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Special Health Report

Nurses Step to the Front

In hamlets and high-tech hospitals, nurses are taking on bigger roles

By Samantha Levine and Angie C. Marek

When white-haired Harry Curry shuffles into the Minnie Hamilton Health Care Center in rural Grantsville, W.Va., he says he'll see only "his doctor." That's his name for Teresa Ritchie, the nurse practitioner who looks after the 71-year-old at this tiny complex tucked in the Appalachian hills. And it's not really a misnomer. The veteran nurse takes on everything from minor surgery to emergency room crises. Ritchie has admitting privileges at area hospitals, still unusual for a nurse, and can prescribe medication with just a doctor's checkoff. Her autonomy surprises her as much as anyone. "When I started out, nurses were not told we could think for ourselves," says the West Virginia native, who delivers care with a dollop of down-home gossip and finds ways to give her predominantly low-income patients free medicine. "We just did what a doctor planned out for us."

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- Pharmacists: Drugstores offer more than just pills
- Nurses: The shortage that won't quit
- On Health: Medical practice has become a group effort

But those times are long gone. Many of the country's more than 2 million nurses are taking on jobs that were once the purview of physicians, like administering chemotherapy and running their own primary-care practices. They are carving new niches in fields such as genetics and computerized patient records, where nurses were once hard to find, and bringing philosophies oriented toward health promotion and problem prevention to geriatric care and case management. "When we are allowed to think outside the box, there is a lot we can do," says Jane Barlow, a University of North Carolina nurse who is developing a disability screening and intervention system for children in her home state. "In every situation, there is more that nurses can do if they feel empowered."

The seeds of nurses' liberation from doctors' white coattails were sown in the 1960s. That's when a nationwide shortage of primary-care physicians, especially in rural and inner-city areas, pushed many nurses into advanced roles. "Nurses were doing things that most people thought just

physicians were doing, like seeing patients and recommending medication," says Lynne Vigesaa, who in 1972 became the first nurse practitioner in the state of Washington and later helped write the state's regulations defining and governing that role. Through the 1980s, the idea of nurses' doing more than just assisting doctors gained acceptance as patients began seeking out nurses--who seemed to have more time for them--and resistance from physicians' organizations eased. States began formalizing nurses' expanded roles. "It's pretty amazing, when you think about it," says Vigesaa, who now manages a dermatology clinic outside Seattle.

Filling a void. The advent of managed care also opened doors. The law defining health maintenance organizations was passed in 1973. But the idea--prepaid plans that enroll members and arrange their care from a designated network of doctors--brought on serious complications. The plans often tightly control how, when, and why doctors offer medical services. The reimbursements doctors get from the plans are prearranged but haven't all risen in step with the ballooning cost of healthcare. That problem now extends beyond HMO s to all insurance plans, doctors complain, which means they must see ever increasing numbers of patients to remain profitable. Those busy schedules have created voids in patient care--and nurses are filling them. "When patients call doctors for advice these days, many times nurses are the ones at the other end of the line," says Patricia Rowell, a senior policy fellow for the American Nurses Association.

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Over time, as the hours and roles of medical residents and interns changed, many nurses with master's degrees who specialized in fields such as pediatrics were called upon to perform tasks once reserved only for the med-school set. Rowell, a pediatric nurse practitioner, remembers hearing of her colleagues in infant intensive-care units being allowed to insert breathing tubes down the throats of delicate babies. "It was an incredible thing," she says. These trends are continuing today as residents' exhausting schedules are further cut back--for reasons of patient safety.

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As nurses are asked to do more, they are also trained to do more. In 1980, 60 percent of nurses received their basic education through on-the-job training courses in hospitals. That number was cut in half by 2000. During that same time, the share of nurses earning associate's degrees more than doubled, to 40 percent. The number of nurses pursuing master's degrees and doctorates has tripled over the past two decades--by 2000, one in 10 registered nurses had made the leap. And the number of doctoral programs nationwide has grown from 52 in 1990 to 93 today. By 2015, the American Association of Colleges of Nursing wants all nurses doing advanced practice work that now requires at least a master's degree--this includes nurse practitioners, clinical nurse specialists, nurse midwives, and nurse anesthetists--to hold a doctorate of nursing practice.

Nurses already have rigorous training. Most undergraduate nursing schools require students to take a variety of courses, from

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statistics to biology, before they can even enter the nursing program. Once in a program, students' classes include anatomy and ethics, and they must complete several practicums. After earning an undergrad degree, every student must pass a nationally standardized test before officially becoming a nurse.

Rules governing what nurses are allowed to do with this training vary by state. "You sometimes push for 15 years, so hard, just to take one baby step," says Marie-Annette Brown, a nursing professor at the University of Washington who helped lobby to give nurses in her state more power to prescribe medication. Before such efforts, nurses could not prescribe controlled substances like morphine without doctors' supervision. That's still the case, though, in 37 states that demand a doctor's sign-off. But 27 states allow nurses to open their own private practices without a doctor in the house. Many nurses still have trouble, however, persuading insurance companies to reimburse them for their work.

Whole-patient care. But more than the ability to prescribe drugs, nurses are pushing to practice a breed of care that bears their unique imprint. "More so than doctors, we focus on health promotion, the strategy of teaching our patients how to live healthier lives," Brown explains. This means helping patients manage their symptoms and chronic conditions and avoid health pitfalls like poor diets. "If I have a child with diabetes, I try to teach him to self-regulate his condition," says Rowell. "But I also tell him to . . . engage in after-school activities; don't be afraid to live a normal life."

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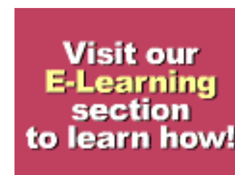

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Looking at the whole patient is critical for oncology nurse Ann Welsh. As a senior nurse in the chemotherapy division at the University of Pittsburgh Medical Center's Hillman Cancer Center, she is doing more than she could have imagined when she graduated with an associate's degree in nursing from Northern Virginia's Marymount University in 1973. At that point, she was given a little white nurse's cap and went to work on the National Cancer Institute's pediatric ward. "Early on, I was the liaison between the doctor and the patient," she explains. But through the 1980s, as more cancer treatment moved to an outpatient basis, her responsibilities grew to coordinating most aspects of her patients' therapy regimen. With her understated manner, Welsh, 51, gently administers chemo to hundreds of patients. Though she closely collaborates with Hillman's oncologists, there's nary a doctor in sight while she sets up complicated webs of intravenous drips for folks like Mario Urlini, a hearty 83-year-old who's getting his last treatment for non-Hodgkin's lymphoma. While Welsh connects the clear tubes, Urlini's wife, Grace, looks on and says: "I went through two major operations, and I never found a nurse like Ann."

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Welsh also trouble-shoots problems with patients, such as sorting out whether an older man with worrisomely low blood counts can undergo needed cataract surgery. Patients call Welsh, not their physicians, with day-to-day concerns. "I know them inside and out, so I can assess if there is a big change," she says. "We can take better care of our patients if we use our own judgment, provided we know them and fully understand the course of their disease." As for that nurse's cap? "I wore it for a few months," says Welsh. Then she threw it out.

Balancing act. The ability of nurses to balance complex elements of long-term care while acting as counselors has made them a good fit as case managers. They work as the

primary contact for patients, like the elderly, who have complex treatment plans. They can help eliminate frustrating redundancies among various doctors' offices and keep a constant record of detailed medical regimens. In San Francisco, gerontology expert and nurse Monika Pettross started her own case-manager business four years ago. One year into the venture, she began working with an elderly woman whose family found a suicide note in her home. Pettross, 32, discovered that some of the patient's medications could badly interact and lead to depression. After suggesting changes to the woman's prescriptions, she helped place her in a therapy program and counseled the family on how best to offer support. After two months, the woman was looking for a part-time job. Pettross still works with her today. "This work is so important I can't take off a badge in my free time and walk away from it," says Pettross.

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Pettross is on to something. As people live longer and the nation's 78 million baby boomers approach retirement, more nurses are taking on elder care. The federal National Institute of Nursing Research is devoting millions of research dollars to the topic. One project explored the effect of delivering education and follow-up care at home to older patients hospitalized for heart trouble, says institute director Patricia Grady. Home delivery decreased the number of visits to the hospital, saving $4,845 in Medicare expenses per patient.

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Nurses are also walking the cutting edge of health technology. They are at the vanguard in shifting hospitals away from mountains of problematic paper patient charts to automated, computer-based systems that cut down on de-lays and errors, says Scott Young, director of health information technology at the federal Agency for Health Research and Quality. About an hour south of Pittsburgh at Uniontown Hospital, Chief Nursing Officer Rebecca Ambrosini is one of those pioneers. Tired of 40-plus-page medical charts that "were never where we needed them when we needed them," she helped make a monumental change. After two years of work, nearly 85 percent of Uniontown's patient information is now available in a user-friendly desktop program called PowerChart. Only about 13 percent of U.S. hospitals have done anything like this.

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The Uniontown system not only records patients' vital stats, like allergies and blood pressure, but also automatically sends doctors' orders to nurses, organizes reminders on necessary lab work, and sets up schedules free of hassles like double booking. The program also fires off automatic requests for help from social workers and even interpreters if one is needed. "Before, you had to pick up a phone and call for this assistance--if you remembered," says Darlene Ferguson, a critical-care nurse who is now Uniontown's director of clinical informatics and runs the system on a day-to-day basis. "We would grab a paper towel, write down what we needed, and stuff it in a pocket."

New ventures. At first, this high-tech onslaught made some Uniontown nurses a little nervous. "Some people talked about quitting" because they were worried about using computers, says registered nurse Donna Martin. But Ambrosini and Ferguson ran hours of workshops to get everyone up to speed. Now, wireless PowerChart workstations on wheels line the beige hallways at the 230-bed facility. Nurses roll the computers into patients' rooms to take information and update charts with a keyboard and mouse rather than paper and pencil. There also are computer

stations that are built into the walls and fold up like Murphy beds.

Nurses are also gaining ground in one of the fastest-growing areas of medical practice: genetics. According to Grady, of the nursing research institute, it makes sense for nurses to be involved in this fast-moving field because while genes may put patients at risk for health problems, changes in lifestyle and habits--a topic close to nurses' hearts--can help mitigate them. One recipient of the institute's funding is Lorraine Frazier, who holds a doctorate in nursing, a postdoc in genetics, and a teaching position at the University of Texas at Houston College of Nursing. Several years ago, when she first told a molecular medicine researcher that she wanted to work with him, "he was surprised," she says. "No nurse had ever asked to do that. Then, he asked me what nurses do." Now he knows. Frazier runs studies looking at how genetics shape the risks faced by patients with unstable heart disease; the results will eventually help tailor treatments for these patients.

For all its advances, nursing is still bedeviled by one old problem: lack of respect. When it comes to funding for nursing research, for instance, the money is a trickle. The nursing institute's budget makes up just 0.5 percent of the overall research pot at the National Institutes of Health. And according to a recent survey from VHA, a Texas-based healthcare cooperative, disrespect often takes a more direct, virulent form: abuse by doctors. Hospital nurses report vicious arguments. This toxic environment causes a breakdown in communication that can adversely affect care.

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Down in Grantsville, nurse practitioner Ritchie hopes that the research that is going on will not just win more respect one day but will also help her patients with chronic illnesses. In her green cargo pants, black turtleneck (from which hangs her ever present stethoscope), and lug-soled boots, Ritchie ducks from crowded office to examining room to the "extra medicine" supply closet as country music plays on a boombox. She tells Harry Curry she'll go to Wal-Mart and buy him more of the salve he likes to rub on his dry, scaly shins. Then she tells another patient, Delberta Hickman, that it's OK to trust in Jesus to heal her diabetes but that medicine can help, too. She gives a 15-year-old girl free antibiotics and an enormous stack of condoms. "I plan to stay here," says Ritchie. "I couldn't leave my patients."

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It's a simple thing really, says Uniontown's Ferguson: "A nurse always wants to make things better."

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