

# REFORMER FROM THE O.R.

TRICIA HUNTER, RN, MN, A FORMER OPERATING ROOM NURSE AND STATE LEGISLATOR, WOULD LIKE TO SEE A DISCUSSION AROUND LIMITING EXPENSIVE MEDICAL CARE WHEN MORE COST-EFFECTIVE APPROACHES ARE AVAILABLE.

**T**ricia Hunter had enough. It was the 1980s, and the registered nurse (RN) had been in practice since 1974. She had just moved to California when legislation was proposed that would eliminate licensing requirements for nurses, making the attainment of an RN or other nursing license a mute achievement. It was time to act.

"If you want to get a nurse involved in politics, go after her license," says Hunter, RN, MN, a former operating room nurse and state legislator, and currently a lobbyist who partners with another nurse in running Government Relations Group, Inc., a health-care consulting firm in Sacramento.

Successfully fighting that legislation was Hunter's segue into politics. Through her membership in the California chapter of the American Nurses Association, Hunter was appointed to the state's Board of Registered Nursing, where for eight years she worked on policy issues and came to realize that she enjoyed helping to craft healthcare legislation.

So she decided to do more of it. In 1989, Hunter was elected to the California legislature, where she served two terms.

"I was the director of surgery in a new heart program in a San Diego hospital at the time," Hunter says. "I literally went from the operating room to the state assembly."

As a legislator, Hunter helped craft laws on Medicaid and nursing practice, and legislation that served as the state's initiation into healthcare reform. Hunter also worked on healthcare legislation during the 1990s in various capacities as a government appointee.

"Even though a lot of times my name wasn't on the legislation, I was the one meeting in the office, helping to negotiate between Gov. [Pete] Wilson and our Democratic leadership to get something passed," Hunter says.

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What this all means is that Hunter has been thinking about healthcare reform for a long time. Although she advocates employee-man-dated insurance, she says a national policy is not the answer to the country's healthcare problems. "Healthcare reform is going to

happen, and it's not going to happen at the federal level," she says. "I don't have a problem with national standards, but there isn't a cookie-cutter process that will fix every state."

Even more fundamental to reform, she says, is the issue of spending limits. Currently, there are no limits on the amount of care that must be given, even in grave cases, but there are limits on funding that care.

"That's where we have failed in policy," she says. "When you can't turn somebody with a minor illness away from an emergency department, we are saying that everyone has a right to whatever level of care they seek—even if there are

more cost-effective and clinically efficacious ways to provide that care."

To cut healthcare costs, quality-of-life factors must enter into the decision about the type of care to give, she says, meaning there has to be more use of palliative and hospice care, rather than more expensive acute care.

"There has to be a combination of a care mandate and recognition that there are limits to what services we can provide, as well as a discussion of what those limits are going to be. We have to move in that direction," she says. "The uninsured impact us all." ■

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