

HEALTHCARE PROFESSIONALS

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Learning Objectives

After completing this chapter, the reader should be able to

- understand the role of healthcare professionals in the human resources management function of healthcare organizations;
- define the elements of a profession, with an understanding of the theoretical underpinnings of the healthcare professions in particular;
- describe the healthcare professions, which include the majority of healthcare workers, and the required educational levels, scopes of practice, and licensure issues for each;
- relate knowledge of the healthcare professions to selected human resources management issues and systems development; and
- comprehend the changing nature of the existing and emerging healthcare professions in the healthcare workforce, particularly the impact of managed care.

Introduction

Healthcare professionals are central to the delivery of high-quality healthcare services. Extensive training, education, and skills are essential in meeting the needs and demands of the population for safe, competent healthcare. These specialized techniques and skills that healthcare professionals acquired through systematic programs of intellectual study are the basis for socialization into their profession. Additionally, the healthcare industry is labor intensive and is distinguished from other service industries by the number of licensed and registered personnel that it employs and the variety of healthcare fields that it produces. These healthcare fields have emerged as a result of the specialization of medicine, development of public health, increased emphasis on health promotion and prevention, and technological advances and growth.

Because of this division of labor within medical and health services delivery, many tasks that were once the responsibility of medical providers have been delegated to other healthcare personnel. Such delegation of duties raises important questions for the industry: Should healthcare providers other than those specifically trained to practice medicine be considered professionals in their own right? To what extent should their scope of practice be extended?

In this chapter, we respond to the aforementioned questions by defining key terms, describing the healthcare professions and labor force, explaining the role of human resources in healthcare, and discussing key human resources issues that affect the delivery of healthcare.

Professionalization

Although the terms “occupation” and “profession” often are used interchangeably, they can be differentiated.

An *occupation* enables workers to provide services, but it does not require skill specialization. An occupation is the principal activity that supports one's livelihood. However, it is different from a profession in several ways. An occupation typically does not require higher skill specialization. An individual in an occupation is usually supervised, adheres to a defined work schedule, and earns an hourly wage rate. An individual in an occupation may be trained for a specific job or function and, as a result, is less able to move from one organization to another.

A *profession* requires specialized knowledge and training that enable professionals to gain more authority and responsibility and to provide service that adheres to a code of ethics. A professional usually has more autonomy in determining the content of the service he or she provides and in monitoring the workload needed to do so. A professional generally earns a salary, requires higher education, and works with more independence and mobility than do nonprofessionals.

The distinction between an occupation and a profession is important because the evolving process of healthcare delivery requires professionals who are empowered to make decisions in the absence of direct supervision. The proliferation of knowledge and the skills needed in the prevention, diagnosis, and treatment of disease has required increasing levels of education. Undergraduate- and/or graduate-level degrees are now required for entry into virtually every professional field. Some professions, such as pharmacy and physical therapy, are moving toward professional doctorates (i.e., PharmD and DPT, respectively) for practice.

A countervailing force against the increasing educational requirements of the healthcare professions is ongoing change in the mechanisms for delivery and payment of services. With consolidation of the healthcare system and

the rise of managed care, along with its demands for efficiency, fewer financial resources are available. As a result, healthcare organizations are pressured to replace highly trained—and, therefore, more expensive—healthcare professionals with unlicensed support personnel. Fewer professionals are being asked to do more, and those with advanced degrees are required to supervise more assistants who are functionally trained for specified organizational roles.

Functional training produces personnel who can perform tasks but who may not know the theory behind the practice; understanding theory is essential to becoming fully skilled and able to make complex management and patient care decisions. Conversely, knowing the theory without having the experience also makes competent practice difficult. When educating potential healthcare professionals, on-the-job training or a period of apprenticeship is needed, particularly in addition to basic coursework. Dreyfus and Dreyfus (1996) contend that both theoretical knowledge and practiced response are needed in the acquisition of skill in a profession. These authors lay out five stages of abilities that an individual passes as he or she develops a skill:

1. *Novice*. At this stage, the novice learns tasks and skills that enable him or her to determine actions based on recognized situations. Rules and guidelines direct the novice's energy and action at this stage.
2. *Advanced beginner*. At this stage, the advanced beginner has gained enough experience and knowledge that certain behaviors become automatic, and he or she can begin to learn when tasks should be addressed.
3. *Competent*. At this stage, the competent individual has mastered the practiced response of definable tasks and processes and has acquired the ability to deal with the unexpected events that may not conform to plans.
4. *Proficient*. At this stage, the proficient individual has developed the ability to discern a situation, intuitively assess it, plan what needs to be done, decide on an action, and perform the action more effortlessly than possible in the earlier stages.
5. *Expert*. At this stage, the expert can accomplish the goals without realizing that rules are being followed because the skill and knowledge required to reach the goal have become second nature.

Theoretical understanding is melded with practice in each progressive stage. Functional training can help an individual progress through the first three stages and can provide the individual with calculative rationality or inferential reasoning ability to be able to apply and improve theories and rules learned. For skill development at the proficient and expert levels, deliberative rationality or ability to challenge and improve theories and rules learned is required. Healthcare professionals need to become experts in fields where self-direction, autonomy, and decision making for patient care may be required (Dreyfus and Dreyfus 1996).

Healthcare Professionals

The healthcare industry is the largest and most powerful industry in the United States. It constitutes more than 6.5 percent of the country's total labor force and nearly 15 percent of the gross domestic product. Healthcare professionals include physicians, nurses, dentists, pharmacists, optometrists, psychologists, nonphysician practitioners such as physician assistants and nurse practitioners, healthcare administrators, and allied health professionals. The allied health professions are a huge group that consists of therapists, medical and radiologic technologists, social workers, health educators, and other ancillary personnel. Healthcare professionals are represented by professional associations. Table 4.1 provides a sample of professional associations in healthcare.

Healthcare professionals work in a variety of settings, including hospitals; ambulatory care centers; managed care organizations; long-term-care organizations; mental health organizations; pharmaceutical companies; community health centers; physician offices; laboratories; research institutions; and schools of medicine, nursing, and allied health professions. According to the Bureau of Labor Statistics (BLS 2007), healthcare professionals are employed by the following:

- hospitals (34.5 percent),
- nursing and personal and residential care facilities (23.0 percent),
- physician offices and clinics (17.1 percent),
- home health care services (6.9 percent),
- dentist offices and clinics (6.3 percent), and
- other health service sites (12.2 percent).

The U.S. Department of Labor recognizes about 400 different job titles in the healthcare sector; however, many of these job titles are not included in our definition of healthcare professionals. For example, almost one-third of those employed in the healthcare sector probably belong in the support staff category—that is, employees who are part of the patient care team or involved in delivering health services. These approximately 2.2 million nursing aides, home health aides, and personal attendants are critical to the delivery of healthcare services (BLS 2007).

The primary reasons for the increased supply and demand for healthcare professionals include the following interrelated forces:

- technological growth,
- specialization,
- changes in third-party coverage,
- the aging of the population, and
- the proliferation of new and diverse healthcare delivery settings.

TABLE 4.1
Resource Guide
for the
Healthcare
Professional

<i>Organization</i>	<i>Target Audience</i>	<i>Website</i>
Health Professions		
Pew Health Professions Commission	Future health professions	http://futurehealth.ucsf.edu
American College of Healthcare Executives: Health Management Careers	Future healthcare managers and administrators	www.healthmanagementcareers.org
Accrediting Organizations		
Accreditation Association for Ambulatory Health Care	Ambulatory healthcare facilities	www.aaahc.org
Accreditation Council for Graduate Medical Education	Graduate medical education programs	www.acgme.org
American Osteopathic Association	Osteopathic hospitals and health systems	www.osteopathic.org
Commission on Accreditation of Rehabilitation Facilities	Rehabilitation facilities	www.carf.org
The Joint Commission	Hospitals and health systems	www.jointcommission.org
National Committee for Quality Assurance	Health plans	http://web.ncqa.org
American Association of Blood Banks	Blood banks	www.aabb.org
American College of Surgeons	Surgeons	www.facs.org
American College of Surgeons: Commission on Cancer	Cancer programs	www.facs.org/cancer
College of American Pathologists	Clinical laboratories	www.cap.org

Professional Associations

American College of Healthcare Executives	Healthcare executives	www.ache.org
National Association of Health Services Executives	African-American healthcare executives	www.nahse.org
Institute for Diversity in Health Management	Healthcare managers, students, organizations, diversity programs	www.diversityconnection.org

TABLE 4.1
Continued

<i>Organization</i>	<i>Target Audience</i>	<i>Website</i>
Medical Group Management Association	Physician practice managers and executives	www.mgma.com
American Hospital Association: American Society for Healthcare Human Resources Administration	Healthcare human resources professionals	www.hrleader.org
American College of Physician Executives	Physician executives	www.acpe.org
American College of Health Care Administrators	Long-term-care administrators	www.achca.org
Association for Healthcare Documentation Integrity	Medical transcriptionists	www.ahdionline.org
American Association of Nurse Anesthetists	Nurse anesthetists	www.aana.com
American Association for Respiratory Care	Respiratory therapists	www.aarc.org
American Health Information Management Association	Medical records and information management professionals	www.ahima.org
American Medical Technologists	Medical technologists	www.amt1.com
American Nurses Association	Registered nurses	www.ana.org
American Association for Homecare	Homecare administrators	www.aahomecare.org
American Occupational Therapy Association, Inc.	Occupational therapists	www.aota.org
American Organization of Nurse Executives	Nurse executives	www.aone.org
National League for Nursing	Nurse faculty and educators	www.nln.org
American Physical Therapy Association	Physical therapists	www.apta.org
American Society for Clinical Pathology	Pathologists and laboratory professionals	www.ascp.org
American Society of Health-System Pharmacists	Health system pharmacists	www.ashp.org

TABLE 4.1
Continued

<i>Organization</i>	<i>Target Audience</i>	<i>Website</i>
American Society of Radiologic Technologists	Radiologic technologists	www.asrt.org
American Speech-Language-Hearing Association	Speech-language pathologists; audiologists; and speech, language, and hearing scientists	www.asha.org
Healthcare Financial Management Association	Controllers, chief financial officers, and accountants	www.hfma.org
Healthcare Information and Management Systems Society	Health information and technology managers	www.himss.org
National Cancer Registrars Association	Cancer registry professionals	www.ncra-usa.org

Trade Associations

American Hospital Association	Hospitals, health systems, and personal membership groups	www.aha.org
Federation of American Hospitals	Investor-owned hospitals and health systems	www.fah.org
Association of American Medical Colleges: Council of Teaching Hospitals and Health Systems	Teaching hospitals and health systems	www.aamc.org/members/coth
Catholic Health Association of the United States	Catholic hospitals and health systems	www.chausa.org
America's Health Insurance Plans	Health insurers	www.ahip.org

This chapter focuses primarily on nurses, pharmacists, selected allied health professionals, and healthcare administrators.

Nurses

The art of caring, combined with the science of healthcare, is the essence of nursing. Nurses focus not only on a particular health problem but also on the whole patient and his or her response to treatment. Nurses work in many

different areas, but the common thread of nursing is the nursing process, which has five steps (ANA 2008):

1. *Assessment*. This involves collecting and analyzing physical, psychological, and sociocultural data about a patient.
2. *Diagnosis*. This entails making a judgment on the cause, condition, and path of the illness.
3. *Planning*. This revolves around creating a care plan that sets specific treatment goals.
4. *Implementation*. This includes supervising or carrying out the actual treatment plan.
5. *Evaluation*. This focuses on continuous assessment of the plan.

Nurses also serve as patient advocates, multidisciplinary team members, managers, executives, researchers, and entrepreneurs.

Nurses make up the largest group of licensed healthcare professionals in the United States. According to the "National Sample Survey of Registered Nurses (NSSRN)," the United States has 2.9 million registered nurses (RNs), of whom more than 1.8 million (83.2 percent) are employed in healthcare organizations (HRSA 2006a). Approximately 56 percent of employed RNs, or 1.6 million, work in hospitals, while 15 percent, or 435,000, work in community or public health settings. Complementing this workforce are 749,000 licensed practical nurses, or licensed vocational nurses as they are known in some states (BLS 2006).

According to the demographic profiles from the NSSRN (HRSA 2006a), most nurses are women. In 2004, the average age of a nurse was 46.8 years old, nearly two years older than in 1997, when the average age was 44.5 years. The aging of the workforce is also reflected in the demographics of nurses: The RN population under 30 years old dropped, from 25 percent in 1980 to 8 percent in 2004. Meanwhile, the percentage of nurses older than 54 years increased to 25.2 percent in 2004, compared to 20.3 percent in 2000 and 16.9 percent in 1980. Only 5.8 percent of RNs are men, and only 11 percent of RNs come from racial/ethnic minority backgrounds.

Registered Nurses and Licensed Practical Nurses

All U.S. states require nurses to be licensed to practice. The licensure requirements include graduation from an approved nursing program and successful completion of a national examination. Educational preparation distinguishes the two levels of nurses.

RNs must complete an associate's degree in nursing (ADN), a diploma program, or a baccalaureate degree in nursing (BSN) to qualify for the licensure examination. ADN programs generally take two years to complete and are offered by community and junior colleges, and hospital-based diploma programs can be completed in about three years. The fastest growing avenue for nursing education is the baccalaureate preparation, which typically can be

completed in four years and is offered by colleges and universities. Licensed practical nurses (LPNs), on the other hand, must complete a state-approved program in practical nursing and must achieve a passing score on a national examination. Each state maintains regulations and practice acts that delineate the scope of nursing practice for RNs and LPNs.

Among employed RNs, about 34 percent hold associate's degrees, 20 percent have hospital-based program diplomas, and 34 percent possess BSN degrees. In 2004, 13 percent of nurses reported having a master's degree or a doctoral degree (HRSA 2006a). In addition to licensure and educational achievements, some nurses obtain certification in specialty areas such as critical care, infection control, emergency nursing, surgical nursing, and obstetric nursing. The nursing field comprises many specialties and subspecialties; certification in these areas requires specialty education, practical experience, and successful completion of a national examination. Some nurses obtain certification in these specialty areas because certification helps them maintain their professional associations. To remain certified, continued employment, continuing education units, or reexamination may be required.

An advanced practice nurse (APN) is a nurse with particular skills and credentials, which typically include basic nursing education; basic licensure; a graduate degree in nursing; experience in a specialized area; professional certification from a national certifying body; and, if required in some states, APN licensure (National Council of State Boards of Nursing 2006). The APN specializes as a nurse practitioner, certified nurse midwife, certified registered nurse anesthetist, or clinical nurse specialist.

Advanced Practice Nurses

The APN role is defined by seven core competencies or skillful performance areas. The first core competency of direct clinical practice is central to and informs all of the other areas, as follows (Hamric 2005):

- Direct clinical practice (central)
- Expert guidance and coaching of patients, families, and other care providers
- Consultation
- Research skills, including use and implementation of evidence-based practice, evaluation, and conduct
- Clinical and professional leadership, which includes competence as a change agent
- Collaboration
- Ethical decision-making skills

Additional core competencies may be needed in each specialty area that an APN pursues. The largest number of APNs is made up of nurse practitioners (NPs), who may further specialize in acute care or community settings or for particular client groups such as adults, children, women, or psychiatric/mental health populations.

Each state maintains its own laws and regulations regarding recognition of an APN, but the general requirements in all states include licensure as an RN and successful completion of a national specialty examination. Some states permit certain categories of APNs to write prescriptions for certain classes of drugs. This prescriptive authority varies from one state to another and may be regulated by boards of medicine, nursing, pharmacy, or allied health. Some states require physician supervision of APN practices, although some managed care plans now include APNs on their lists of primary care providers.

APN Specialization Certified nurse midwives (CNMs) specialize in low-risk obstetric care, including all aspects of the prenatal, labor and delivery, and postnatal processes. Certified registered nurse anesthetists (CRNAs) complete additional education to specialize in the administration of various types of anesthesia and analgesia to patients and clients. Often, nurse anesthetists work collaboratively with surgeons and anesthesiologists as part of the perioperative care team. Clinical nurse specialists (CNSs) hold master's degrees, have successfully completed a specialty certification examination, and are generally employed by hospitals as nursing "experts" in particular specialties. The scope of the CNS is not as broad as that of the NP; CNSs work with a specialty population under a somewhat circumscribed set of conditions, and the management authority of patients still rests with physicians. In contrast, NPs have developed an autonomous role in which their collaboration is encouraged, and they generally have the legal authority to implement management actions.

Pharmacists

In the foreseeable future, the pharmacy profession will continue to undergo extensive change. Until the 1970s, pharmacists performed the traditional role of preparing drug products and filling prescriptions. In the 1980s, however, pharmacists expanded that role. Pharmacists now act as an expert for clients and patients on the effects of specific drugs, drug interactions, and generic drug substitutions for brand-name drugs.

To be eligible for licensure, pharmacists must graduate from an accredited bachelor-degree program in pharmacy, successfully complete a state board examination, and obtain practical experience or complete a supervised internship. After passing a national examination, a registered pharmacist (RPh) is permitted to carry out the scope of practice outlined by state regulations. The trend in pharmacy has been to broaden education to include the terminal degree Doctor of Pharmacy (PharmD). Many pharmacy schools offer this program for those interested in research careers, teaching, higher administrative responsibility, or being part of the patient care team. This educational preparation also requires successful completion of a state board examination and other practical clinical experience, as outlined by state laws.

Allied Health Professionals

The term “allied health professionals” is generally not well understood because of its ambiguous definition (O’Neil and Hare 1990) and a lack of consensus about what such a role constitutes. In general, allied health professionals complement the work of physicians and other healthcare providers, although one may also be a provider. The U.S. Public Health Service defines an allied health professional as follows (Health Professions Education Extension Amendments of 1992, Section 701 PHS Act):

... a health professional (other than a registered nurse or a physician assistant) who has received a certificate, an associate’s degree, a bachelor’s degree, a master’s degree, a doctoral degree, or post-baccalaureate training in a science related to health care; who shares in the responsibility for the delivery of health care services or related services, including (1) services relating to the identification, evaluation and prevention of disease and disorders, (2) dietary and nutrition services, (3) health promotion services, (4) rehabilitation services, or (5) health systems management services; and who has not received a degree of doctor of medicine, a degree of doctor of osteopathy, a degree of doctor of veterinary medicine or equivalent degree, a degree of doctor of optometry or equivalent degree, a degree of doctor of podiatric medicine or equivalent degree, a degree of bachelor science in pharmacy or equivalent degree, a graduate degree in public health or equivalent degree, a degree of doctor of chiropractic or equivalent degree, a graduate degree in health administration or equivalent degree, a degree of doctor of clinical psychology or equivalent degree, or a degree in social work or equivalent degree.

A debate on the exclusiveness and inclusiveness of this definition continues. Some healthcare observers consider nursing, public health, and social work to fall under the umbrella of allied health, but these professions are often categorized as separate groups. Figure 4.1 lists the major categories that compose the allied health profession and the job titles and positions that normally fall under each category.

According to the “2006 National Occupational and Wage Estimates for Healthcare Personnel,” the allied health professions constitute 45.5 percent of the healthcare workforce in the United States (BLS 2007). This number excludes physicians, nurses, dentists, pharmacists, veterinarians, chiropractors, and podiatrists. The allied health profession is the most heterogeneous of the personnel groupings in healthcare.

The National Commission on Allied Health (1995) broadly divided allied health professionals into two categories of personnel: (1) therapists/technologists and (2) technicians/assistants. Some of the job titles presented in Figure 4.1 may not fit into these two categories. In general, the therapist/technologist category represents those with higher-level professional training

FIGURE 4.1
Major
Categories of
the Allied
Health
Profession and
Professional
Titles

Behavioral Health Services	
• Substance abuse counselor • Home health aide • Mental health aide	• Community health worker • Mental health assistant
Clinical Laboratory Sciences	
• Laboratory associate • Laboratory technician	• Laboratory microbiologist • Chemist (biochemist) • Microbiologist • Associate laboratory microbiologist
Dental Services	
• Dental assistant • Dental laboratory technologist	• Dental hygienist
Dietetic Services	
• Dietitian • Dietary assistant	• Assistant director of food service • Associate supervising dietitian
Emergency Medical Services	
• Ambulance technician	• Emergency medical technician
Health Information Management Services	
• Director of medical records • Assistant director of medical records • Medical record specialist	• Senior analyst of medical records • Health information manager • Data analyst • Coder
Medical and Surgical Services	
• Electroencephalograph technician • Electroencephalograph technologist • Operating room technician • Biomedical equipment technician • Biomedical engineer • Cardiovascular technologist	• Medical equipment specialist • Electrocardiograph technician • Dialysis technologist • Surgical assistant • Ambulatory care technician
Occupational Therapy	
• Occupational therapist • Occupational therapy assistant	• Occupational therapy aide
Ophthalmology	
• Ophthalmic technician • Optometric aide	• Optician

FIGURE 4.1
Continued**Physical Therapy**

- Physical therapist
- Physical therapy assistant

Radiological Services

- Nuclear medicine technician
- Radiation technician
- Ultrasound technician
- Medical radiation dosimetrist
- Nuclear medicine technologist
- Diagnostic medical sonographer
- Radiologic (medical) technologist

Rehabilitation Services

- Art therapist
- Exercise physiologist
- Recreational therapist
- Recreation therapy assistant
- Addiction counselor
- Addiction specialist
- Psychiatric social health technician
- Music therapist
- Dance therapist
- Rehabilitation counselor
- Rehabilitation technician
- Sign-language interpreter

Orthotics/Prosthetics

- Orthopedic assistant

Respiratory Therapy Services

- Respiratory therapist
- Respiratory therapy assistant
- Respiratory therapy technician

Speech-Language Pathology/Audiology Services

- Audiology clinician
- Staff audiologist
- Staff speech pathologist
- Speech clinician

Other Allied Health Services

- Central supply technician
- Medical illustrator
- Podiatric assistant
- Veterinary assistant
- Health unit coordinator
- Chiropractic assistant
- Home health aide

and who are often responsible for supervising those in the technician/assistant category. Therapists/technologists usually hold a bachelor's or a higher-level degree, and they are trained to evaluate patients, understand diagnoses, and develop treatment plans in their area of expertise. On the other hand, technicians/assistants are most likely to have two years or less postsecondary education, and they are functionally trained with procedural skills for specified tasks.

Educational and training programs for the allied health profession are sponsored by a variety of organizations in different academic and clinical settings. They range from degree offerings at colleges and universities to clinical programs in hospitals and other health facilities. Before 1990, one-third of allied health programs were housed in hospitals, although hospitals graduated only 15 percent of their students (O'Neil and Hare 1990). The Association of Schools of Allied Health Professions (ASAHP 2007) includes these among its membership: 112 academic institutions, 2 professional associations, and approximately 200 individual members. Junior or community colleges, vocational or technical schools, and academic health centers can all sponsor allied health programs. These programs can also be stand-alone when aligned with an academic health center, or they can be under the auspices of the school of medicine or nursing if a specific school of allied health professions does not exist. Dental and pharmacy technicians/assistants may or may not be trained in their respective schools or in a school of allied health professions.

A vast number of the undergraduate allied health programs are accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP), a freestanding agency that in 1994 replaced the American Medical Association's Committee on Allied Health Education and Accreditation. The formation of CAAHEP was intended to simplify the accrediting process, to be more inclusive of allied health programs that provide entry-level education, and to serve as an initiator of more far-reaching change. Some key allied health graduate programs, such as physical therapy and occupational therapy, are accredited through specialty professional accreditation organizations.

Healthcare Administrators

Healthcare administrators organize, coordinate, and manage the delivery of health services; provide leadership; and guide the strategic direction of healthcare organizations. The variety and numbers of healthcare professionals they employ; the complexity of healthcare delivery; and environmental pressures to provide access, quality, and efficient services make healthcare institutions among the most complex organizations to manage.

Healthcare administration is taught at the undergraduate and graduate levels in a variety of settings, and these programs lead to a number of different degrees. The settings include schools of medicine, public health, healthcare business, and allied health professions. A bachelor's degree in health administration allows individuals to pursue positions such as nursing home administrator, supervisor, or middle manager in healthcare organizations. Most students who aspire to have a career in healthcare administration go on to receive a master's degree. (For a detailed description of various career paths and options, see Haddock, McLean, and Chapman 2002).

Graduate education programs in healthcare administration are accredited by the Commission on Accreditation of Healthcare Management

Education. Most common degrees include the master of health administration (MHA), master of business administration (MBA) with a healthcare emphasis, master of public health (MPH), or master of public administration (MPA). However, the MHA degree, or its equivalent, has been the accepted training model for entry-level managers in the various sectors of the healthcare industry. The MHA program, when compared to the MPH program, offers core courses that focus on building business management (theory and applied management), quantitative, and analytical skills and that emphasize experiential training. In addition, some MHA programs require students to complete three-month internships or 12-month residencies as part of their two- or three-year curricula. Some graduates elect to complete postgraduate fellowships that are available in selected hospitals, health systems, managed care organizations, consulting firms, and other health-related organizations.

A growing number of healthcare administrators are physicians and other clinicians. As evidence, membership in the American College of Physician Executives (ACPE 2007) has increased to more than 10,000 in 2007, up from 5,700 in 1990, although stable since 2000. Physicians, nurses, and other clinicians refocus their careers on the business side of the enterprise, getting involved in the strategy, decision making, resource allocation, and operations of healthcare organizations. A traditional management role for physician executives is the chief medical officer (or a similar position) in a hospital, overseeing the medical staff and serving as a liaison between clinical care and administration. Likewise, a typical management career path for nurses is to become the chief nursing officer, with responsibility for the clinical care provided by employed professional staff.

Typically, chief medical officers begin their careers practicing medicine, then they slowly transition into the operations side of healthcare. However, physician executives work at every level and in every setting in healthcare. Many physician executives earn a graduate degree such as an MHA or an MBA if interested in pursuing a formal educational program in healthcare administration and management. As of 2007, 49 medical schools offer a combined MD/MBA program, and two medical schools offer the MD/MHA dual degrees (AAMC 2007). Whether physician executives start as administrators or later shift to become executives after clinical practice, they represent for other doctors an alternative way to make an impact on healthcare delivery.

Nursing home administrator programs require students to pass a national examination administered by the National Association of Long Term Care Administrator Boards. Passing this examination is a standard requirement in all states, but the educational preparation needed to qualify for this exam varies from state to state. Although more than one-third of states still require less than a bachelor's degree as the minimum academic preparation, approximately 70 percent of the practicing nursing home administrators have,

at a minimum, a bachelor's degree. As the population continues to live longer, the demand and educational requirements for long-term-care administrators are estimated to increase, along with the growth of educational programs targeted to this sector.

Considerations for Human Resources Management

The role of human resources management (HRM) in healthcare organizations is to develop and implement systems, in accordance with regulatory guidelines and licensure laws, that ensure selection, evaluation, and retention of healthcare professionals. In light of this role, human resources (HR) personnel should be aware that each of the healthcare professions, and often the subspecialties within those professions, has specific requirements that allow an individual to qualify for an entry-level job in his or her chosen profession. The requirements of national accrediting organizations (e.g., the Joint Commission), regulatory bodies (e.g., the Centers for Medicare & Medicaid Services), and licensure authorities (e.g., state licensure boards) should be considered in all aspects of HRM. In this section, we briefly discuss some of the issues that a healthcare organization's HR department must consider when dealing with healthcare professionals.

Qualifications

In developing a comprehensive employee-compensation program, HR personnel must include the specific skill and knowledge required for each job in the organization. Those qualifications must be determined and stated in writing for each job. The job description usually contains the level of education, experience, judgment ability, accountability, physical skills, responsibilities, communication skills, and any special certification or licensure requirements. HR personnel need to be aware of all specifications for all job titles within the organization. This knowledge of healthcare professionals is necessary to ensure that essential qualifications of individuals coincide with job specifications, and it is also necessary for determining wage and salary ranges (see Chapter 7).

Licensure and Certification

An HR department must have policies and procedures in place that describe the way in which licensure is verified on initial employment. Also, HR must have a system in place for tracking the expiration dates of licenses and for ensuring licensure renewal. Therefore, HR must be conscientious about whether the information it receives is a *primary verification* (in which the information directly comes from the licensing authority) or a *secondary verification* (in which a candidate submits a document copy that indicates licensure

has been granted, including the expiration date). Certifications must be verified during the selection process, although certifications and licenses are generally not statutory requirements. Many healthcare organizations accept a copy of a certification document as verification. If the certification is a job requirement, systems must be in place to track expiration dates and to access new certification documents.

Career Ladders

In selecting healthcare professionals, HR personnel must consider past employment history, including the explanation of gaps in employment. To assess the amount of individual experience, evaluating the candidate's breadth and depth of responsibility in previous jobs is essential. Many healthcare organizations have career ladders, which are mechanisms that advance a healthcare professional within the organization. Career ladders are based on the Dreyfus and Dreyfus model of novice to expert (explained earlier in the chapter), and experience may be used as a criterion for assignment of an individual to a particular job category. In addition, healthcare organizations may conduct annual reviews of employees who have leadership and management potential. This review entails that HR works with senior management to assess the competency, ability, and career progression of employees on an ongoing basis.

Educational Services

Healthcare professionals require continuous, lifelong learning. Healthcare organizations must have in-house training and development plans to ensure that their healthcare professionals achieve competency in new technologies, programs, and equipment and are aware of policy and procedure changes. Certain competencies must be renewed annually in areas such as cardiopulmonary resuscitation, safety and infection control, and disaster planning.

In addition to developing specific training programs, healthcare organizations should provide orientation for all new employees. Such organization-specific training enables the leadership to share the values, mission, goals, and policies of the institution. Such clear communication often serves as a retention tool that enables employees to better understand how the organization works and how to be successful in that organization. Similarly, some professions and licensing jurisdictions may require continuing education that is profession specific.

A healthcare organization can provide training and development in a variety of ways. On one end of the spectrum, training and development can be outsourced to a firm that specializes in conducting educational programs. Conversely, another option is to consolidate all training and development in-house, which are managed typically by the HR department. Regardless of how each healthcare organization provides continuing education, training and development should be a priority. Strong programs can be viewed as recruitment

and retention tools. As such, healthcare organizations must be cognizant of fiscal resources necessary to support these educational requirements.

Practitioner Impairment

Healthcare professionals are accountable to the public for maintaining high professional standards, and the governing body of a healthcare organization is, by statute, responsible for the quality of care rendered in the organization. This quality is easily jeopardized by an impaired practitioner. An *impaired practitioner* is a healthcare professional who is unable to carry out his or her professional duties with reasonable skill and safety because of a physical or mental illness, including deterioration through aging, loss of motor skill, or excessive use of drugs and alcohol.

The HR department must periodically evaluate the performance of all healthcare professionals in the organization to ensure their competence (i.e., the basic education and training necessary for the job) and proficiency (i.e., the demonstrated ability to perform job tasks). Mechanisms must be in place to identify the impaired practitioner, such as policies and procedures that describe how the organization will handle investigations, subsequent recommendations for treatment, monitoring, and employment restrictions or separation. Hospitals, for instance, usually have a process in place for the board of directors (which has the ultimate responsibility for the quality of care delivered in the organization) to review provider credentials and performance and to oversee any employment actions. Each national or state licensing authority maintains legal requirements for reporting impaired practitioners.

As a result of ever-increasing changes in the health professions, in the foreseeable future, new challenges and opportunities, such as the issues described in this section, will face the HR department of every healthcare organization.

Changing Nature of the Health Professions

In the 1990s, we entered a new era of uncertainty in healthcare, one faced with a quickening pace of change (Begun and White 2008). Within this framework, new ways of thinking are rewarded as the meaning of health is redefined, the boundaries of healthcare professionals are reshaped, and the outcomes of healthcare professional interventions are measured in terms of quality of life. Changes in the organization and financing of healthcare services have shifted delivery from the hospital to outpatient facilities, the home, long-term-care facilities, and the community. This is largely the result of three major forces: (1) a shift in managed care reimbursement to outpatient settings and a focus on cost containment; (2) technological advances, such as

telemedicine and the electronic medical record; and (3) medical innovation—the science of medicine has progressed to the point that complicated procedures that once required several nights of stay can now be treated with a simple procedure or even solely with medication. These changes are intended to improve the delivery of healthcare while reducing cost and increasing access for patients.

As the setting for the delivery of care continued to change, so did arrangements between physicians and healthcare organizations. For instance, physicians can function as individual providers (either in solo or group practice) and refer patients to the hospital. Typically, these private-practice doctors have admitting privileges to the hospital but are not governed by the hospital, do not serve as attending physicians, and infrequently participate on hospital committees. Physicians considered “on staff” at any hospital are those who refer and treat patients at that hospital. They are credentialed by the hospital credentialing committee (usually managed by the chief of staff office) and are governed by the medical staff bylaws. This is a common type of hospital-provider arrangement.

However, a trend toward hospitals employing physicians has been growing. In this arrangement, physicians are on staff, referring to and treating at only the hospital that employs them. Because they are considered employees, physicians are not only held to the HR policies of the healthcare organization but are also governed by the medical staff bylaws. Physicians who are employed by a hospital can also maintain a private practice.

Finally, the field of hospitalists is also growing. Typically, these physicians do not run their own practice aside from their hospital employment. Hospitalists work full time for the hospital and are trained in delivering specialized inpatient care. Regardless of the type of arrangement, most hospitals have a chief medical officer, or a similar position, who oversees the roles and responsibilities of the hospitalist as a member of the medical staff; the hospitalist’s employee issues and responsibilities are typically managed by the HR department. These hospital–physician arrangements get more complex in academic medical centers, which must integrate the roles and responsibilities of the physicians, the hospital, and the medical school.

As a result of the changing environment and decreased reimbursement, more primary care physicians are joining or forming group practices. Large physician-owned group practices offer several advantages to physicians, including competitive advantage with vendors and manufacturers, improved negotiating power with managed care organizations, shared risk and decision making, and improved flexibility and choice for patients. Physicians usually own or share ownership in the group practice and, therefore, are responsible for the business operations. Typically, group practices employ an office manager who works closely with the physicians to manage the day-to-day operations. Often, a full-time administrator is on staff not only to manage everyday issues but also to formulate strategies and oversee personnel,

billing and collection, purchasing, patient flow, and other functions. Many group practices opt to outsource their business functions, including human resources, to specialized firms. For complete details on medical practice management, go to www.mgma.com.

These shifts in various healthcare settings and arrangements have changed the roles, functions, and expectations of the healthcare workforce and gave way to the emergence of the following issues.

Supply and Demand

Throughout the twentieth century, the nursing labor market cycled through periods of shortages and surpluses (Lynn and Redman 2005; Aiken et al. 2002; Kovner 2002; Coile 2001; Jones 2001; Buerhaus, Staiger, and Auerbach 2000). The beginning of the twenty-first century brought the nursing and allied health professions the challenge of keeping pace with the demand for their services. Indicators of demand include numbers of vacancies, turnover rates, and an increase in salaries. To fill positions, hospitals—the largest employers of nurses and allied health professionals—have raised salaries, provided scholarships, and given other incentives such as sign-on bonuses and tuition reimbursement.

The supply of nurses and allied health professionals is reflected in the number of students in educational programs and those available for the healthcare workforce. Future supply of such professionals continues to be threatened by the following factors:

- *The aging of the nursing workforce.* According to the results of the 2004 National Sample Survey of Registered Nurses (HRSA 2006a), the average age for all nursing faculty was 51.6, and for nursing faculty who have doctoral degrees, it was 55.4 (up from 53.5 in 2003).
- *The decline in available educational resources.* Almost two-thirds (68.5 percent) of the nursing schools that responded to the 2006 American Association of Colleges of Nursing (AACN 2007a) survey identified faculty shortages as a reason for not accepting all qualified applicants into entry-level baccalaureate programs. The survey also noted lack of classroom space and clinical facilities and budgetary restraints.
- *The decline in nursing school enrollees.* From 1995 through 2000, enrollment decreased by 21 percent. From 2001 through 2007, increases of 3.7 to 16.6 percent were observed, but more than 30,000 qualified applicants were turned away from baccalaureate nursing programs in 2007 (AACN 2007a).

As a result, recruitment of nursing and allied health professions students has become a major focus of practitioners, professional associations, and academic institutions. In response, healthcare organizations (in addition to increasing salaries) are developing innovative ways to recruit and retain nurses

and allied health professionals. Such developments include opening or sponsoring new schools, offering shorter and more flexible shifts, and providing child care.

Alternative Therapies

Alternative therapies have gained more popularity, judging by the growing number of publications on this topic in the lay press and in academic literature. A turning point in this acceptance and increased respectability was the sentinel study of the prevalence of the use of alternative or unconventional therapies (Eisenberg et al. 1993). In the study, Eisenberg and colleagues concluded that one in three adults relied on treatments and interventions that are not widely taught at medical schools in the United States; examples of these alternative interventions included acupuncture and chiropractic and massage therapies. In a follow-up study, Eisenberg and colleagues (1998) determined that, from 1990 to 1997, visits to alternative medicine practitioners increased by 47.3 percent. Another study reported that 75 (60 percent) out of the 125 medical schools that participated in the survey offered a course in complementary or alternative medicine (Wetzel, Eisenberg, and Kaptchuk 1998). Additionally, consumers are demanding the use of alternative therapies, and hospitals have begun offering more of these services (Clement et al. 2006). As the use of alternative therapies continues to gain acceptance and to be integrated in medical school curriculum, this specialty area may be more and more considered as an emerging healthcare profession.

Nonphysician Practitioners

With the advent of managed care, greater reliance has been placed on nonphysician practitioners. Collaborative practice models with nurse practitioners, physician assistants, pharmacists, and other therapists are appropriate to both acute and long-term healthcare delivery. Strides have been made in the direct reimbursement for some nonphysician healthcare provider services, which is an impetus for further collaboration in practice. The consolidation and integration of the healthcare delivery system have not, however, eliminated slack and duplication of services. Although the changes attributed to managed care have led to the promotion and use of less-costly sites for care delivery, a larger impact on the division of labor among all healthcare professionals, and thus on health professions, may yet occur.

Licensure and Certification

The use of nonphysician practitioners at various sites may be viewed as an opportunity for the growth of nursing, pharmacy, allied health professions, and health administration. Alternatively, Hurley (1997) contends that it may lead to concerted efforts to repeal professional licensure and certification in healthcare. If policymakers jump on the bandwagon, this deregulation may lead to

not only the demise of some healthcare professions but also the proliferation of functionally trained, unlicensed personnel. The use of personnel who have less education will have greater implications for the existence and growth of educational programs in academic medical centers. The use of unlicensed support personnel poses concerns about the intensity and quality of healthcare delivered. When fewer highly trained professionals are employed to oversee operations and care delivery, the potential for adverse outcomes increases. Aiken, Sochalski, and Anderson (1996) found that, although the percentage of RNs increased overall, fewer nurses per patient were available in the mid-1990s than in the 1980s to provide care for more acutely ill patients. The net effect was a relative increase in nonclinical personnel, which added stress for those who were expected to supervise unlicensed staff and to care for sicker patients. This is a trend that continues to affect the provision of healthcare (Aiken et al. 2002).

Recruitment and Retention

Recruitment and retention of healthcare professionals are important in the face of continuing shortages in key healthcare professions, including nursing and allied health professions. The American Hospital Association (2007) reported an average hospital nurse vacancy rate of 8.1 percent. The RN vacancy rate is projected to be 20 percent by 2020 (Buerhaus, Staiger, and Auerbach 2000; Heinrich 2001). This vacancy rate is related to an RN shortage, which is estimated to be in the range of 340,000 to 1 million nurses by 2020 (Auerbach, Buerhaus, and Staiger 2007; HRSA 2006b). Nearly 17 percent of RNs were not employed in nursing in 2004, which was a 26.2 percent increase over the 1992 rate (HRSA 2006a). Letvak (2002) predicted that one in five nurses planned to leave the profession and turnover costs could be up to two times a nurse's salary. Fifty-five percent of nurses reported their intention to retire between 2011 and 2020 in a survey released in 2006 (AACN 2007b), which would further contribute to the RN shortage. Similarly, the American Hospital Association (2007) reported vacancy rates among allied health professionals (e.g., occupational and physical therapists, laboratory technologists, imaging technicians) that range from 6 percent to 11 percent of needed positions. These shortages require current professionals to treat more patients and to work longer hours. Such conditions can contribute to emergency department diversions, increased patient wait times, and decreased patient safety.

In response, healthcare organizations need to develop and execute recruitment and retention programs. These programs require senior management support and dedicated financial and human resources. Such programs should focus on building a culture of retention. While salary is an important aspect of employee recruitment and retention, other aspects of work are also influential, such as leadership support, ability to contribute to the organization and provide quality care to patients, degree of autonomy, engaging in positive relationships with direct supervisors and peers, good working

conditions, and ability to maintain a work-life balance. Additional tools for retaining employees include conducting employee-engagement surveys, providing mentoring, and making training programs available.

One innovative way to differentiate a hospital from its competitors, which helps in recruitment and retention, is to achieve Magnet status. In 1993, the American Nurses Credentialing Center's Magnet Recognition Program was developed as a way to specifically recognize excellence in nursing services at the institutional level and to benchmark best practices to be disseminated throughout the industry. Hospitals that apply for and achieve Magnet status have created and demonstrated a professional practice environment that ensures quality outcomes. These hospitals are recognized for their best practices in nursing care, improved patient outcomes, and increased workplace satisfaction. The actual evaluation process is based on nine Magnet standards, the completion of an intensive written application, and a two-day site visit by a team of nurse scholars. Hospitals that do not wish to engage in the application process can benefit greatly from using Magnet strategies to create a culture based on excellence in nursing and patient care (Pieper 2003). For more information on Magnet status, see www.nursecredentialing.org/magnet.

Entrepreneurship

Given the bureaucratic nature of organizations, the regulation of the healthcare industry, and additional constraints by payers and managed care, many healthcare professionals are choosing to pursue opportunities on their own. The service economy coupled with knowledge-based professions may encourage pursuit of new and different ventures for individuals who have the personality, skills, and tenacity to go into business for themselves. An entrepreneur must have a mix of management skills and the means to depart from a traditional career path to practice on one's own.

White and Begun (1998) characterize the entrepreneurial personality traits of a profession in terms of its willingness to take the risks associated with undertaking new ventures. Each profession may be categorized either as defending the status quo, which therefore entails little risk (defender professions), or as looking for new and different opportunities with greater risk (prospector professions). White and Begun view the more entrepreneurial professions as more diversified in terms of processes and services delivered. The accrediting bodies of such entrepreneurial professions encourage educational innovation that may extend to nontraditional careers. Each of the healthcare professions has, to greater or lesser extents, defender and prospector aspects.

Workforce Diversity

Each of the healthcare professions must continue to monitor and encourage diversity in its membership because the demographic shifts that the United States is going through will have an impact on the workforce composition in

the coming decades. Although workforce diversity is a broad concept, it focuses on our differences in gender, age, and race; these aspects not only reflect the population that healthcare serves but also the people who provide the services. Some professions are dominated by one gender or the other, which is illustrated by the predominantly female field of nursing or the historically predominantly male field of health administration. The health administration profession, however, has made strides in recent years as more female administrators have entered the field. Labor shortages and employee turnover are common in the healthcare professions. Consequently, healthcare executives must balance the needs of new entrants into the profession and those already in the profession.

Changes in the ethnic and racial composition of the workforce are proportional to the changes in the size and age of the population (D'Aunno, Alexander, and Laughlin 1996). Because many healthcare professionals are racial/ethnic minorities, a concerted effort needs to be made to recruit and retain them because the diversity of the members of a profession should reflect the diversity of the members of the population.

Summary

Healthcare professionals are a large segment of the U.S. labor force. Historically, the development of healthcare professionals is related to the following trends:

- Supply and demand
- Increased use of technology
- Changes in disease and illness
- The impact of healthcare financing and delivery

The healthcare workforce is very diverse. The different levels of education, scopes of practice, and practice settings contribute to the complexity of managing this workforce. The coming decades will be characterized by some reforms within the healthcare professions because of increasing pressures to finance and deliver healthcare with higher-quality, lower-cost, and measurable outcomes.

Discussion Questions

1. Describe the process of professionalization. What is the difference between a profession and an occupation?
2. Describe the major types of healthcare professionals (excluding physicians and dentists) and their roles, training, licensure requirements, and practice settings.

3. Describe and apply the issues of human resources management and systems development to healthcare professionals.
4. How has managed care affected the healthcare professions?
5. Who are nonphysician practitioners who provide primary care? What is their role in the delivery of health services?

Experiential Exercise

The purpose of this exercise is to give you an opportunity to explore one healthcare profession in detail.

From all of the healthcare professions, select one for analysis. Table 4.1 provides a starting point for selection. Describe the following characteristics of the profession you selected:

- Knowledge base
- Collective goals
- Training
- Licensure (this varies by state)
- Number of professionals in practice by

1. Vertical differentiation (position, experience, education level)

2. Horizontal differentiation (geography, practice setting, specialty)

- History and evolution of the profession
- Professional associations and their roles
- Competitor professions
- Current strategic issues that face the profession and the profession's position on these issues

To get started on this exercise, you may wish to go to the websites of professional organizations and various state licensing boards. You may also interview members of the profession as well as leaders in the field.

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