HEINRICH, *supra* note 7, at 6-7.

133. § 85/10.9(b); Am. Nurses Ass’n, *ANA State Government Affairs on Mandatory Overtime*, ANA NURSING WORLD, <http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/workplace/Workforce/OvertimeIssues/mandatory12761.aspx> (last visited Oct. 22, 2008) [hereinafter ANA State Gov’t Affairs].

134. § 85/10.9(b).

135. *Id.* § 85/10.9(c)-(d).

136. OR. REV. STAT. ANN. § 441.166(2)(b) (West 2007); Am. Nurses Ass’n, *supra* note 133.

137. W. VA. CODE ANN. § 21-5F-3(a) (West Supp. 2007).

138. CONN. GEN. STAT. ANN. § 19A-490I(b)-(c) (West Supp. 2007).

139. S. Con. Res. 140, 2003 Leg., Reg. Sess. (La. 2003); United Am. Nurses, AFL-CIO, *Legislative Action in the States: Banning Forced Overtime*, <http://www.uannurse.org/legislative/state/overtime.html> (last visited August 14, 2008).

140. MD. CODE ANN., LAB. & EMPL. § 3-421(b) (LexisNexis Supp. 2007).

emergency situation that could not be reasonably anticipated.¹⁴¹ Additionally, legislation enacted in 2001 in Maine would prevent a nurse from being disciplined for refusing to work for more than twelve consecutive hours in certain circumstances.¹⁴² Further, regulations adopted in California around 2001 prohibit an employee scheduled to work a twelve hour shift from working any longer during a twenty-four hour time period except in the case of an emergency.¹⁴³

Shortcomings

Although some of the above state initiatives advance nurse needs, many states have failed to sufficiently incorporate these needs into legislation advancing patient care. Simply stated, many states have fallen short of addressing nurse needs. Consequently, because the needs of nurses constitute a vital aspect of adverse patient care, the failure of state initiatives to address these needs renders this legislation ineffective.

The failure of state initiatives to precisely define exceptions for mandatory overtime promotes employer abuse of nurse services. For example, due to Maine's broad exception to its "time-off" period (as established above), such period is effectively rendered worthless for an employee who performs "essential services for the public."¹⁴⁴ This is because *any* and *every* nurse performs "essential services for the public," therefore, an employer can require *any* and *every* nurse to work mandatory overtime. Likewise, state failures to precisely define "good faith, reasonable attempts" exceptions establish open-ended hospital abuse of nurse services.¹⁴⁵ Further, because these legislative initiatives fail to establish any change in the enforcement of mandatory overtime, they subsequently fail to address the nursing shortage, and are therefore ineffective in reducing hospital malpractice.

B. Federal Initiatives

While several states have enacted legislation regarding adverse patient health care, no such federal legislation exists to provide for a large-scale correction of the public health crisis. Although several federal initiatives have been attempted, each fails to pass Congress'

141. *Id.* § 3-421(c).

142. ME. REV. STAT. ANN. tit. 26, § 603(5) (2007).

143. United American Nurses, *supra* note 139.

144. *See* tit. 26 § 603(3)(B).

145. *See* MD. CODE ANN., LAB. & EMPL. § 3-421(b).

muster. The fact that six such attempts have been introduced to Congress in the recent past illustrates the need for federal legislation to resolve the public health crisis. This section will examine the substance of these attempts and how well they address nurse and patient needs. Similar to many of the state initiatives, a close analysis of the following federal initiatives reveals their failure to address both of these needs, if any at all. It should be no surprise, therefore, that this on-going attempt has failed to establish any responsive federal ground to hospital malpractice.

Although Congress recognizes the importance of nurses to the health care profession, it fails to address their needs. According to Hon. Daniel Lipinski, in celebration of National Nurses Week:

America's nurses comprise our nation's largest health care profession. They continue to meet the different, emerging, and challenging health care needs of the American population in a wide range of settings. Nurses enhance both primary and preventive health care and are an indispensable component in the safety and quality of hospitalized patients. . . . Today, we celebrate registered nursing's accomplishments and efforts to improve our health care system and show our appreciation for the nation's registered nurses not just during this week, but at every opportunity throughout the year.¹⁴⁶

Despite Congress' recognition of nurses as a vital aspect of patient care, federal initiatives toward improving such care have failed to address their needs. Such a failure is especially shocking, considering Congress' acknowledgement of its need to increase patient safety.¹⁴⁷ According to a report made in July, 2005,

[N]ew data was released in Pennsylvania which found [that] more than 11,000 patients acquired infections that resulted in 1,500 deaths and \$2 billion in additional charges. These are new numbers for only one State and are almost half of the previous estimate for infection costs nationwide where tens of thousands of deaths and tens of billions of dollars are spent on infections and errors. . . . Congress owes it to the American people to improve the quality of health care in this country.¹⁴⁸

Why has Congress failed to link these two acknowledgements

146. 152 CONG. REC. E806 (daily ed. May 11, 2006) (statement of Rep. Lipinski).

147. 151 CONG. REC. H6208 (daily ed. July 21, 2005) (statement of Rep. Murphy).

148. *Id.*

together in effective legislation to combat adverse patient care?

The Patient Safety Act (H.R. 4349),¹⁴⁹ sponsored by Representative Maurice Hinchey, failed to generate any improvement in the public health crisis because it did not address nurse needs. The Patient Safety Act required “[a]ny provider under the Medicare program, . . . as a condition of continued participation in such a program, [to] make publicly available information regarding nurse staffing and patient outcomes.”¹⁵⁰ Specifically, it required public availability of information “regarding complaints filed with the [s]tate agency, the Centers for Medicare & Medicaid Services, or an accrediting agency, compliance with the standards of which have been deemed to demonstrate compliance, and data regarding investigations and findings as a result of those complaints and the findings of scheduled inspection visits.”¹⁵¹ It further required the Secretary to verify the information is publically available and have the information audited “as a part of the process to determine whether a provider is eligible for continued participation in the Medicare program.”¹⁵² Although the Act’s monitoring of nurse staffing provided for an adequate initial step in improving health care, it fails to actively respond to the nurse shortage, and is therefore inadequate. That is, its monitoring initiatives must be followed by a subsequent step toward maintaining and encouraging nurses into the system to provide quality health care.

Similarly, although the Patient Safety and Quality Improvement Act (H.R. 3205)¹⁵³ (“Patient Safety & Quality Act”) establishes a health care errors reporting system, it fails to provide a concrete solution for eliminating the source of these errors. The Patient Safety & Quality Act ensures the accountability of the reporting system through the actions of the Secretary of Health and Human Services.¹⁵⁴ However, it fails to recognize a major cause of adverse medical care, the nursing shortage, therefore rendering the Act’s monitoring initiatives useless.

The National Nurse Act’s (H.R. 4903),¹⁵⁵ sponsored by Lois Capps, established the “National Nurse Office”¹⁵⁶ providing the missing step in the Patient Safety Act. Specifically, its establishment of the Office of

149. Patient Safety Act of 2005, H.R. 4349, 109th Cong. (2005).

150. *Id.* § 3(a).

151. *Id.* § 4(b).

152. *Id.* § 4(f).

153. Patient Safety and Quality Improvement Act of 2005, H.R. 3205, 109th Cong. (2005).

154. *See id.* § 923.

155. National Nurse Act of 2006, H.R. 4903, 109th Cong. § 1711 (2006).

156. *Id.* § 1711(a).

the National Nurse aims to (1) “encourage individuals to enter the nursing profession”,¹⁵⁷ (2) “encourage nurses to become educators in schools of nursing”,¹⁵⁸ and (3) “promote public health.”¹⁵⁹ Further, it requires the National Nurse to: (1) “designate four methods of achieving better health that will be given priority”,¹⁶⁰ and (2) “make grants to nonprofit entities to carry out projects for the purpose of educating the public on annual health priorities.”¹⁶¹ Although the National Nurse Act correctly recognizes the need to increase the number of nurses into the health care profession (resolving the nursing shortage), its method in doing so is inadequate. That is, merely recognizing the need for nurses is meaningless without proposing steps to change the working conditions that have contributed to their decline in the health profession, namely mandatory overtime. Consequently, because the National Nurse Act fails to initiate any limitation on mandatory overtime, it is unlikely that merely encouraging individuals to enter the nurse profession will be successful in maintaining quality patient care.

Similarly, the Nurse Staffing Standards for Patient Safety and Quality Care Act of 2005 (H.R. 1222),¹⁶² (“Nurse Staffing Standards Act”) sponsored by Janice Schakowsky, also fails to address nurse needs. The Nurse Staffing Standards Act requires hospitals to implement staffing plans that meet specified ratios for direct care registered nurse-to-patient staffing levels for each unit.¹⁶³ Further, it allows the Secretary of Health and Human Services to further limit such ratios as needed to ensure public safety and to establish ratios for units that are unspecified.¹⁶⁴ Additionally, it requires hospitals to provide the Secretary with their staffing plan and annual updates, and requires the Secretary to conduct audits to ensure implementation of adequate staffing plans.¹⁶⁵ Specifically, it requires the Secretary, acting through the Director of the Agency for Healthcare Research and Quality (“AHRQ”), “to complete a study of licensed practical nurse staffing and its effects on patient care in hospitals,” and to establish requirements for

157. *Id.* § 1711(b).

158. *Id.*

159. *Id.*

160. *Id.* § 1711(c).

161. *Id.*

162. Nurse Staffing Standards for Patient Safety and Quality Care Act of 2005, H.R. 1222, 109th Cong. § 2(a) (2005).

163. *Id.* § 2901(a).

164. *Id.* § 2903(a).

165. *Id.* § 2901(c)(4)(D).

hospitals based on the outcome of the study.¹⁶⁶ Finally, it provides nurses with the right to refuse to accept assignments that would violate staffing requirements for which they are not prepared.¹⁶⁷ Although the Nurse Staffing Standards Act correctly identifies the need to respond to the nursing shortage, similar to the National Nurse Act, it does so blindly without addressing nurse needs. First, it does not provide for any type of limitation on mandatory overtime, which, as previously established, is the crux of the nursing shortage. Second, because the Act fails to implement anything to encourage nurses into the health profession, it fails to meet its aim to provide for nurse-to-patient staffing levels. Finally, its failure to define staffing requirements renders its right of refusal for nurses to accept assignments meaningless.

The Senate's proposal of the Registered Nurse Safe Staffing Act (S. 71)¹⁶⁸ also provides for minimum nurse staffing ratios. Like the Nurse Staffing Standards Act, this Act addresses patient needs without providing nurse needs. The Registered Nurse Safe Staffing Act (1) requires each "participating hospital [to] adopt and implement a staffing system that ensures a number of registered nurses on each shift and in each unit of the hospital to ensure appropriate staffing levels for patient care; (2) provides for the public reporting of certain staffing information, including a daily posting for each shift in the hospital of the "current number of licensed and unlicensed nursing staff directly responsible for patient care"; (3) prescribes recordkeeping, data collection, and evaluation requirements for participating hospitals; (4) specifies civil monetary penalties for violations of such requirements; and (5) provides whistleblower protections.¹⁶⁹ Similar to the former initiatives, the Registered Nurse Safe Staffing Act accurately pinpoints the nursing shortage as a critical facet of the public health crisis. Nevertheless, its proposal is inadequate in solving this crisis because it fails to address the fact that there is a nursing shortage *within* the health care system. That is, before nurse-to-patient staffing initiatives can take place, there must first be enough nurses to further this course of action. Further, because there is a lack of incoming nurses and because the Registered Nurse Safe Staffing Act does not provide for any initiatives to decrease nurse turnover rates, its staffing initiatives are a step ahead of what needs to initially take place. Consequently, despite the reporting system's goal to

166. *Id.* § 2901(b)(3).

167. *Id.* §§ 2905(a); 2902(c).

168. Registered Nurse Safe Staffing Act of 2005, S.71, 109th Cong. § 3(a) (2005).

169. *See id.* § 1889(a)-(e).

resolve hospital malpractice, adverse patient care will continue to grow if the internal nursing shortage remains unaddressed.

Congress' most recent initiative, the Safe Nursing and Patient Care Act of 2005 (H.R. 791; S. 351),¹⁷⁰ sponsored by Representatives Peter Stark (D-CA) and Steven Latourette (R-OH), addresses both patient safety and nurse needs. That is, it proposes to increase the quality of health care delivery through limitations on mandatory overtime.¹⁷¹ The bill's findings illustrate a cyclic relationship between medical malpractice and mandatory overtime.¹⁷² First, the bill establishes that "higher nurse staffing levels result in better patient outcomes."¹⁷³ It recognizes health facility reports of "substantial difficulties in recruiting and retaining" a sufficient nurse staff.¹⁷⁴ The bill's findings attribute such difficulties to job dissatisfaction and overtime, contributing to retention issues.¹⁷⁵ The findings connect the widespread practice of requiring nurses to work extended shifts, resulting in fatigue, medical errors and other consequences that compromise patient safety.¹⁷⁶ Further, the findings support the bill's attempt to limit mandatory overtime.¹⁷⁷

Accordingly, the bill implements provisions that seek to improve health care initiatives and to improve the quality of nurses.¹⁷⁸ First, the bill proposes that "a provider of services" must not require a nurse to work in excess of "[t]he scheduled work shift or duty period of the nurse, . . . 12 hours in a 24 hour period, . . . [or] 80 hours in a consecutive 14-day period."¹⁷⁹ Second, the Act's implementation of a "state of emergency" exception to its prohibition on mandatory overtime further illustrates its attempt to balance nurse needs with patient

170. See Safe Nursing and Patient Care Act of 2005, H.R. 791, 109th Cong. (1st Sess. 2005), available at <http://thomas.loc.gov/cgi-bin/bdquery/z?d109:h791:>.

171. *Id.* § 2(9).

172. See *id.* § 2.

173. *Id.* § 2(2).

174. *Id.* "Evidenced by the fact that approximately 500,000 licensed nurses are not practicing nursing." *Id.*

175. *Id.* § 2(3). "Documented by the Government Accountability Office in a July 2001 report." *Id.*

176. *Id.* § 2(4). The act cites studies that show that mandatory overtime requirements for nurses pose dangers to patients. *Id.* § 2(5). Another study shows that nurses who work shifts of 12.5 hours or more are three times more likely to commit an error than nurses who work standard shifts of 8.5 hours or less. *Id.* § 2(6). Consequently, the acts adopt a prohibition on mandatory overtime that limits a nurse's work shift to no more than 12 hours in a 24-hour period and no more than 80 hours in a consecutive 14-day period. *Id.* § 3(k)(1)(A)-(C).

177. See *id.* § 2(9).

178. See *id.*

179. *Id.* § 3(k)(1)(A)-(C).

needs.¹⁸⁰ Unlike previous initiatives, H.R. 791's careful limitation of a "declared state of emergency" to "an exceptional level of emergency or other medical services to the community," excluding states of emergencies that result from a labor dispute in the health care industry or consistent understaffing, prevents this exception from swallowing the bill's purpose.¹⁸¹ The bill furthers the implementation of its initiatives through its setting forth of a nurse's right to report violations and a requirement for service providers to post notice of this right.¹⁸² Additionally, the bill safeguards against nurse discrimination and retaliatory reporting.¹⁸³ The bill also safeguards service providers from "bad faith" reports through its enforcement of a civil money penalty that is made public.¹⁸⁴ The bill maintains overtime autonomy, keeping in mind patient health as well as nurse financial needs.¹⁸⁵ Finally, the bill's extensive defining of "provider of services" makes sure to apply its regulations to a wide array of patient care.¹⁸⁶

Although the Safe Nursing and Patient Care Act of 2005 failed to pass Congress' muster, it has been recognized as a vehicle toward "transform[ing] the nursing workplace and improv[ing] care."¹⁸⁷ That is,

180. *See id.* § 3(k)(2)(A).

181. *Id.*

182. *Id.* § 3(k)(3)(A)(i), (5)(A). "A nurse may file a complaint with the Secretary against a provider of services who violates the provisions of this subsection . . . the Secretary shall investigate complaints of violations filed by a nurse." *Id.* § 3(k)(3)(A)(i), (B).

(A) Requirement to Post Notice.—Each provider of services shall post conspicuously in an appropriate location a sign . . . specifying the rights of nurses.

(B) Right to File Complaint.—Such sign shall include a statement that a nurse may file a complaint with the Secretary against a provider of services who violate the provisions of this subsection and information with respect to the manner of filing such a complaint.

Id. § 3(k)(5).

183. *Id.* § 3(k)(4)(A).

184. *Id.* § 3(k)(7). "[A] nurse is deemed to be acting in good faith if the nurse reasonably believes . . . (i) that the information reported or disclosed is true; and (ii) that a violation has occurred or may occur." *Id.* § 3(k)(4)(C). The Bill limits its enforcement of a civil money penalty to "patterns of repeated violations." *Id.* § 3(k)(7)(B). The administration of the penalty provides for an Internet publication of the names of providers of services against which such penalties have been imposed upon on the Department of Health and Human Services website. *Id.* § 3(k)(7).

185. *Id.* § 3(k)(8). Section 3(8) provides that nothing in the bill "shall be construed as precluding a nurse from voluntarily working more than any of the periods of time" that a nurse must not be forced to work. *Id.* It is also careful to proscribe that such autonomy must be "consistent with professional standards of safe patient care." *Id.*

186. *Id.* § 3(k)(9)(D). Section 9(D) defines "provider of services" to include hospitals, psychiatric hospitals, hospital outpatient departments, critical access hospitals, ambulatory surgical centers, home health agencies, rehabilitation agencies, clinics (including rural health clinics), and federally qualified health centers. *Id.*

187. *See* Rose Gonzalez, *The Politics of Caring: Proposed Bills Would Transform Nursing Workplace and Improve Care*, AM. J. NURSING, 37, 37 (2005).

the bill's recognition of the cyclic relationship between medical malpractice and mandatory overtime addresses both nurse and patient needs. Unlike former initiatives, the bill does not propose mandatory nurse staffing standards as a remedy for medical malpractice. Rather, it delves deep beyond the surfacing of such malpractice, confronting the reasons that have triggered the minimal staffing that has contributed to low quality patient care. The Safe Nursing and Patient Care Act of 2005 has the right idea—it starts at the root of the problem, nurse dissatisfaction, in order to resolve the 'slap in the face' issue, the public health crisis.

The ANA is an example of the support behind the Safe Nursing and Patient Care Act. As part of its Nationwide Legislative Agenda on the nurse staffing crisis, State Nurses Associations support the enactment of mandatory overtime legislation.¹⁸⁸ Specifically, in 2005, state legislation to prohibit mandatory overtime was enacted.¹⁸⁹

III. POSITIVE IMPACT OF PASSING SAFE NURSING AND PATIENT ACT

A. Tort Liability

Since reducing the number of mistakes made by nurses is one of the strongest motivations behind limiting nurse's mandatory overtime, it is clear that such a law would have a significant effect on the tort liability of both nurses and hospitals.

Typically, a nurse is held to "the standard of care generally observed by other competent nurses under similar circumstances."¹⁹⁰ The applicable standard of care varies according to the circumstances in which the nurse is acting.¹⁹¹ For example, a nurse specialist is held to the higher standard of care observed by a nurse with the same specialty under similar circumstances.¹⁹² This higher standard of care is justified because of the particular license or certification required to be classified

188. AM. NURSES ASS'N, *supra* note 14, at 9.

189. ANA State Gov't Affairs, *supra* note 133.

190. DARLENE M. TRANDEL-KORENCHUCK & KEITH M. TRANDEL-KORENCHUCK, *NURSING & THE LAW* 306, 322 (5th ed. 1997); *see also* NANCY J. BRENT, *NURSES AND THE LAW: A GUIDE TO PRINCIPLES AND APPLICATIONS* 67 (W.B. Saunders Company 1997) ("the law requires the nurse to carry out care in accordance with what other reasonably prudent nurses would do in the same or similar circumstances").

191. TRANDEL-KORENCHUCK & TRANDEL-KORENCHUCK, *supra* note 190, at 306.

192. *Id.* at 306; *see Webb v. Jorns*, 473 S.W.2d 328, 336-37 (Tex. Civ. App. 1971).

as a specialist.¹⁹³ A nurse assisting a physician with a task considered “medical in nature” will be held to the same standard of care as the physician.¹⁹⁴

The applicable standard of care is essential to understand because a nurse’s tort liability for negligence will be proven if it can be shown that a patient’s injury was caused by the nurse’s failure to meet the appropriate standard of care.¹⁹⁵ A nurse’s negligence generally arises in one of the three main steps in the nursing process—assessment, planning, and intervention.¹⁹⁶ As illustrated below, the types of errors classified as tortious negligence during these stages are often the same errors found to increase as nurse’s overtime hours increase. Hospitals are generally covered for the negligence of its employees under professional liability insurance policies.¹⁹⁷ With a legislative ban on mandatory overtime, tort actions filed against hospitals because of the negligence of nurses are likely to decrease.

Medication errors, commonly cited as the most problematic in the public health crisis, can lead to tort liability. Specific errors that have been found negligent are providing the incorrect medication, administering an incorrect dose, using the wrong “route” to administer medicine, and giving medicine at the incorrect time.¹⁹⁸ For instance, a nurse and hospital were found negligent for the nurse’s two hour delay in giving a measles patient medication.¹⁹⁹

193. TRANDEL-KORENCHUCK & TRANDEL-KORENCHUCK, *supra* note 190, at 322 (explaining that the most common types of nurse specialists are nurse anesthetists, nurse practitioners, and nurse-midwives).

194. *Id.* at 306; *Thompson v. Brent*, 245 So. 2d 751, 753 (La. Ct. App. 1971) (holding that “[t]he same rules which govern the duty and liability of physicians in the performance of professional services to their patients apply to nurses as well.”).

195. *See* BRENT, *supra* note 190, at 67; TRANDEL-KORENCHUCK & TRANDEL-KORENCHUCK, *supra* note 190, at 306.

196. TRANDEL-KORENCHUCK & TRANDEL-KORENCHUCK, *supra* note 190, at 306, 328 (pointing out that while there is a fourth step in the nursing process, evaluation, this step does not usually lead to tort liability because it comes after the treatment steps are completed).

197. *See* BRENT, *supra* note 190, at 81 (explaining that many nurses rely on the insurance covered provided by their employer.).

198. TRANDEL-KORENCHUCK & TRANDEL-KORENCHUCK, *supra* note 190, at 322-23.

199. *See* *Gasbarra v. St. James Hosp.*, 406 N.E.2d 544, 547 (Ill. App. Ct. 1980).

B. Effect on Unionization

Unionization of Nursing Industry in General

Union membership is high in the nursing profession, with almost three million registered nurses represented by unions.²⁰⁰ The union structure in the industry consists of state nurses' associations.²⁰¹ At the federal level, these state associations are collectively represented by the ANA.²⁰² The ANA deals with issues that affect nurses countrywide, while the state associations handle more local issues.²⁰³ Thus, the ANA is instrumental in bringing attention to nursing issues through Congressional lobbying.²⁰⁴

While the ANA handles federal issues, state associations are involved in negotiating contracts for nurses with particular hospitals. These nursing unions have been effective in negotiating contract provisions on a range of subjects including overtime, wages, benefits, job security and workplace discipline.²⁰⁵ A survey of contract provisions dealing with overtime negotiated by unions illustrates the effectiveness of these unions in handling such issues.²⁰⁶

The role of unions in negotiating contract provisions limiting mandatory overtime is especially important in states that do not currently have laws banning mandatory overtime. In Massachusetts, the Massachusetts Nurses' Association has been successful in securing limits on mandatory overtime in several hospitals.²⁰⁷ For example, St.

200. Am. Nurses Ass'n Frequently Asked Questions, <http://www.nursingworld.org/FunctionalMenuCategories/FAQs.aspx> (last visited Oct., 22, 2008).

201. *Id.*

202. *Id.*

203. *Id.*

204. *Id.* The ANA describes its own mission as "advanc[ing] the nursing profession by fostering high standards of nursing practice, promoting the economic and general welfare of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the general public." Am. Nurses Ass'n, ANA's Statement of Purpose, <http://www.nursingworld.org/FunctionalMenuCategories/AboutANA/WhoWeAre/ANAsStatementofPurpose.aspx> (last visited Oct. 22, 2008).

205. See Joe Twarog, *The Benefits of Union Membership: Numerous and Measurable*, MASS. NURSES ASS'N (May 2005), <http://www.massnurses.org/labor/education/2005/may/benefits.htm> (State nurses' associations also negotiate contract provisions about hiring, promotions, transfers, layoffs, changes in working conditions, access to patient information, and having a voice in planning for patient care.).

206. See *id.*

207. See Mass. Nurses Ass'n, *Backgrounder on St. Vincent's Hospital Nurses Strike Regarding*

Elizabeth's Hospital's contract limits mandated overtime to four hours in one shift.²⁰⁸ Cambridge Hospital's contract specifies that overtime can only be mandated after an unforeseen emergency and limits the shift of any nurse, even those normally working twelve hours, to thirteen hours.²⁰⁹

The New York State Nurses Association is an especially strong state union, representing over thirty-four thousand nurses.²¹⁰ The union has negotiated contract provisions dealing with mandatory overtime.²¹¹ One such contract was negotiated with the Nyack Hospital, in which mandatory overtime was contractually banned.²¹² This provision was aimed at retaining currently employed nurses and attracting new nurses to work at the hospital.²¹³

The accomplishments effectuated by these state unions demonstrate how widespread the concern about overtime is, even in states without legislation banning it.²¹⁴

Effect of Kentucky River Decision

Due to the National Labor Relations Board's ("NLRB") *Kentucky River*²¹⁵ decision, many nurses risk being reclassified as supervisors.²¹⁶ As supervisors may be barred from union membership, this decision threatens to exclude a large number of nurses from unions and from receiving the benefits of union negotiation.²¹⁷ Thus, federal legislation limiting mandatory overtime is crucial as nurses risk losing the ability to

Mandatory *Overtime* *Issue,* MNA, 2000,
<http://www.massnurses.org/News/2000/000003/strike/backgrnd.htm> (last visited Sept. 11, 2008).

208. *Id.*

209. *Id.*

210. Press Release, N.Y. State Nurses Ass'n, Nyack Registered Nurses Ratify New Contract (Sept. 1, 2006), available at <http://www.nysna.org/news/press/2006/090106.htm>.

211. *See, e.g., id.*

212. *Id.*

213. *Id.*

214. *See* discussion of state initiatives, *supra* Part II.A. Massachusetts has not passed legislation regulating mandatory overtime. Until recently New York had also not passed such legislation. However, in August, 2008, New York Governor David A. Paterson signed a bill into law banning mandatory overtime for registered nurses and licensed practical nurses, which will go into effect July 1, 2009. Press Release, N.Y. State Nurses Ass'n, Governor Signs Mandatory Overtime Bill into Law (Aug. 15, 2008), available at <http://www.nysna.org/news/press/081508.htm>.

215. NLRB v. Ky. River Cmty. Care, Inc., 532 U.S. 706 (2001).

216. James Parks, *Labor Board Ruling May Bar Millions of Workers from Forming Unions*, AFL-CIO Now Blog, Oct. 3, 2006, <http://blog.aflcio.org/2006/10/03/labor-board-ruling-may-bar-millions-of-workers-from-forming-unions>.

217. *Id.*

obtain such benefits through union negotiation.

The *Kentucky River* decision is actually a compendium of three cases dealing with the issue of how to define a supervisor.²¹⁸ In a case dealing specifically with nurses, the NLRB defined permanent charge nurses in a hospital setting as supervisors due to their range of duties, which include monitoring their patients as well as meeting with doctors and the patient's families.²¹⁹ Labor groups have found the classification of charge nurses as supervisors distressing because charge nurses do not have the authority to hire, fire, or discipline other workers.²²⁰ Additionally, labor groups are taking issue with the fact that RNs often rotate charge nurse responsibilities and do not serve in the role most of the time, a fact that the NLRB itself recognized.²²¹

In this way, the NLRB ruling seems to classify charge nurses as supervisors without an understanding of the day-to-day activities in the nursing profession. On a larger scale, the Economic Policy Institute has calculated that 8 million workers across a host of professions, in addition to nursing, are at risk of being classified as supervisors by the ruling.²²²

Nursing unions have been outspoken in their opposition to the *Kentucky Rivers* ruling. Union leaders claim that the decision does not make sense in terms of the day-to-day realities of the nursing profession.²²³ A spokesperson for the Oregon Nurses' Association

218. See *Ky. River Cmty. Care, Inc.*, 532 U.S. at 708; James Parks, *supra* note 216.

219. *Oakwood Healthcare, Inc.*, 348 N.L.R.B. No. 37, at 2, 9-10 (Sept. 29, 2006), available at http://www.nlr.gov/shared_files/Board%20Decisions/348/348-37.pdf ("Charge nurses are responsible for overseeing their patient care units, and they assign other RNs, licensed practical nurses ("LPNs"), nursing assistants, technicians, and paramedics to patients on their shifts. . . . Charge nurses may also take on their own patient load, but those who do assume patient loads will sometimes, but not always, take less than a full complement of patients.").

220. H.J. Cummins, *Will a Government Regulatory Ruling Create 8 Million New Bosses? The National Labor Relations Board Clarified Who is a Supervisor. Or Did It?*, STAR TRIB., Nov. 16, 2006, at 1D.

221. See *Oakwood Healthcare, Inc.*, 348 N.L.R.B. No. 37, at 2, 14 ("Twelve RNs at the hospital permanently serve as charge nurses, while the other RNs take turns rotating into the charge nurse position . . . [d]epending on the patient care unit and the work shift, the rotation of the charge nurse position may be worked out by the RNs among themselves, or it may be set by higher-level managers. The frequency and regularity with which a particular RN will serve as a "rotating" charge nurse depends on several factors (i.e., the size of the patient care unit in which the RN works, the number of other RNs who serve as rotating charge nurses in that unit, and whether the unit has any permanent charge nurses.); Cummins, *supra* note 220, at 1D (explaining that the ruling classifies a supervisor as someone who oversees other workers only to ten to fifteen percent of the time).

222. Cummins, *supra* note 220, at 1D (pointing out that the Economic Policy institute analyzed thirty six professions including accountants, bank tellers, computer scientists, cooks, carpenters, private security guards, and pharmacists).

223. United American Nurses, AFL-CIO, *UAN Message Platform: NLRB Charge Nurse*

expressed concern that the ruling would discourage nurses from working in roles that could be perceived as supervisory, thus disrupting the coordinated delivery of care to patients.²²⁴ While unions have been outspoken in their opposition to the decision, its recentness does not allow for determining whether or not their concerns are well-founded. However, the probable loss of union power in the nursing industry resulting from the ruling does strengthen the need for federal legislation regulating mandatory overtime. Without a strong union presence, the nursing industry depends on such legislation to effectively deal with the overtime issue.

IV. SYNTHESIS PROPOSAL AND EFFECTIVE STRATEGIES FOR PASSAGE

A. Synthesis Proposal

This section examines the good and the bad of the state legislation, regarding patient care and the nursing shortage that has been discussed. Furthermore, this section establishes a synthesis proposal for federal legislation that combines the strengths of these legislative initiatives, maximizes these strengths through careful defining of their significant aspects, and corrects their weaknesses. This proposal seeks to correct the current health crisis, addressing the root of its problem, the nurse shortage and its contributing factors. Accordingly, the following initiative addresses the nurse shortage by addressing nurse needs. Specifically, it proposes to provide for (1) “good faith reasonable attempts”²²⁵ to obtain voluntary nurses to work overtime when patient loads require greater nurse care; (2) a “complaint system”²²⁶ to reinforce these attempts; (3) a “time-off” period²²⁷ for nurses who work overtime; (4) a limitation on the amount of overtime that a hospital may mandate, or that a nurse may volunteer;²²⁸ (5) a guarantee that nurses may

Decision, June 2006, <http://www.uannurse.org/Kentucky/messages.html> (discussing NLRB’s lack of understanding about nursing culture).

224. See Robin J. Moody, *Nurses Who Act as Supervisors Could Run Afoul of Rules*, PORTLAND BUS. J., Oct. 13, 2006, available at <http://portland.bizjournals.com/portland/stories/2006/10/16/story10.html>.

225. See discussion of state legislative initiatives, *supra* Part II.A; N.J. STAT. ANN. § 34:11-56a32 (West Supp. 2007).

226. See N.J. ADMIN. CODE § 8:43E-8.10 (2007).

227. See ME. REV. STAT. ANN. tit. 26 § 603(5) (2007).

228. See 210 ILL. COMP. STAT. ANN. 85/10.9(B) (West 2007).

volunteer overtime;²²⁹ and (6) protection against retaliatory measures taken against nurses.²³⁰

Good Faith Reasonable Attempts

New Jersey's defining of "reasonable attempts"²³¹ to obtain voluntary workers during an "unforeseeable emergent circumstance" illustrates the importance of recognizing nurse needs in response to patient needs. Analogous to New Jersey's initiative, our proposal sets forth that these efforts must require the hospital employer to: (1) "contact all qualified employees who have made themselves available to work extra time;" (2) "seek the use of qualified per diem staff;" (3) "seek [qualified] personnel from a contracted temporary agency when such staff is permitted by law," regulating applicable collective bargaining agreements; and (4) provide time to make family arrangements.²³² Further, our proposal seeks to enforce the requirement to contact all qualified employees who have made themselves available to work additional hours, through a sign-up sheet that will be passed around by a supervisory nurse of each division (or department) of every hospital.²³³

Complaint System

Similar to New Jersey, our proposal sets forth a "complaint system" to enforce the requirement of "good, faith reasonable attempts" described above. These steps provide a nurse's right to complain up to two years following the date of the assigned mandatory overtime if she believes that the overtime was not a response to an "unforeseen emergent circumstance," "reasonable efforts" were not exhausted, and time to make family arrangements was not provided for.²³⁴ Accordingly, this facet of our proposal ensures that our initiative will take effect. At the same time, however, our providing of a two year time period for a nurse to file a complaint ensures hospital efficiency. That is, this time frame protects against the possibility of an infinite number of complaints that would impede supervisory interests to the detriment of patient health

229. See § 34:11-56a34.

230. See 85/10.9(c)-(d).

231. See § 34:11-56a32.

232. *Id.*; § 34:11-56a34.

233. See § 34:11-56a34.

234. See N.J. ADMIN. CODE § 8:43E-8.10 (2007).

interests.

Time-Off Period

Additionally, state implementation of a two-day “time-off” period, following mandatory overtime also addresses nurse health concerns.²³⁵ Specifically, the enforcement of mandatory overtime contributes to the fatigue that plagues the aging nurse workforce.²³⁶ This proposed “time-off” period seeks to alleviate slow-downs in reaction time, decreases in energy, and diminished attention that has contributed to medical errors.²³⁷

Voluntary Overtime Limit

A statute legislating mandatory overtime must include a provision limiting the amount of voluntary overtime that a nurse is allowed to work. Public safety concerns involving patient safety are substantial, whether the overtime in question is mandatory or worked voluntarily.²³⁸ In addition, overtime in general has been found to increase the risk of injury to nurses themselves.²³⁹ Thus, it is necessary to specify that there is a cut off point to the amount of voluntary overtime that can be worked. We propose that shifts should be limited to twelve hours. This restriction is based on findings that work performance is adversely affected when nursing shifts exceed twelve hours.²⁴⁰ Further, there should be a limit to the amount of hours any nurse can work in a consecutive period. We propose that no nurse should be able to work more than sixty hours in a seven day period. This restriction, based on recommendations issued by the Institute of Medicine, deals with the underlying issue of employee burn out that is heavily linked to the industry wide dissatisfaction.²⁴¹

235. See Trends in Nurse Overtime, *supra* note 12, at 184.

236. *Id.* at 184, 189.

237. See *id.*

238. *Id.* at 184 (examining in a study the negative effects of nursing overtime without distinguishing between mandatory and voluntary overtime due to similar safety concerns).

239. Impact of Nursing, *supra* note 71, at 88 (citing exploratory study finding that nurses working overtime reported increased injury to themselves).

240. Safe Nursing and Patient Care Act of 2005, H.R. 791 109th Cong. § 2(6) (2005) (“nurses who worked shifts longer than twelve and a half hours were three times more likely to commit . . . error[s]”); Trends in Nurse Overtime, *supra* note 12, at 189.

241. See H.R. 791 § 2(5); Trends in Nurse Overtime, *supra* note 12, at 184.

Clear Allowance of Voluntary Overtime

While recognizing the need for a limit on voluntary overtime, effective legislation must expressly provide that neither mandatory overtime restrictions nor voluntary overtime caps should impede the ability of nurses from working overtime if they choose. This type of clause should be included in any legislation affecting mandatory overtime to make clear that nurses can work overtime if they desire.

Although critics may suggest that this provision undermines the purpose of a bill attempting to reduce the negative effects associated with overtime, a strict limit on the number of hours worked as discussed above reinforces the bill's foremost goal of protecting patient's safety while allowing a nurse to reap the economic benefits of overtime. Opponents should also take note that the nursing industry, represented by unions, has lobbied strongly for passing mandatory overtime legislation, pointing out the threat overtime poses for patients, and therefore its concern with public safety.²⁴² Thus, the legislature should defer to the judgment of individual nurses in terms of whether they are capable of working overtime during a given shift. Additionally, making clear allowances for voluntary overtime is essential in light of the current nursing shortage.²⁴³ Providing nurses with the ability to schedule their own overtime would lead to greater job satisfaction, which would help alleviate the shortage.²⁴⁴ In fact, studies support this by showing that "magnet hospitals—hospitals known for excellent nursing care and nurses who are more satisfied with their work—provide for nurse self-scheduling, which suggests greater nurse control of overtime."²⁴⁵ Finally, a clause making it clear that voluntary overtime is not prohibited is necessary so that employers do not ban voluntary overtime in an effort to avoid getting into trouble. It is likely that the absence of this clause would leave employers confused about what repercussions would result from nurses working overtime, leading employers from unnecessarily restricting the amount of overtime that can be worked.

242. See *Nurses Ban Mandatory Overtime in New Contract*, PEOPLE'S WKLY. WORLD, Sept. 21, 2002, www.pww.org/article/articleprint/1989.

243. For a detailed discussion of the nation's nursing shortage see *supra* Part I.

244. See *Trends in Nurse Overtime*, *supra* note 12, at 184 ("Lack of control of work schedules . . . is one of the reasons RNs give for their dissatisfaction with hospital work. . . . Surveys of RNs report that getting 'better hours' is one of the reasons many nurses give for working in other fields." (citations omitted)).

245. *Id.* (citations omitted).

Anti-retaliation Measures

The necessity of protecting nurses from retaliation for refusing to work overtime or reporting such actions has been incorporated into the mandatory overtime legislation of several states.²⁴⁶ Likewise, the “Nurse Nondiscrimination Protections” enumerated in the Safe Nursing and Patient Care Act prohibit retaliatory behavior toward a nurse who abstains from overtime, reports a violation of the statute, participates in an investigation into violations of the statute, or discusses such violations with other employees or union representatives.²⁴⁷ In addition, the statute explicitly bars an employer from filing a complaint against a nurse for refusing to work mandatory overtime.²⁴⁸ The broad protections outlined in the Safe Nursing and Patient Care Act should be incorporated into any mandatory overtime legislation as they prohibit employers from using unfair means to coerce nurses into working overtime.

B. Effective Strategies for Passage

Despite congressional efforts,²⁴⁹ federal responses to the current health crisis regarding the nursing shortage have consistently failed. Although the Safe Nursing and Patient Care Act of 2005 addresses the root of the problem (i.e. nurse dissatisfaction) in order to resolve this crisis, there seems to be more to this congressional struggle than getting the “right stuff” into a federal statute. The passage of this type of statute will depend upon political environment, and its appeal to good policy regarding the groups that such a statute will impact: nurses, patients, and hospitals.

Political Appeal; Likelihood of Passage Under Democratic Congress

While the Safe Nursing and Patient Care Act has been awaiting approval since 2005, it has a higher likelihood of passage under the newly elected Democratic congress. Traditionally, the Democratic Party has been associated with a more sympathetic view towards union

246. The mandatory overtime legislation of Illinois, Maine, and Washington include protection from retaliatory behavior. See discussion of state initiatives *supra* Part II.

247. H.R. 791 at § 1866(k)(4)(A).

248. See *id.* at § 1866(k)(4)(B) (An employer “may not file a complaint or a report against a nurse with the appropriate State professional disciplinary agency because the nurse refused to comply with a request to work mandatory overtime”).

249. See discussion of federal legislative initiatives, *supra* Part II.

rights.²⁵⁰ This view has been reinforced as the Democrats have championed a raise in the minimum wage and the Employee Free Choice Act, aimed at protecting workers' rights to union membership.²⁵¹ More specific to the nursing industry, the Democratic National Committee Chairman, Howard Dean, spoke out against the NLRB *Kentucky River* ruling that has the potential to remove the ability of a large numbers of nurses to join a union.²⁵² Dean criticized the Republican party for cutting workers' protections and being hostile to worker's rights, such as overtime protection.²⁵³

Under a Democratic congress, union leaders expect the political climate to be more welcoming toward their efforts.²⁵⁴ This attitude was shown by Greg Tarpinian, director of the Change to Win coalition, in saying, "the victory for Democrats is certainly a victory for working Americans."²⁵⁵

Good Policy

Michelle Artz, Associate Director of Government Affairs at the ANA, suggests that appeal to good policy is a significant factor in getting legislation passed at the federal level. According to Ms. Artz, "in the end what you are talking about is worker and employer," referring to the tension between nurses and hospitals. Although hospitals aim to serve their patients with high quality (nurse) care, they desire to do so with the freedom to conduct their 'businesses' as they please, free from government intrusion.²⁵⁶ Accordingly, Ms. Artz explains that the congressional environment is simply not "ripe" enough to deal with angry hospitals, resentful of intrusion into their business conduct.²⁵⁷ Therefore, the above proposal must be "marketed" in the right way; it must appeal to employer hospital concerns while achieving nurse needs and focusing on patient needs. This type of marketing is not

250. See Moira Herbst, *The Return of Workers' Rights*, BUSINESSWEEK.COM, Nov. 10, 2006, http://www.businessweek.com/bwdaily/dnflash/content/nov2006/db20061110_831393.htm?chan=search.

251. *Id.*

252. The Democratic Party, Dean Statement on Bush Labor Board Moving to Strip Workers' Rights, July 13, 2006, http://www.democrats.org/a/2006/07/dean_statement_22.php.

253. *Id.*

254. Herbst, *supra* note 250.

255. *Id.* The Change to Win coalition "represents six million workers in unions such as the SEIU and the Teamsters." *Id.*

256. *Id.*

257. *Id.*

false advertising. The marketing of the proposal in this way would respond to the public health crisis as its primary aspect, addressing nurse needs as ancillary to its resolution.

*Lauren Kugielska & Melissa Linker**

*We would like to thank our faculty adviser, family, friends, and the journal for making the publication of our piece possible.