SUNSET EVALUATION REPORT

NURSES

Chapter 457, Hawaii Revised Statutes

A Report to the Governor and the Legislature of the State of Hawaii

Submitted by the
Legislative Auditor of the State of Hawaii

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FOREWORD

Under the "Sunset Law," licensing boards and commissions and regulated programs are terminated at specified times unless they are reestablished by the Legislature. Hawaii's Sunset Law, or the Hawaii Regulatory Licensing Reform Act of 1977, scheduled for termination 38 occupational licensing programs over a six-year period. These programs are repealed unless they are specifically reestablished by the Legislature. In 1979, the Legislature assigned the Office of the Legislative Auditor responsibility for evaluating each program prior to its repeal.

This report evaluates the regulation of nurses under Chapter 457, Hawaii Revised Statutes. It presents our findings as to whether the program complies with the Sunset Law and whether there is a reasonable need to regulate nurses to protect public health, safety, or welfare. It includes our recommendation on whether the program should be continued, modified, or repealed.

We acknowledge the cooperation and assistance extended to our staff by the Board of Nursing, the Department of Commerce and Consumer Affairs, and other officials contacted during the course of our examination.

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TABLE OF CONTENTS

LIST OF TABLES

Chapter 1

INTRODUCTION

The Hawaii Regulatory Licensing Reform Act of 1977, or Sunset Law, repeals statutes concerning 38 state licensing boards and commissions over a six-year period. Each year, six to eight licensing statutes are scheduled to be repealed unless specifically reenacted by the Legislature.

In 1979, the Legislature amended the law to make the Legislative Auditor responsible for evaluating each licensing program prior to its repeal and to recommend to the Legislature whether the statute should be reenacted, modified, or permitted to expire as scheduled. In 1980, the Legislature further amended the law to require the Legislative Auditor to evaluate the effectiveness and efficiency of the licensing program, even if he determines that the program should not be reenacted.

Objective of the Evaluation

The objective of the evaluation is: To determine whether, in light of the policies set forth in the Sunset Law, the public interest is best served by reenactment, modification, or repeal of Chapter 457, Hawaii Revised Statutes.

Scope of the Evaluation

This report examines the history of the statute on the licensing of nurses and the public health, safety, or welfare that the statute was designed to protect. It then assesses the effectiveness of the statute in preventing public injury and the continuing need for the statute.

Organization of the Report

This report consists of three chapters: Chapter 1, this introduction and the framework developed for evaluating the licensing program; Chapter 2, background information on the regulated industry and the enabling legislation; and Chapter 3, our evaluation and recommendation.

Framework for Evaluation

Hawaii's Regulatory Licensing Reform Act of 1977, or Sunset Law, reflects rising public antipathy toward what is seen as unwarranted government interference in citizens' lives. The Sunset Law sets up a timetable terminating various occupational licensing boards. Unless reestablished, the boards disappear or "sunset" at a prescribed moment in time.

In the Sunset Law, the Legislature established policies on the regulation of professions and vocations. The law requires that each occupational licensing program be assessed against these policies in determining whether the program should be reestablished or permitted to expire as scheduled. These policies, as amended in 1980, are:

1. The regulation and licensing of professions and vocations by the State shall be undertaken only where reasonably necessary to protect the health, safety, or welfare of consumers of the services; the purpose of regulation shall be the protection of the public welfare and not that of the regulated profession or vocation.

2. Where regulation of professions and vocations is reasonably necessary to protect consumers, government regulation in the form of full licensure or other restrictions on the professions or vocations should be retained or adopted.

3. Professional and vocational regulation shall be imposed where necessary to protect consumers who, because of a variety of circumstances, may be at a disadvantage in choosing or relying on the provider of the services.

4. Evidence of abuses by providers of the services shall be accorded great weight in determining whether government regulation is desirable.

5. Professional and vocational regulation which artificially increases the costs of goods and services to the consumer should be avoided.

6. Professional and vocational regulation should be eliminated where its benefits to consumers are outweighed by its costs to taxpayers.

7. Regulation shall not unreasonably restrict entry into professions and vocations by all qualified persons.

We translated these policy statements into the following framework for evaluating the continuing need for the various occupational licensing statutes.

Licensing of an occupation or profession is warranted if:

1. There exists an identifiable potential danger to public health, safety, or welfare arising from the operation or conduct of the occupation or profession.

2. The public that is likely to be harmed is the consuming public.

3. The potential harm is not one against which the public can reasonably be expected to protect itself.

4. There is a reasonable relationship between licensing and protection of the public from potential harm.

5. Licensing is superior to other optional ways of restricting the profession or vocation to protect the public from the potential harm.

6. The benefits of licensing outweigh its costs.

The potential harm. For each regulatory program under review, the initial task is to identify the purpose of regulation and the dangers from which the public is intended to be protected.

Not all potential dangers warrant the exercise of the State's licensing powers. The exercise of such powers is justified only when the potential harm is to public health, safety, or welfare. "Health" and "safety" are fairly well understood. "Welfare" means well-being in any respect and includes physical, social, and economic well-being.

This policy that the potential danger be to the public health, safety, or welfare is a restatement of general case law. As a general rule, a state may exercise its police power and impose occupational licensing requirements only if such requirements tend to promote the public health, safety, or welfare. Under particular fact situations and statutory enactments, courts have held that licensing requirements for paperhangers, housepainters, operators of public dancing schools, florists, and private land surveyors could not be justified.[1] In Hawaii, the State Supreme Court in 1935 ruled that legislation requiring photographers to be licensed bore no reasonable relationship to public health, safety, or welfare and constituted an unconstitutional

1. See discussion in 51 *American Jurisprudence*, 2d., "Licenses and Permits," Sec. 14.

encroachment on the right of individuals to pursue an innocent profession.[2] The court held that mere interest in the practice of photography or in ensuring quality in professional photography did not justify the use of the State's licensing powers.

The public. The Sunset Law states that for the exercise of the State's licensing powers to be justified, not only must there be some potential harm to public health, safety, or welfare, but also the potential harm must be to the health, safety, or welfare of that segment of the public consisting mainly of consumers of the services rendered by the regulated occupation or profession. The law makes it clear that the focus of protection should be the consuming public and not the regulated occupation or profession itself.

Consumers are all those who may be affected by the services rendered by the regulated occupation or profession. Consumers are not restricted to those who purchase the services directly. The provider of services may have a direct contractual relationship with a third party and not with the consumer, but the criterion set forth here may be met if the provider's services ultimately flow to and adversely affect the consumer. For example, the services of an automobile mechanic working for a garage or for a U-drive establishment flow directly to the employer, but the mechanic's workmanship ultimately affects the consumer who brings a car in for repairs or who rents a car from the employer. If all other criteria set forth in the framework are met, the potential danger of poor workmanship to the consuming public *may* qualify an auto mechanic licensing statute for reenactment or continuance.

Consumer disadvantage. The consuming public does not require the protection afforded by the exercise of the State's licensing powers if the potential harm is one from which the consumers can reasonably be expected to adequately protect themselves. Consumers are expected to be able to protect themselves unless they are at a disadvantage in selecting or dealing with the provider of services.

Consumer disadvantage can arise from a variety of circumstances. It may result from a characteristic of the consumer or from the nature of the occupation or profession being regulated. Age is an example of a consumer characteristic which may cause the consumer to be at a disadvantage. The highly technical and complex

2. *Terr. v. Fritz Kraft*, 33 Haw. 397.

nature of the occupation is an illustration of occupational character that may result in the consumer being at a disadvantage. Medicine and law fit into the latter illustration. Medicine and law were the first occupations to be licensed on the theory that the general public lacked sufficient knowledge about medicine and law to enable them to make judgments about the relative competencies of doctors and lawyers and about the quality of services provided them by the doctors and lawyers of their choice.

However, unless otherwise indicated, consumers are generally assumed to be knowledgeable and able to make rational choices and to assess the quality of services being provided them.

Relationship between licensing and protection. Occupational licensing cannot be justified unless it reasonably protects the consumers from the identified potential harm. If the potential harm to the consumer is physical injury arising from possible lack of competence on the part of the provider of service, the licensing requirement must ensure the competence of the provider. If, on the other hand, the potential harm is the likelihood of fraud, the licensing requirements must be such as to minimize the opportunities for fraud.

Alternatives. Depending on the harm to be protected against, licensing may not be the most suitable form of protection for the consumers. Rather than licensing, the prohibition of certain business practices, governmental inspection, or the inclusion of the occupation within some other existing business regulatory statute may be preferable, appropriate, or more effective in providing protection to the consumers. Increasing the powers, duties, or role of the consumer protector is another possibility. For some programs, a nonregulatory approach may be appropriate, such as consumer education.

Benefit-costs. Even when all other criteria set forth in this framework are met, the exercise of the State's licensing powers may not be justified if the costs of doing so outweigh the benefits to be gained from such exercise of power. The term, "costs," in this regard means more than direct money outlays or expenditure for a licensing program. "Costs" includes opportunity costs or all real resources used up by the licensing program; it includes indirect, spillover, and secondary costs. Thus, the Sunset Law asserts that regulation which artificially increases the costs of goods and services to the consumer should be avoided; and regulation should not unreasonably restrict entry into professions and vocations by all qualified persons.

Chapter 2

BACKGROUND

Chapter 457, Hawaii Revised Statutes, regulates the practice of nursing in Hawaii. It is unlawful for persons to practice as nurses or as practical nurses for compensation unless they are properly licensed under Chapter 457.

Occupational Characteristics

Nursing, as a distinct profession, is usually dated from the Crimean War when Florence Nightingale pioneered the providing of care to the wounded. Since then, the education, the functions, and the roles of nurses have changed dramatically. Today, nurses provide a wide range of services that are essential in promoting, maintaining or restoring health or in the prevention of illness. They administer medication and treatment to patients and often have primary responsibility for patient care.

The profession has been characterized by rapid growth. Before the 1870s, there were virtually no trained nurses in the United States. Subsequently, the number of training schools proliferated from 15 in 1880 to 34 in 1900, to 2,286 by 1927. The number of graduates increased from 157 in 1880 to over 18,000 in 1927.[1]

Originally, training consisted mainly of apprenticeships in hospitals. There were questions about the quality of such training. Some perceived that it was conducted more to provide hospitals with students to care for patients than to provide students with a nursing education.

In the 1890s, two professional nursing organizations, which later became the National League of Nursing (NLN) and the American Nurses' Association (ANA), organized with the aim of controlling the profession and the growth of substandard nursing schools. These two organizations sought to obtain licensure for nurses so that a nurse with formal training could be differentiated from an untrained worker.

1. Philip A. Kalisch and Beatrice J. Kalisch, *The Advance of American Nursing*, Boston, Little Brown, 1978, p. 350.

As a result of their efforts, the first nurse registration act was passed in North Carolina in 1903, and by 1923, all the states had nursing registration laws.[2] The registration laws restricted the use of the title RN to those who met certain qualifications.

Despite registration, there was little uniformity among the states in the qualifications required of nurses. Some states required no preliminary education and only completion of a two-year general hospital course, while some required a high school education and a three-year nurse training course. Other states required only passage of an examination.[3]

Correspondingly, there was a wide range of training programs, from hospital training to academic programs. The first college level training program for nurses was introduced at the University of Minnesota in 1909.[4] However, the majority of nurses continued to be trained in hospital diploma programs through the 1950s.

During the 1930s, because of the difficult employment situation, nursing organizations began to press for mandatory state registration and for recognition of a two-tiered delineation of nursing qualifications and activities. Starting in New York in 1938 and spreading throughout the country after World War II, two levels of licensure were created, one for registered nurses (RNs) and one for licensed practical nurses (LPNs).[5] RNs were generally those who had undergone formal training programs and gave bedside care whereas LPNs handled mostly housekeeping chores for hospital wards or looked after non-acute care cases in patients' homes, tasks usually learned on the job.

In the post-war decades, there was a shortage of nurses. At the same time, the educational background of many nurses increased significantly. A two-year experimental program established at Columbia University in the 1950s caught on quickly across the country and began to replace the previously common form of

2. Bonnie Bullough, "The Law and the Expanding Nursing Role" in *The Nursing Profession,* ed. Norma L. Chaska, New York, McGraw-Hill, 1978, p. 311.

3. Kalisch and Kalisch, *The Advance of American Nursing,* p. 341.

4. *Ibid.,* p. 337.

5. Bullough, in *The Nursing Profession,* p. 311.

nurses training in hospital diploma schools.[6] By the 1960s, the shift to college campuses for nurses training was in full gear nationwide. Growing numbers of nurses had bachelor and masters degrees, and in 1964, the first comprehensive doctoral program in nursing was offered by the University of California, San Francisco.[7] By 1980, there were some 1,403 nurses training programs in the United States with 127 masters degree programs and several doctoral degree programs.[8]

Today, there are three main types of training for RNs in America: (1) two-year associate degree programs offered by community and junior colleges; (2) three-year diploma programs offered by hospitals and independent schools; and (3) bachelor degree programs offered by colleges and universities. Generally, the training received determines the kinds of job opportunities open to RNs. Administrative and supervisory positions are available primarily to those with baccalaureate or advanced degrees.

LPNs receive their training in trade or vocational schools, community or junior colleges, and hospitals. Training programs usually consist of one year of classroom study and clinical practice.

Along with these changes in training and functions, new levels of nursing practice emerged in the 1960s. Nurse practitioners (NPs) who combine some of the functions of nurses and physicians, began to gain recognition in the fields of midwifery and pediatrics. They began to provide primary health care.

Primary health care is usually defined as the care a consumer receives at the initial point of contact with the health care system and the continuation of that care. The primary health care nurse practitioner provides the initial diagnosis of patients, their referral to physicians if necessary, the continuation of their care and maintenance of their health. They perform physical examinations, diagnostic assessments, and other tasks usually beyond those performed by RNs. Their practice includes such specialties as midwifery, pediatrics, family practice, community health, and mental health.

6. Kalisch and Kalisch, *The Advance of American Nursing*, p. 593.

7. *Ibid.*, p. 598.

8. U.S. Bureau of Labor Statistics, *Occupational Outlook Handbook*, 1982-83 Edition, Washington, D.C., 1982, p. 70.

Closely associated with the emergence of NPs has been the movement towards specialization by RNs who became "clinical specialists." They receive advanced training in such areas as medical/surgical nursing, psychiatric nursing, etc. They generally perform in clinical settings, such as hospitals.

Today, registered nurses constitute America's largest single category of professionals engaged in the field of health care, and practical nurses comprise the largest category of health technicians. In 1980, America had over 1.1 million employed registered nurses, two-thirds of these employed full-time.[9]

Hospitals are the principal employers of RNs. Only a third do not work in hospitals. In 1980, employment outside of hospitals included 86,000 in nursing homes, 70,000 in doctors' and dentists' offices, and 25,000 as occupational health nurses in business and industry. Some 63,000 RNs served as public or community health nurses and 38,000 worked as nurse educators.[10]

Of the nation's 550,000 licensed practical nurses in 1980, about 60 percent worked in hospitals, the others mostly in nursing homes, rehabilitation centers, psychiatric hospitals, and long-term care facilities. Only a few worked in the homes of patients.[11]

As of October 1983, there were 7,892 registered nurses in Hawaii, 6,050 with addresses in the State. There were 2,850 licensed practical nurses, 2,485 with Hawaii addresses.[12] RNs and LPNs together constitute one-sixth of all licensees handled by the Professional and Vocational Licensing Division in the Department of Commerce and Consumer Affairs (DCCA).

Table 2.1 shows that a substantial number of new licensees are added each year. The largest number of new licensees are licensed registered nurses from other jurisdictions who become licensed in Hawaii by endorsement, i.e., they are licensed without having to take any additional training or tests if the board finds that they have met standards comparable to those in Hawaii. Seventy-eight percent of all

9. *Ibid.*, p. 169.

10. *Ibid.*, p. 170.

11. *Ibid.*, p.183.

12. State of Hawaii, Department of Commerce and Consumer Affairs, *Geographic Report*, October 1983.

newly licensed RNs in Hawaii in the past three years are RNs from outside of Hawaii. However, the majority of LPNs, 53 percent, are Hawaii residents.

Table 2.1

Number of New RN and LPN Licensees

	1980–81	*1981–82*	*1982–83*	*Total*
RN				
Hawaii Residents	239	234	199	672
Out-of-State Endorsement	623	918	827	2368
LPN				
Hawaii Residents	248	229	163	640
Out-of-State Endorsement	178	176	203	557
Total	1288	1557	1392	4237

Source: Department of Commerce and Consumer Affairs, Licensing Records.

History of Nursing Regulation in Hawaii

In 1917, Hawaii's Territorial Legislature enacted a bill to register nurses. A legislative committee stated that the bill "does not prevent nurses who have not been registered from practicing for hire, but enables persons who do so desire to secure the services of a nurse possessing certain qualifications. The Bill . . . will be particularly advantageous to residents of the other islands since residents can wireless to Honolulu for a registered nurse and be sure of securing a nurse who is competent. It would also place our residents who are nurses on a par with those who graduate from schools of nursing elsewhere, and insure them at least equal treatment."[13]

That legislation, signed into law as Act 163, created a five-member board composed of three fully trained and experienced nurses, one physician, and the secretary of the medical examiners board. The initial board of nurses was empowered to:

- adopt rules and regulations governing its operations;
- conduct examinations and evaluate applicants' qualifications;

13. House Committee on Health, Police and Military, Report on House Bill No. 377, April 18, 1917.

- maintain a record of all registered nurses;
- investigate complaints; and
- make an annual report to the Governor on its official actions and financial disbursements.

Other than to spell out the grounds for cancelling or suspending a nurse's certification of registration, the statute changed little until 1945. With the end of World War II, Hawaii joined New York, California, and Louisiana in adopting a mandatory practice law. Henceforth, nursing for compensation was illegal for those without a license. LPNs were also recognized for the first time.

In 1959, the present definition of nursing, taken from the ANA's model act of 1955, was enacted and the nursing board was to be composed entirely of nurses. The board was also granted the power of injunctive relief to enforce its system of registration and licensing.

The next major statutory revision came in 1970. The board was enlarged to seven members by adding two LPNs. Distinct qualifications for the licensing of practical nurses were also specified. The 1970 amendments also authorized the board to accredit schools of nursing.

In 1978, the Legislature increased board membership to nine by adding two representatives of the public. Legislation in 1982 officially transferred to the Department of Commerce and Consumer Affairs the authority to "receive, arbitrate, investigate, and prosecute complaints." The Board of Nursing, like other boards under DCCA, retained its authority to take disciplinary action against errant licensees. The most recent change took place in 1983 when the Legislature deleted the requirement for board members to have had at least five years of experience in administering or teaching in a nursing program.

Current Regulation of Nurses in Hawaii

Registered nurses. Chapter 457, HRS, defines nursing in terms of its practice as a registered nurse and its practice as a licensed practical nurse. The definition of the practice of nursing as a registered nurse is:

"... the performance for compensation of any act in the observation, care, and counsel of the ill, injured, or infirm, or in the maintenance of health or prevention of illness of others, or in the supervision and teaching of other personnel, or the administration of medications and treatments as prescribed by a licensed physician or dentist, requiring substantial specialized judgment and skill and based on knowledge and application of the principles of biological, physical, and social sciences. The foregoing shall not include acts of medical diagnosis or prescription of therapeutic or corrective measures."[14]

To be licensed as a registered nurse, an applicant must be a high school graduate or equivalent, graduate from an accredited school of nursing, and pass a prescribed national examination. A nurse already licensed elsewhere may be licensed in Hawaii by "endorsement" if standards comparable to those set for Hawaii are met. The board requires applicants to have completed a minimum nursing curriculum consisting of not less than 64 units, of which 51 units must include the following: 8 units in scientific understanding, 9 in the social sciences, 2 in professional development and responsibility, and 32 in nursing practice and allied sciences.

Practical nurses. The definition of the practice of nursing as a licensed practical nurse is the "performance for compensation of selected acts in the care of the ill, injured, or infirm under the direction of a registered nurse or a licensed physician or a licensed dentist, and not requiring the substantial specialized skill, judgment, and knowledge required in the practice of a registered nurse."[15]

To qualify as a licensed practical nurse, an applicant must be a high school graduate or equivalent, complete a prescribed curriculum in a state accredited program for LPNs, and pass a written examination. The minimum curriculum for licensure must include not less than 30 units in scientific understanding, social sciences, personal development and responsibility, and the practice of practical nursing. As in the case of RNs, an LPN licensed in another state or country may be licensed in Hawaii by endorsement if Hawaii's standards are met.

14. Section 457-2(2), HRS.

15. Section 457-2(3), HRS.

The board. The five RN members of the board must be graduates of state accredited educational programs with at least baccalaureate degrees in nursing. The two LPNs must be graduates from state accredited training programs for LPNs. Both RN and LPN members must be currently licensed in Hawaii and have had at least five years of successful experience as an RN or LPN respectively, with three years of active experience immediately prior to appointment or reappointment.

The board may deny, revoke, or suspend a license for any of the following reasons: fraud or deceit in relation to a license; gross immorality; incompetence due to negligence or personal habits; intemperate or addicted use of drugs; mental incompetence; unprofessional conduct; or willful violation of Chapter 457, HRS. The board also has the power to obtain injunctive relief in the courts against any person or institution not abiding by the law or the board's rules.

The board accredits nursing programs in the State. Educational programs for RNs or LPNs must meet the standards set by the board. These standards include evidence of sufficient funding and of suitable planning and staffing; a dean and faculty who meet stipulated requirements for education and experience; an instructional load which permits each faculty member an opportunity for self-improvement, research, student guidance, and curriculum development; a student-faculty ratio in the clinical area of not greater than 12 to 1; an adequate record system on student performance; adequate facilities for classroom work, library, laboratories, administration, etc.; and a curriculum fulfilling specified numbers of units in the natural sciences, social sciences, professional development, and laboratory practice. Similar standards are set for practical nurses albeit with fewer requirements.

From time to time the board's executive secretary or an authorized respresentative is expected to survey each nursing program in the State to determine whether the program meets accreditation standards. If a program does not meet standards and fails to correct conditions cited in writing, the board has the power to discontinue the program after holding an appropriate hearing.

Chapter 3

EVALUATION OF THE REGULATION OF NURSING

This chapter contains our evaluation of the need to regulate nursing, our assessment of the adequacy of the current licensing system and regulatory operations, and our recommendations for improvement.

Summary of Findings

We find that:

1. The practice of nursing encompasses many life-threatening situations and there is a continued need to regulate both the nursing profession and the training of nurses to ensure the protection of public health and safety.

2. The definition of nursing in Chapter 457 is almost three decades old and does not reflect completely current nursing practices. The board should consider ways to improve the definition of the current scope of practice.

3. It is questionable whether the board's approval of faculty for nursing programs is within its legal purview, and its standards for nursing faculty are too rigid.

4. The surcharge assessed of nurses for the compliance resolution fund does not have a reasonable relationship to the cost of services rendered to nurses from that fund.

5. Administrative support to the board has failed to meet with the board's expectations. The department's job description for its executive secretaries is inaccurate and fails to emphasize responsiveness to board needs.

6. The statute requiring the executive secretary to have knowledge of and experience in nursing is not being followed.

The Need for Regulation

Nurses are by far the most numerous of the health professionals. They care for the sick, assist the disabled, and provide advice on how to maintain and improve health. For a significant portion of people who seek medical care, there will be more contact with nurses than with any other health professional.

As noted earlier, nurses perform a wide span of tasks, from the very simple to complex, professional techniques. In hospitals today, nurses handle all the medication and intravenous treatment, gather much of the information in physical examinations, administer electrocardiographs, and do a major portion of counseling, post-hospital follow-up, and health education.

They offer guidance and direction to those working under their supervision and collaborate with other health professionals in planning and delivering health care. Although they normally work under the supervision of a doctor, nurses also exercise professional judgment and initiative. Many nurses function much on their own, including those working in a public health capacity, running well-baby clinics, and running hospital wards during nights when few doctors are on the scene.

Nursing care has become increasingly sophisticated. Diagnostic and therapeutic procedures that were formerly practiced by physicians have now become standard nursing practice. New trends in primary health care by nurse practitioners (NP) and specialized practice by clinical specialists place more direct responsibility and accountability on nurses for the welfare of patients.

With these new trends, nurses have an ever greater impact on public health and safety. A review that assessed research on the impact of nurses noted a 1978 study showing that the only health resource that made an apparent difference in outcome was nursing; increases in nurses per capita were associated with greater decreases in mortality than any other health resource. The review pointed to another national study conducted at Stanford University which suggested that a 24-fold difference in postoperative death rates for certain surgical procedures was related directly to the quality of nursing and surgical care.[1]

1. Linda H. Aiken, "Nursing Priorities for the 1980's: Hospitals and Nursing Homes," *American Journal of Nursing*, February 1981, pp. 324-330

Incompetence or negligence in nursing practice could easily endanger the public. Nurses frequently hold people's lives in their hands. Mistakes in administering medication or careless intravenous treatment could lead to death. An improperly trained nurse could misread a patient's vital signs or bungle a physical examination.

The rationale for enacting Hawaii's licensing law in 1917 remains valid today: to provide the public with nurses who are competent and have certain qualifications and also to provide for comparable standards of training and competence with other jurisdictions. Licensing is needed to help prevent untrained, unqualified, or incompetent persons from practicing. A system for establishing minimal competence is essential to ensure that the public is provided with proper nursing care.

Scope of Practice

Due to rapid changes in biomedical knowledge, in the delivery of health care, and in the expansion and specialization of nursing practice, many states have changed their nursing practice acts to reflect current trends in nursing. Since 1971, 38 states have amended their nurse practice acts to permit trained nurses to diagnose, prescribe drugs, and do other things previously prohibited by medical practice acts. As of 1979, Hawaii was one of only seven states to have a law specifically prohibiting diagnosing and prescribing by a nurse.[2]

Idaho was the first of the 38 states to revise its nursing practice act to permit diagnosis and treatment. Permitted practices are determined jointly by the Idaho Board of Medicine and the Board of Nursing under rules and regulations promulgated by the joint board.[3] Other states have expanded their nursing practice acts by omitting or limiting the prohibition on diagnosis and treatment or by rewriting the definition of nursing using broader language.

Another trend has been primary care by nurse practitioners and clinical specialists. Many states have also amended their nurse practice acts to allow more

2. Hedvah L. Shuchman, et al., *Self-Regulation in the Professions: Medicine,* Glastonbury, Conn., The Futures Group, July 1981, p. 43.

3. Frances I. Waddle, *Legal Regulation of Nursing Practice,* prepared for the American Nurses' Association, Kansas City, September 1981.

independent practice by NPs and specialists, but surveys show that there is a lack of uniformity in state regulation of these nurses.

In some states, no significant changes were made as the NP role was considered to be within the legal scope of nursing practice. In other states, new definitions of nursing roles replaced previous statutes. Many states amended their nursing practice acts by permitting *additional acts,* including some acts which are traditionally considered medical acts.[4] Thirty-one states have made provisions, either through statutes or through rules to recognize new categories of nurses such as NPs, certified nurse anesthetists, and certified nurse midwives.

The definition of nursing and expanded nursing practice has become an issue elsewhere, not just among health professionals but also between licensing boards over who should govern these new kinds of providers. Some states, like Idaho, have established joint arrangements of some sort between their medical and nursing boards. Others have provided for collaboration through a joint committee consisting of members of both boards or even the creation of a new joint board to govern NPs and other physician assistants.

Hawaii does have nurses who function as NPs and as clinical specialists. They are found in hospitals and emergency rooms. Others who function largely on their own are public health nurses who go out into the community and nurses who run well-baby clinics.

In addition, there are five midwives in Hawaii who are certified as such by the State Department of Health. They are permitted to attend cases of normal childbirth and to provide prenatal, intro-partum, and post-partum care for the newborn. Midwives here normally are associated with physicians and work under their supervision. This means that they have a formal written association with a physician but the physical presence of the physician is not required.

The definition of nursing in Chapter 457, HRS, apparently has not presented a legal barrier to qualified nurses who wish to perform in more specialized or expanded roles even though it specifically prohibits acts of medical diagnosis and prescription.

4. *Ibid.*

However, it should be amended to reflect current practice and to provide the public with more options in health care.

Studies have shown that nurse practitioners are qualified to perform such tasks as physical examinations, simple diagnosis, vaccinations, health education, and basic treatment procedures. In 1981, the Council of State Governments noted that probably 60 to 85 percent of all ambulatory visits could be effectively and safely handled by health professionals such as nurse practitioners without physician intervention.[5]

The board should monitor the regulation of expanded and specialized nursing practice in other states and evaluate and suggest to the Legislature appropriate amendments that could be made to the definition of nursing in order to enhance nursing practice in Hawaii.

Regulatory Operations

We found few problems with the regulatory operations of the Board of Nursing. We observed that board members take their responsibilities seriously and do their work conscientiously. The board schedules a full day's meeting at least 11 times a year, occasionally running two-day meetings with the extra day devoted to such matters as reviewing future licensing examinations. A major portion of the board's attention is focused on accreditation and faculty qualifications, revising rules, reviewing correspondence from other state boards, evaluating questionable cases for licensure, and reviewing disciplinary cases. In the following sections, we discuss some of the board's operations and make suggestions for improvement.

Licensing. Most of the screening of individuals for licensing is conducted by staff of the Department of Commerce and Consumer Affairs (DCCA); first by a licensing clerk, then by the executive secretary for the Board of Nursing. Only questionable cases and those cases appealed by applicants are referred to the board.

We find that improvements have been made in the licensing exam. For over 30 years, the board used a national examination called the State Board Test Pool Exam (SBTPE) based on uniform standards established by the Council of State Boards of

5. Scott Seymour, "Rural Health Services: A Sample of State Efforts," *Innovation*, Council of State Governments, August 1980, p. 5.

Nursing [now known as the National Council of State Boards of Nursing (NCSBN)]. These exams were developed, designed, and graded by the National League of Nursing, another private organization, on contract with the NCSBN. There were five parts to the SBTPE exam: obstetrics, pediatrics, surgery, medicine, and psychiatric, and applicants had to have passing scores on each part.

Dissatisfaction with the SBTPE began to surface in the 1970s. California took the lead in commissioning its own evaluation of the test and found weaknesses such as bias. One major complaint was that the examination did not sufficiently emphasize those skills and situations peculiar to nursing. Since then, new test standards have been developed by the NCSBN, resulting in a new test developed and administered by a division of the publishing firm of McGraw-Hill.

The first exam partially under the new system, the National Council Licensing Examination, known by the acronym NCLEX-RN, was given in July 1982. The first full test under the system was one for licensed practical nurses (LPN), the NCLEX-PN, which was given in October 1982. The first full examination for registered nurses (RN) was administered in February 1983.

Formerly, applicants were required to pass each of five portions of the SBTPE. The passing score for Hawaii between November 1974 to November 1981 was set at 375, or 25 points above the 350 passing score set by all other states (after November 1981, the passing score was reset at 350). This meant that RNs in other states could not obtain licenses by endorsement in Hawaii unless they had passing scores of 375 in each of the five sections.

Under the new NCLEX system, in common with all the other states, Hawaii uses a single passing score of 1600 for the test as a whole. The new test focuses on nursing as a process and what a nurse should do in various situations ranging from maternal and child care, to obstetrics, surgery, medicine, and psychiatric nursing. It is still too early to evaluate the effectiveness of the new examination in ensuring competency but the testing and grading system is an improvement over past practices.

Accreditation. Besides licensing, the board's other principal responsibility is to ensure that schools of nursing meet minimum standards through accreditation

reviews. Accreditation by the board has been useful in identifying and resolving problems in nursing programs in Hawaii. For example, a nurse training program was established on the Big Island to serve what was believed to be a need for locally trained nurses. Yet it was discovered that the principal employer of nurses, Hilo Hospital, would not hire graduates of the local educational program, even those who received their practical experience in that hospital. The situation deteriorated to the point where students had to be shipped to Honolulu to get their in-hospital training. In its capacity of evaluating the educational program, the board managed to bring about a resolution between the two state institutions. A similar situation occurred on Maui and also was resolved through the efforts of the Board of Nursing.

Faculty review. As part of its accreditation standards for nursing programs, the board has established minimum qualifications for nursing faculty. The rules say that the minimum requirements are as follows:

- a baccalaureate degree in nursing, preferably a graduate degree in nursing, education, or health related field;
- at least three years of acute care nursing experience in one of the areas of teaching expertise for those who have only a baccalaureate degree;
- courses for academic credit in three areas: curriculum development, evaluation, and teaching methods.

In order to enforce these standards, the board requires all nursing programs at the University of Hawaii to complete a "Faculty Data Sheet" form for each new faculty hire and to submit this to the board for its approval.

The faculty data sheet requires the university to submit information on the prospective faculty member's academic preparation, a copy of the applicant's transcripts, list of specific academic courses taken in teaching methods, curriculum development and evaluation, employment record, and a list of proposed classroom and clinical responsibilities.

The board's review of university faculty is questionable in several respects. It is doubtful that the board has the legal authority to deny or approve the hiring of faculty at the university. This infringes on the powers of the Board of Regents (BOR). Moreover, the approval process is not spelled out in the board's rules. Only

the standards are in the rules. Finally, the standards appear to be restrictive and the board has made frequent exceptions to the standards.

Approval of faculty. Both the State Constitution and the statutes vest the BOR of the University of Hawaii with the sole power to exercise control over the University of Hawaii. Article X, Section 6 of the State Constitution says that the BOR shall have exclusive jurisdiction over the internal organization and management of the university. Section 304-11, HRS, says that the BOR shall appoint such deans, directors, other members of the faculty, and employees as may be required to carry out the purposes of the institution.

In 1981, Act 57 specifically changed the powers of the Board of Nursing by amending Section 457-5(a)(2) which had empowered the Board of Nursing to approve curricula for nursing programs. The purpose was to resolve an apparent constitutional conflict between the power granted to the Board of Nursing to prescribe standards and approve nursing curricula and the power of the BOR to have sole authority to approve programs and curricula at the university. Act 57 removed the board's authority to approve curricula for educational programs but allowed it to continue to set standards.

The board's present approval of university faculty also appears to be in conflict with the powers granted to the BOR. The board's actions appear even more untenable as it has no rules which set forth the approval process. It is something which is being done by custom only.

Standards for nursing faculty. The university appears to have difficulty finding nursing faculty who satisfy the board's minimum qualifications. This situation grew acute after November 1978 when the board raised the requirements for faculty from a baccalaureate degree to a masters degree. Between January 1978 and April 1980, the board had to make 14 exceptions to its own rules to allow faculty to teach who did not meet its standards. After being warned by the attorney general's staff that the board could not continue making exceptions to a rule, the board returned the minimum educational qualification to a baccalaureate degree in March 1982.

Even with the reduced qualifications, there continues to be a problem. The reason appears to be the board's insistence that prospective faculty members have

coursework for academic credit in each of the three areas of curriculum development, evaluation, and teaching methods. The board goes to the extent of reviewing the proposed faculty members' transcripts and asking for course descriptions to make sure that the courses have been taken.

The rules allow the board to make exceptions to their standard for a limited period of time depending on the needs of the individual nursing program. The board has used this to continue to make exceptions. However, the basis for exceptions is unclear and the board has been inconsistent in its use of exceptions. For example, sometimes the board will disapprove immediately faculty who lack coursework in teaching methods or one of the other required courses. Other times, the board will allow the faculty to work for one semester. Still other times the board will approve the faculty on the condition that they make up the deficiency by taking the required courses while they teach.

The board appears to be unsure which position to take. At one meeting, the board first approved two persons to teach for one semester only as one lacked a course in curriculum and the other lacked a course in teaching methods. Subsequently, in reconsidering the action, the board decided to disapprove the two persons. At the next meeting the board again approved one of the faculty for one semester only.

The board also appears to waive the coursework requirement in certain cases. The board first disapproved a faculty hire on the basis that the faculty lacked the required coursework. However, based on the faculty member's reported excellence in teaching elsewhere, the board appears to have waived its requirements and approved the appointment.

The board should work with the university to make sure that its standards for faculty are reasonable and relevant. There is no evidence that coursework in curriculum development, evaluation, and teaching methods is essential for effective teaching at the university level. It is not a customary requirement for other university faculty. Once the board has set reasonable and relevant standards, approval of faculty is a decision that should be left to the university. The board says that it approves faculty in order to ensure the quality of nursing programs. However, the appropriate method for the board to use to ensure quality is through its accreditation reviews.

Fees for the Compliance Resolution Fund

It is a general policy of the State that there should be a reasonable relationship between the revenues derived from any fees assessed and the cost or value of services rendered. For example, Section 26-9(k), HRS, gives the director of the DCCA power to increase or decrease any fees assessed by any board or commission placed within the department for administrative purposes in order to maintain a reasonable relationship between the fees assessed and the cost of services provided.

A surcharge of $10 is now assessed of all licensees for the DCCA's compliance resolution fund. The fund was created by Act 60, SLH 1980, to enable the DCCA's Regulated Industries Complaints Office (RICO) to hire attorneys and investigators to handle the backlog of complaints at DCCA.

There are more than 10,000 licensed nurses in Hawaii, each paying $10 a year into the resolution fund for a total of around $100,000 per annum. Yet the nursing profession only generates an average of four complaint cases a year to be investigated and resolved by personnel paid from that fund. At the same time, for example, licensed contractors number only some 5,400 and so contribute about $54,000 to that fund while generating between 350 and 400 complaints each year that require investigation, hearings, and sometimes prosecution. This means that nurses complaint cases are just 1 percent of the number of contractor complaint cases. Yet, nurses provide almost twice as much in fees.

To launch the fund, it was probably expedient to assess a single surcharge on all licensees. However, adjustments should be made as experience reveals the relative demands on the resolution fund by the various licensing categories. By the time the next biennial renewal of nursing licenses comes up in 1985, DCCA will have had more than two years of experience in RICO's expanded operation. DCCA should be able by then to project likely workloads and expenses by different licensing categories. Fees for the fund should then be set on a pro rata basis for each category according to the number of investigations arising from complaints during the prior two-year period.

Administrative Support

The Board of Nursing, like other regulatory boards in DCCA's Division of Professional and Vocational Licensing is composed of unpaid volunteers. For many of them service on the board is a burden. Yet they assume the task as they believe in the board's responsibilities and its beneficial role. In turn, they should be given a commensurate level of support from the administration.

Newly appointed board members receive an orientation. They report that this is helpful in introducing them to their duties. However, this is merely the beginning and new board members need more than copies of relevant statutes, rules, organization charts, and copies of the minutes of two prior board meetings to become full working members of the board.

One of the problems is that DCCA appears to have no policies on the kinds of support to be given to board members. The job description for executive secretaries is out of date and service to boards vary with individual executive secretaries.

Policies and procedures manual. One example of a simple but useful aid to board members would be a policies and procedures manual. Board members report that they have difficulty at their meetings answering questions affected by prior policies set by earlier boards, or by previous attorney general opinions, or by data on regulatory operations in Hawaii and elsewhere. At one time, each board member was given a manual which included an up-to-date collection of board policies, current applications forms and handouts, opinions from the attorney general, procedures for tests, and general background information.

No additions have been made to the office copy of that manual since December 1980 when the former executive secretary retired. Board members are now expected to keep their own manual and to pass theirs on to their successor. The department's own copy is badly out of date. According to that copy, Castle Hospital still has a nurse training program, a majority of members present at a meeting may constitute a valid vote, budget preparation never went beyond 1972, there are no public members on the board, and "nurse practitioner" applies to any nurse. All of these are, of course, no longer correct, but they do indicate how archaic the manual has become.

Consequently, time is wasted at board meetings discussing questions that could be answered with a quick reference to a basic manual. As it is now, the board must rely on individual memories.

Executive secretary. A board of volunteers needs to rely heavily on departmental staff for administrative support, for appropriate information when needed, for a smooth flow of board work, the resolution of potentially controversial issues, groundwork for board actions, and the efficient handling of routine administrative tasks.

The DCCA's job description for its executive secretaries fails to emphasize service and responsiveness to board needs. It is no longer even accurate. The job description is one common to all executive secretaries within the DCCA's Professional and Vocational Licensing Division. It says that 45 percent of the executive secretary's time should be spent on "investigations, inspections, and hearings," functions which were totally transferred to RICO in 1982. According to the job description only 3 percent of the executive secretary's time should be spent on "research, statistics, and reports."

The job description should be revised to reflect current duties, with greater emphasis placed on time to be spent in preparing for meetings, in research and analysis in response to board requests for information, and in assisting in board operations.

As a final comment, Section 457-6(b)(1), HRS, requires the executive secretary to the board to have thorough administrative ability and knowledge of and experience in nursing field. The former executive secretary to the Board of Nursing was an RN. When the former secretary retired, DCCA did not appoint another RN to the position.

In responding to the board's request that another RN be appointed as executive secretary, the director of DCCA noted that the department does not enjoy the ability of providing executive secretaries with specific backgrounds tailored to each board. Instead, it must maintain flexibility in the assignment of executive secretaries to serve its boards in the most effective manner.[6] If this is the department's position

6. Letter to Mrs. June Nakashima, Chairman, Board of Nursing, from Dr. Mary G. F. Bitterman, Director, Department of Commerce and Consumer Affairs, March 2, 1981.

and the Legislature agrees, the issue should be laid to rest completely by repealing the requirement for the executive secretary to have knowledge of and experience in nursing.

Recommendations

We recommend as follows:

1. *Chapter 457, HRS, be reenacted to continue the regulation of nurses and their training. In reenacting the law, the Legislature should consider removing the requirement that the executive secretary have knowledge of and experience in the nursing field.*

2. *The Board of Nursing monitor and evaluate the regulation of expanded and more specialized nursing practice elsewhere to develop recommendations for appropriate amendments to be made to the definition of nursing in Chapter 457, HRS.*

3. *The board discontinue its approval of nursing faculty and consult with the University of Hawaii in developing reasonable and relevant criteria for nursing faculty.*

4. *The Department of Commerce and Consumer Affairs monitor the impact of each category of licensees on the compliance resolution fund so that statutory amendments can be made to ensure that the surcharge assessed of licensees bears a reasonable relationship to costs of services provided.*

5. *The department ensure that the board is given the support that it needs to function effectively by reassessing the job description and duties of its executive secretaries. At the same time, the department should develop policies to ensure that its executive secretaries provide more uniform and responsive services to their boards.*

APPENDIX

RESPONSES OF AFFECTED AGENCIES

COMMENTS ON AGENCY RESPONSES

A preliminary draft of this Sunset Evaluation Report was transmitted on November 16, 1983 to the Board of Nursing and the Department of Commerce and Consumer Affairs for their review and comments. A copy of the transmittal letter to the board is included as Attachment 1 of this Appendix. A similar letter was sent to the department. The responses from the board and the department are included as Attachments 2 and 3.

The board found the report to be comprehensive and agrees that regulatory operations of the board could be significantly improved by implementing statutory, rule, or operational changes in several key areas. The board also states that it will be discussing our recommendations at its meeting in January 1984 and that it will provide a full report on these recommendations to the Legislature.

The department agrees with our recommendation that the requirement for the executive secretary to have knowledge of and experience in the nursing field should be removed from the statute and that the job description of the executive secretary and the board's policy and procedures manual should be revised. The department says that it will explore the matter of fees for the compliance resolution fund and that it will work closely with the boards and commissions in determining any proposals for changes in the fee structure.

ATTACHMENT 1

THE OFFICE OF THE AUDITOR
STATE OF HAWAII
465 S. KING STREET, RM. 500
HONOLULU, HAWAII 96813

CLINTON T. TANIMURA
AUDITOR

November 16, 1983

Mrs. June S. Nakashima, Chairperson
Board of Nursing
Department of Commerce and Consumer Affairs
State of Hawaii
Honolulu, Hawaii 96813

Dear Mrs. Nakashima:

Enclosed are 10 preliminary copies, numbered 4 through 13, of our *Sunset Evaluation Report, Nurses.* These copies are for review by you, other members of the board, and your executive secretary. This preliminary report has also been transmitted to Dr. Mary G. F. Bitterman, Director, Department of Commerce and Consumer Affairs.

The report contains our recommendations relating to the regulation of nurses. If you have any comments on our recommendations, we would appreciate receiving them by December 16, 1983. Any comments we receive will be included as part of the final report which will be submitted to the Legislature.

Since the report is not in final form and changes may possibly be made to it, access to this report should be restricted solely to those officials whom you might wish to call upon to assist you in your response. We request that you exercise controls over access to the report and ensure that the report will not be reproduced. Should you require additional copies, please contact our office. Public release of the report will be made solely by our office and only after the report is published in its final form.

We appreciate the assistance and cooperation extended to us.

Sincerely,

Clinton T. Tanimura

Clinton T. Tanimura
Legislative Auditor

Enclosures

ATTACHMENT 2

GEORGE R. ARIYOSHI
GOVERNOR

MARY G. F. BITTERMAN
DIRECTOR

DICK H. OKAJI
LICENSING ADMINISTRATOR

BOARD OF NURSING
STATE OF HAWAII
PROFESSIONAL & VOCATIONAL LICENSING DIVISION
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
P. O. BOX 3469
HONOLULU, HAWAII 96801

December 12, 1983

The Honorable Clinton T. Tanimura
Legislative Auditor
The Office of the Auditor
465 S. King Street, Room 500
Honolulu, Hawaii 96813

Dear Mr. Tanimura:

Thank you for the opportunity to comment on your sunset evaluation report on nurses. We found the report to be comprehensive and agree that regulatory operations of the board could be significantly improved by implementing statutory, rule, or operational changes in the areas you have recommended.

Since the report contains recommendations involving major issues, we will discuss them more thoroughly at our next meeting scheduled for January 6, 1984. Input from all members will be evaluated and consolidated and a full report on your recommendations will be presented to the 1984 Legislature.

Very truly yours,

June S. Nakashima, RN

(Mrs.) June S. Nakashima, R.N.
Chairman

ATTACHMENT 3

GEORGE R. ARIYOSHI
GOVERNOR

MARY G. F. BITTERMAN
DIRECTOR
Commissioner of Sec[illegible]s

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS
1010 RICHARDS STREET
P. O. BOX 541
HONOLULU, HAWAII 96809

DONALD D.H. CHING
DEPUTY DIRECTOR

December 12, 1983

The Honorable Clinton T. Tanimura
Legislative Auditor
The Office of the Auditor
465 S. King Street, Room 500
Honolulu, Hawaii 96813

Dear Mr. Tanimura:

Thank you for the opportunity to comment on your sunset evaluation report on nurses.

The Department of Commerce and Consumer Affairs is in agreement with the Legislative Auditor's recommendations that the statute requiring the executive secretary of the Board of Nursing to have knowledge of and experience in the nursing field be removed and that the job description of the executive secretary and the board's practices and procedures manual be revised accordingly.

The Auditor also recommended that the department monitor the impact of each category of licensee on the compliance resolution fund so that statutory amendments might be made to ensure that the surcharge assessed of licensees bears a reasonable relationship to the cost of services rendered.

The law of 1982 establishing the compliance resolution fund to cope with the significant backlog of consumer complaints will expire on July 1, 1987. A uniform assessment on all licensees, including nurses, was provided for in order to aggregate sufficient monies to support the disposition of complaints in a timely and professional manner.

The department believes that because of the varying impact on the public's health and welfare by different groups of licensees a simplistic assessment formula based on the number of complaints generated would not serve the best interests of the general

public. Although arriving at a formula tailored to each board may be extremely difficult, the department will nonetheless explore the matter and work closely with the thirty boards and commissions in determining any proposals for change in the compliance resolution fee structure.

Sincerely yours,

Mary G. F. Bitterman
Director