Through the 1990s most hospitals were involved in restructuring. As a result, maintaining professional nursing practice is challenging in these cost-constrained hospital environments. In new models of care, professional nursing practice expectations are often reconceptualized into multidisciplinary care team structures in which the team is empowered and becomes the focus rather than the individual nurse caring for her or his patient. Given that nurses provide the greatest part of patient care in hospitals, professional nursing practice has the potential to differentiate one hospital from another. Consequently, it is in the strategic interest of organizational policy makers to implement initiatives that support professional nursing practice.

Through the 1990s, a preponderance of hospitals were involved in initiatives to reduce operating costs. The ongoing pressure from the expansion of managed care, increased competition, and the passing of the Balanced Budget Act of 1997, is expected to continue reducing hospital financial margins through the early 2000s. Despite a recent reallocation of dollars back into the Medicare program, Medicare reimbursement is still not keeping pace with rising hospital expenses. The confluence of these pressures spurs hospitals to continue implementing cost reduction initiatives.

Historically, reducing the number of employees has been the most common approach for reducing organizational operating costs and restructuring a common strategy for reducing the number of employees. While the overall success of hospital restructuring to date is arguable, quite likely, restructuring hospital services will continue well into the new millennium. Conceptually, restructuring is the implementation of an integrated configuration of organizational work processes and people. Operationally, hospital restructuring may involve the redesign of a variety of care and service processes; multi-skilling and cross-training; and changes in roles, responsibilities, and staffing levels. While staffing levels can be increased as a result of restructuring, more often they are reduced. Restructuring initiatives vary in scale and scope from hospital to hospital. These initiatives involve change on patient care units in one or more of the following areas: nurse staffing, the model of care, and professional nursing practice.

Maintaining professional nursing practice is challenging in cost-constrained hospital environments. Restructuring initiatives, particularly those associated with downsizing nursing staff, have raised the concern of staff nurses and consumers. These health care constituents express concern about the perception of a declining number of RNs at the bedside, nurses who are too busy to act on behalf of their patients, and patients who may not be receiving the quality of care they deserve.

Barnum views restructuring positively, arguing that the process facilitates a re-evaluation of professional nursing practice. Responsible restructuring initiatives facilitate the re-evaluation of the kind of tasks that are not complex and may be delegated, leaving the RN to provide the more complex patient care. The centrality of the nurse-patient relationship can be enhanced through restructuring. By delegating away non-nursing activities, professional nursing practice is preserved and patient outcomes enhanced.

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Manthey\(^{24}\) believes that the determination of professional practice expectations should be an explicit and discrete step in restructuring models of care. She argues that professional nursing practice expectations (e.g., the level of autonomy, control of decision-making, physician collaboration, responsibility, accountability, and authority) have a direct and powerful impact upon staffing levels—more than any other restructuring decision.\(^{24}\)

In the new models of care, independent professional nursing practice expectations are often reconceptualized into multidisciplinary care team structures, in which the team is empowered and becomes the focus rather than the individual nurse caring for her or his patients.\(^{25-26}\) In some models, the centrality of the nurse-patient relationship is minimized or negated.\(^{27}\) Critics view this as a step backward for professional nursing.\(^{28-29}\)

The empirical literature is beginning to demonstrate a link between the model of care and professional practice attributes yielding the best outcomes.\(^{30-32}\) However, more empirical analysis is needed. How does change in the organization of hospitals affect professional nursing practice and in turn, patient outcomes?

**Professional Nursing Practice**

Contemporary professional nursing practice involves a myriad of essential activities and attributes. The American Nurses Association\(^{19}\) broadly defines the professional practice of nursing as: 1) the attention to the full range of human responses to health and illness; 2) the integration of objective data with subjective data gained from the patient’s experience; 3) the application of scientific knowledge to diagnosis and treatment; and 4) the provision of a caring relationship. Barnsteiner\(^{41}\) suggests that while there will be variation among hospitals, a critical skill set for professional nursing practice includes: the application of clinical knowledge and judgment; care coordination; competent communication; and both change management and leadership skills. A spirit of inquiry and critical thinking are important qualities for professional nursing practice as well.\(^{34}\) Contemporary professional practice also requires a focus on nursing-sensitive outcomes.\(^{35-36}\)

All of these qualities provide an internal platform for operationalizing contemporary evidenced-based practice. Evidenced-based practice involves the synthesis of knowledge not only from clinical expertise and research reports, but also from a variety of other sources such as: retrospective or concurrent chart review; quality improvement and root cause analysis; international, national, and local practice standards; infection control studies; pathophysiological reports; cost effectiveness analysis; benchmarking studies; and patient satisfaction surveys.\(^{37}\)

Caring is another fundamental element of professional practice that contributes to a mutually rewarding relationship between nurses and patients and leads to better outcomes for nurses and patients as well.\(^{38-40}\) Balasco and Cathcart\(^{41}\) believe that caring requires standards of moral agency, discretionary judgment, and patient advocacy. Unfortunately, critics believe that hospital nursing is seldom organized to promote continuity of care, critical to achieving caring relationships with patients.\(^{39}\)

In a recent study conducted over a 3-year period, 22 cancer patients were asked to identify qualities of nursing practice that are important to them.\(^{42}\) Eight hallmarks of professional nursing practice were identified: professional knowledge; rapport or a human connection with the patient; shared decision-making between the nurse and the patient; individualized treatment; caring or nurturing attention; promptness in meeting patient care needs; having the same nurse as often as possible; and nurses coordinating care with other providers.

Some models of care position professional nurses to independently manage and direct the care of an assigned group of patients using assistive personnel.\(^{37}\) In these models, nurses delegate, or reallocate responsibility, for nursing tasks formally performed by a registered nurse, to an unlicensed worker.\(^{43-44}\) Hall\(^{44}\) argues that managing patients' care directly and managing a group of care providers require two different skill sets. Managing a group of care providers involves delegating patient care activities to be performed by an individual consistent within his or her license or scope of practice and the provision of guidance, evaluation, and follow up.\(^{45}\)

The American Organization of Nurse Executives (AONE)\(^{46}\) describes the role of the nurse as evolving, and professional practice as containing a unique constellation of value-based processes that assist patients in their response to illness (e.g., empowerment, self-discovery, autonomy, independence, and partnership). The AONE identifies elements of the evolving health care system that influence nursing practice:

- Networks of providers across the care continuum;
- Collaboration among health professionals regarding interdependent functions;
- Partnerships with consumers;
• Collective accountability;
• Advocacy for those who cannot advocate for themselves; and
• Leadership in cost-effective patient care.

The AONE states that professional nursing practice is shifting from a task-focus to an outcomes-focus in models where each registered nurse is accountable for his or her practice. Consequently, each nurse must be involved in quality management and performance evaluation programs that lead to improvements in both patient care and professional practice.46

Unfortunately, there is inconsistency between the professional ideal and the real world of clinical practice.47-48 In a classic piece on professional nursing practice that still has relevance to today, McClure47 points out that all contemporary nurses consider themselves to be professional. She makes a distinction between the presence of professionalism (a value of autonomy and the prestige associated with professional status) and the lack of it (little knowledge about research and the theoretical basis for practice). Others note that there are nurses who are autonomous and exert a high degree of authority by providing direction to others and others that prefer taking direction.48

Other Important Attributes

The Magnet Hospital study is a seminal qualitative study identifying the attributes of professional nursing practice in hospitals that were known to attract and retain nurses.49-50 An empirical evaluation of a subset of magnet hospitals was later conducted to identify what variables created the magnetism that led to the attraction and retention of nurses as well as high levels of nurse satisfaction and quality patient care.51-52 As recommended by Sovie49 a series of follow-up studies are empirically validating a subset of findings from the original magnet hospitals and examining them in relation to nursing's contribution to patient outcomes.50-52

Consensus in the literature regarding magnet hospital studies supports the findings that professional nursing practice in a hospital setting entails autonomy in clinical decision-making, control of the practice environment, and good communication with physicians.53-56 While not explicitly included in magnet hospital studies, three other attributes are associated with professional practice: responsibility; authority; and accountability.54-55

Autonomy

Autonomy in clinical decision-making occurs whenever a nurse makes an independent judgment about the presence of a clinical issue and then provides the resolution through nursing care. Mundinger47 argues that autonomy gives identity, independence, and authority to nursing practice and adds power as well. Autonomous nursing care is not a nurse providing medical care without medical supervision, rather, it is a nurse providing nursing therapy that complements and at times overlaps medical therapy.57 Autonomous nursing practice is the ability to offer a unique therapy and the ability to provide that therapy without permission from a physician. In reality there are few professional groups that are fully autonomous. Consequently, rather than a fixed characteristic, autonomy is a matter of degree.47

In order for professional nurses in hospitals to achieve autonomy, four basic requirements must be fulfilled: 1) there must be rigorous demands on competence and skills; 2) the patient care unit should be organized around the nurse-patient relationship; 3) there must be systematic methods of assessing and reassessing the nursing staff, and 4) nurses must have the right to request consultations.57 In Scott and colleagues'56 analysis of magnet hospital research, two dimensions of autonomy are identified: clinical and organizational. Clinical autonomy relates to the scope of practice for which staff nurses are accountable. Organizational autonomy is a characteristic of environments in which staff nurses are participants in the decision-making process that guides the unit and the organization.

Two empirical studies report that greater nurse autonomy leads to better patient outcomes.50,52 Aiken et al.52 report that, after controlling for a variety of organizational and patient characteristics, the intra-organizational status of nursing leads to greater autonomy allowing nurses to act on behalf of their patients thereby reducing mortality rates. Aiken and Sloane50 argue that specialized AIDS units represent a form of unit specialization whereby nurses' knowledge of patients increases thereby enhancing clinical autonomy. In these studies, autonomy is measured by 3 items: nursing's control of its own practice, freedom to make important decisions about care, and not being placed in a position of having to do things that are against nursing judgment.50

Control of Decision-making

There is a fine line between autonomy and control of decision-making. Professional practice implies control over the terms of the work but also control over its content and regulation of its standards.23,55 Authoritarian control—often encountered in the bureaucratic
hospital environment—and professional autonomy are incompatible. Ensuring professional practice (nursing’s autonomous control over a patient’s nursing care) requires decentralized control of decision-making at the patient care unit level. Decentralized decision-making does not mean total lack of managerial control, rather, a practice environment conducive to allowing nurses to think and act.

Aiken and colleagues argue that nurses’ control over the practice setting found in specialized AIDS units and magnet hospitals leads to better patient outcomes. In Aiken et al., increased control by nurses is related to enhanced patient satisfaction. Control is measured by the perceived presence of adequate support services, allowing time to be spent with patients, enough time and opportunity to discuss patient care problems with other nurses, enough registered nurses on staff to provide quality patient care, and a head nurse who is a good manager and leader.

Collaboration With Physicians

The ANA describes nurse-physician collaboration as an authentic partnership, in which power on both sides is valued, where each recognizes and accepts spheres of activity and responsibility, where each mutually safeguards the interests of each other, and where each recognizes a commonality of goals. Jones reports that it is becoming widely accepted that collaborative relationships between nurses and physicians affect outcomes for patients, nurses, physicians, and hospitals. Unfortunately, a recent comprehensive review of the vast literature concerning physician-nurse relationships describes a clinical workplace full of tension and strife, with nurses impatient to effect change, while physicians, representing the status quo, are skeptical if not oblivious to the need for change.

Nurses in the original magnet study describe collaborative physician-nurse relationships as an important component of professional nursing practice. The nurses in magnet hospitals describe the relationship between nurses and physicians as one that contains mutual respect for each other’s knowledge and a mutual concern for the provision of quality patient care. The importance of nurse-physician collaboration achieved greater recognition after two multi-hospital studies of intensive care units found that the interaction between physicians and nurses accounted for the variation in ICU patient mortality and ICU patient length-of-stay. Scott and colleagues point out that evaluation of nurse-physician interaction is absent in follow up studies of magnet hospitals, however, it is still considered an essential attribute of professional practice.

Responsibility

Responsibility refers to being entrusted with a particular function. Delegation involves transferring responsibility for the performance of a task from one person to another. According to Manthey, allocating responsibility is fairly easy, getting nurses to accept it is not. For optimal professional practice there should be a clear allocation of responsibility as well as an acceptance of responsibility for decision making. While some think that too little responsibility has been an impediment to the growth of professionalism, others argue that too much responsibility has led to an overly intensified work environment.

Authority

Authority is an action step that requires fulfilling the function for which you have responsibility. The delegation of authority should be commensurate with a nurse’s responsibility. Delegation to assistive personnel involves transferring authority to competent individuals to perform specific tasks in specific situations.

Authority involves the use of power and as a predominately women’s profession, nursing has had its difficulties in this area. Nurses’ discomfort with assuming authority permits perpetuation of an inappropriate level of external control and thwarts the advancement of professional nursing practice. How nurses accept authority affects their acceptance of responsibility and accountability for clinical decision-making.

Accountability

Accountability is the acceptance of responsibility for the outcomes of care. A system of accountability is a characteristic of professional nursing practice that is based on predetermined standards set by clinical nursing experts. According to Manthey in professional practice models, each nurse is answerable for the consequences of his or her actions and accountability is the flip side of the responsibility coin. When a nurse delegates to patient care activities to assistive personnel, she/he retains accountability for the delegation but transfers authority, responsibility and accountability for the activity or task.
Barnum argues that nurses are being held accountable in new ways. These new ways often have nothing to do with nurses' effectiveness in achieving patient care delivery goals, e.g., expectations regarding corporate compliance. Appropriate mechanisms to monitor accountability should be in place so that the quality of decision-making by the nurse can be evaluated.

Summary of Professional Nursing Practice

Professional nursing practice in the new millennium has evolved to include a broad array of activities and attributes in increasingly complex practice settings. Some of these qualities, particularly autonomy and control over the practice setting, are related to the achievement of patient outcomes in multi-hospital empirical studies. The hospital environment, despite a migration of patients to the outpatient setting, is the major employer of nurses and provider of care to patients. Consequently, it is in the best interests of organizational policy makers to enhance professional nursing practice.

Enhancing Professional Practice

One way to enhance professional practice, defined as nursing's autonomous decision-making control over a patient's nursing care, is to minimize the authoritarianism tendency in hospitals. The paternalistic and bureaucratic nature of hospitals has historically constrained the development of professional nursing practice. Nurses can become more autonomous if the organizational context in which they practice supports such a level of professionalism.

Another way to enhance professional practice is to design appropriate models of care that support evolving professional development as described by Benner. Models of care provide the framework to support professional development from the novice level to competent levels and help sustain professional practice at the proficient and advanced levels. The philosophical underpinnings of primary nursing, considered synonymous with a professional model of nursing practice, seem to enable professional practice in hospitals. The continuity of assignments and responsibility from admission to discharge enhances nurse's knowledge of patients. When the interaction between patients and nurses and nurses and physicians is consistent: good things happen. When the interactions are consistent, nurses are in a better position to demonstrate their competence thereby obtaining greater autonomy and control in patient care domains in which they are knowledgeable.

Ensuring staffing levels is yet another way to enhance professional practice. Aiken et al. argue that the better the staffing the more likely nurses' will be able to assess and act upon patients' needs consistent with professional practice. They theorize that the greater the status of nurses within hospitals, the better the staffing levels and the higher the RN skill mix, and that this leads to better hospital and patient outcomes.

Critics of hospital restructuring charge that the lower RN skill mix reverses the professionalization of hospital nursing brought about by primary nursing and may actually compromise patient outcomes. Brannon criticizes restructuring efforts that reintroduce and cross-train non-professional workers and drastically reverse RN staffing to levels characteristic of team nursing. He argues that these efforts are not in the interest of professional nurses or quality patient care given that patient intensity in hospitals has increased. Despite these compelling arguments, nursing labor force analyses indicate that hospital restructuring involving the reduction of RNs and introduction of unlicensed personnel may be increasing.

The Hospital's Business Imperative

In order to remain attractive to managed care organizations, hospitals have a threefold business imperative to reduce operating costs, optimize hospital length-of-stay, and achieve good patient outcomes. Historically, labor costs constitute approximately one half of hospital operating costs. Nursing staff, who provide the bulk of patient care, represent a substantial percentage of the hospital workforce and associated labor costs. Consequently, nursing labor cost reduction has been a cornerstone of hospital restructuring initiatives.

Reducing resource consumption through length-of-stay reduction (LOS) is often another cornerstone of hospital restructuring initiatives. Length-of-stay reduction involves the implementation of a variety of strategies to modify and monitor provider practice patterns. Hospitals have been successful at reducing the overall length-of-stay. Whether this reduction results from internal restructuring of care processes or external managed care organization utilization management practices is debatable. Regardless of the cause, patient length-of-stay is declining.
and results in an increase in the severity of illness and complexity of nursing care of the patients remaining in hospitals.\textsuperscript{2,4} Several studies demonstrate a direct relationship between severity of illness and nurse staffing: as severity goes up so does the need for nurse staffing.\textsuperscript{2,4,5}

Length-of-stay reduction poses a challenge to the provision of professional nursing care. In addition to the requirements for expedited clinical care, there is increased pressure to accelerate patient and family teaching. Expedited clinical care and accelerated teaching requires exquisite professional nursing practice so that nurses may act swiftly and surely on behalf of their patients.

**A Troubling Paradox**

Reducing nursing labor costs in the presence of rising acuity presents a dilemma to organizational policy makers such as nurse executives who are also responsible for designing models of care that achieve good patient outcomes. More and more payers are demanding data about the results of care delivery. Increasingly outcomes are an integral part of accreditation and regulatory requirements. Consumers are also requesting information about outcomes.\textsuperscript{6} While cost and length-of-stay management are important for a hospital’s competitive position, so is achieving good outcomes.

Professional nursing practice is an important link to achieving good outcomes for both patients and hospitals.\textsuperscript{19,50,69,77-80} Yet, a lack of resources and a waning commitment to nursing are common as evidenced when nurse executives are not involved at the highest levels of organizational decision-making.\textsuperscript{81} In this next era of restructuring, a better understanding is needed regarding organizational mechanisms that enhance professional nursing practice such as models of care and nurse staffing, and their relationship to patient outcomes.

**Models of Care**

A model is a configuration of nursing practice or a pattern for delivery of care.\textsuperscript{82} Models of nursing care, also referred to as nursing or patient care delivery systems, have undergone a number of changes: from team nursing in the 1960s, to primary nursing in the 1970s, to care and service team models in the 1990s. Professional nursing practice, particularly the attributes of autonomy, control of decision-making, collaboration with physicians, authority, responsibility, and accountability are influenced by a model of care.\textsuperscript{83}

**Team Nursing**

The philosophy of team nursing emerged as a result of the severe nursing shortage and medical technology explosion after WWII.\textsuperscript{84} Team nursing uses a mix of care providers, usually RNs, licensed practical nurses (LPNs), and nurse’s aides (NAs), who work together to provide total care to an assigned group of patients. Team nursing is based upon the belief that when the patient care activities and efforts of a diverse group of care givers are coordinated by a professional nurse, the group’s total effort will surpass what can be done individually.\textsuperscript{85}

Professional nursing practice in team nursing is characterized by a relatively high level of autonomy for the team leader but low level of autonomy for RN team members. Yet, team nursing is perceived to be a form of true decentralization in which decision-making authority is at clinical level closer to the patient.\textsuperscript{86} While communication is important in team nursing, most of the intensive communication activities are among team members, not with physicians. The professional nurse as team leader has responsibility for patient care and has the authority to delegate patient care activities to team members. The team members are responsible for the providing the patient care but, the team leader is accountable for ensuring that the care is delivered by the team.\textsuperscript{86}

The team model gave the era of “care through others” its name. Team nursing is criticized for being task-oriented resulting in a high level of fragmentation of patient care and little direct nursing care by the team leader.\textsuperscript{87} In addition, the overwhelming demands of managing groups of patients and delegating to staff often creates frustration in professional nurses because the emphasis is on coordinating the tasks and team members, not patient care.\textsuperscript{88}

**Primary Nursing**

Primary nursing emerged in hospitals during the late 1970s as a result of the rising complexity of patient care and the generalized dissatisfaction with team nursing. The philosophical underpinnings of primary nursing in which accountability and responsibility for patient care is assigned to a single primary nurse from admission to discharge enhances the professionalism of nurses and care of patients.\textsuperscript{54,68,69} The primary nurse provides direct care for the patient and family when on duty. An associate nurse provides care in the primary nurse’s absence. Zander\textsuperscript{80} describes an evolving model of primary nursing, case management, in which the primary nurse...
serves as a resource allocator, using necessary resources to facilitate the patient’s goal attainment.

Because the nurse providing direct care for her or his patients from admission to discharge is highly knowledgeable about her or his patients, the model is associated with a high level of clinical autonomy. In its best sense, the primary nursing care structure runs parallel to the physician structure. Both the continuity of care assignments and increased clinical knowledge leads to more authority and enhanced physician collaboration, consistent with professional practice. This in turn leads to increased responsibility and accountability, albeit for a defined group of patients. The higher levels of responsibility and accountability require less centralized control and administrative coordination.

Though primary care became associated with the belief an RN must be the exclusive provider of care, the model can be implemented with any staff mix. The relative low cost of an RN at the time of the model’s inception made the substitution of RNs for other care providers cost-effective and practical. However, even as the trend toward using an all RN staff slowed as a result of the nursing shortage and higher RN salaries, the research does not demonstrate unequivocally that primary nursing is more expensive than team nursing. As nursing salaries and a shortage of RNs increased, once again organizational policy makers began to redesign models of care.

**Care and Service Team Models**

Care and service team models developed in the 1990s and combined the characteristics of both team and primary nursing. As with team and primary models, care and service team models are implemented differently from hospital to hospital, from unit to unit, and from shift to shift. This difference makes measurement and evaluation of models across hospitals very difficult.

Common components of care and service team models include an empowered staff, multidisciplinary collaboration, multiskilled workers and a case management approach to patient care. The models evolved from a vision of autonomous nurses to vision of an empowered staff, from a vision of greater physician-nurse collaboration to greater multidisciplinary collaboration, from RNs providing the bulk of care to multi-skilled workers providing a variety of tasks previously performed by an RN, and from a goal-orientation to an outcome-orientation to patient care.

Generally, restructured models of care include new categories of assistive personnel, referred to as multi-skilled workers, nurse extenders, and unlicensed assistive personnel, who provide unit or clinical support. Some organizations maintain the philosophical underpinnings of primary nursing and examine new ways to keep the RN in direct contact with the patient by delegating away non-nursing activities. Other organizations put a new value on “leveraging” or delegating the work of patient care in their models.

Whether these new roles are a complement or substitute for professional nursing care is arguable. The literature is confounding as to whether newer models bring the nurse closer to the patient by delegating away non-nursing responsibilities or distance them by burdening them with management responsibilities of lesser trained workers.

The philosophical underpinnings associated with primary nursing such as continuity of primary nurse assignments are not always explicit in care and service team models. The focus changes from the centrality of the nurse-patient relationship to a patient-centered team approach. Like the preceding team models, coordinating the multidisciplinary team is time consuming and difficult to operationalize. A gap often exists between the vision of a multidisciplinary team and their actual functioning. According to Benner, professional levels of interdependence generally develop when nurses achieve the proficient and expert levels of clinical practice. Proficient and expert clinical practice generally takes three to five years to develop. In actuality, the majority of nurses practice at the competent level, a level at which the interdependence skill set is not yet fully developed.

Another issue compounds the challenge of developing multidisciplinary care teams. In care and service team models, the individual autonomous performance of nurses evolves into an interdependent empowered teams that make patient care decisions. In some models this actually threatens the boundaries and work jurisdictions of the individual professions. At a time when multidisciplinary collaboration is an expectation, nurses report that they have less time than ever to communicate with other members of the health care team.

Like team and primary nursing, care and service team models yield control of the practice environment to those closest to patient care. This control is framed by pre-determined evidenced-based plans of care such as protocols and clinical pathways. Care and service team models often introduce a case manage-
ment component separate from managing the daily activities of patient care. Consequently, these models to some degree change the delivery of patient care and professional nursing practice. As case managers work with primary nurses to achieve outcomes, the accountability becomes shared as opposed to individual. Professional nursing practice requires that nurses retain control of decision-making and the autonomy to make alternative decisions in the interest of patient care and as the situation warrants.

Responsibility and accountability change quite dramatically for professional nurses in care and service team models. The responsibility and accountability for outcomes is often shared among the team versus an individual primary nurse. Depending upon the model, the nurse may have authority over a mix of different assistive personnel. The nurse is still responsible and accountable for activities delegated to assistive personnel. There is wide variation in reports of the changing mix of RN and assistive personnel. The perception of a declining number of RNs leads to perceptions of declining professional nursing practice.

**Perceptions of Declining Professional Practice**

A recent survey report of over 7500 nurses across the country indicates nurses perceive they are taking care of more patients, are cross-trained to take on other responsibilities, and have less time to document all aspects of nursing care. In the same study, almost 60% of nurses perceive that the quality of care they are providing does not meet their professional standards. In addition, in an era when multidisciplinary care team models are popular, over 57% of nurses report that they have less time than ever to consult with other members of the health care team.

In another large survey examining the impact of healthcare reform on nursing practice, nurses report that it is not possible to give the amount of care to patients that they deserve and desire. While health care consumers believe that good hospital care means good nurses, nurses are finding it increasingly difficult to keep the “care” in nursing care.

Nurse executives, who are often part of the hospital's top management team, have a significant influence regarding clinical decisions as part of that team. In their executive roles, they offer different perspectives of the impact of restructuring in hospitals. Shindul-Rothschild et al. report that the perceptions of nurse executive respondents (n = 226) consistently differed from those of all other nurse respondents. A national survey of 152 nurses executives in 84 Veterans Administration Medical Centers reports that almost three quarters believe that restructuring initiatives are not affecting nursing practice and patient care.

Other prominent nursing leaders express concern that patients may be left behind in the wave of managed care. Clifford finds that hospital restructuring results in a decline in bedside staff nurses and leaves nursing indistinct in the restructured models of care. In addition, she finds that patient care unit restructuring changes the conventional central mechanisms for discussing and communicating patient care issues. In Clifford's case study, one hospital restructuring initiative actually dismantled the nursing department and in the post-restructuring phase it is evident that other departments relied on the nurses to coordinate patient care planning. This hospital failed to recognize the centrality of nursing to their model of care and paid an unfortunate price for the error.

**Nurse Staffing**

The perception of staff nurses that there is a significant reduction of professional staff members caring for patients is not validated by empirical studies. While Buerhaus and Staiger's 1999 study does acknowledge a significant decline in the growth of RN employment, there is no evidence as yet that indicates that the RN staffing levels per bed have declined.

Aiken et al. and Speetz explain the discrepancy between the perceptions of staff nurses and the empirical data. Aiken et al. believe the contributing factors are related to: 1) the overall decline in nursing personnel despite constant RN employment; 2) the highly publicized restructuring initiatives at some hospitals, and 3) the increasing mismatch between RN supply and hospital job availability. Speetz believes the reductions in the length-of-stay in the presence of a declining growth rate in the use of RNs is a major contributing factor to staff nurse perceptions.

**Empirical Studies of Professional Nursing Practice**

Unfortunately, there is a deficiency of empirical studies to support conclusions or decision-making regarding the relationship among restructuring, professional practice, and patient outcomes. There are even fewer studies that explore the process.
mechanisms (e.g., professional nursing practice), and its relationship to patient outcomes.\textsuperscript{19,30,32}

Nurse executives need empirical evidence regarding the relationship among nurse staffing, professional nursing practice, models of care, and patient outcomes to provide the basis for organizational policy decisions. The empirical literature on these is growing but is insufficient to draw conclusions. As some organizational policy makers declare that primary nursing is obsolete, an examination of the evolving role of professional nursing practice in hospitals and its contribution to patient outcomes is necessary.\textsuperscript{70}

**Conclusion**

Despite the fact that increasingly the success of hospital restructuring is being questioned, the ongoing pressure to reduce operating costs compels its continuation, at least in some form. Professional nursing practice, which involves a myriad of activities and attributes, influences patient and hospital outcomes. Given that nurses provide the greater part of patient care in hospitals, professional nursing practice has the potential to differentiate one hospital from another and thus enhance its competitive position. Consequently, it is in the strategic interest of organizational policy makers to implement initiatives that support professional nursing practice.

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