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Where Have All the Nurses Gone? The Continuing Saga of the Nursing Shortage

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WHERE HAVE ALL THE NURSES GONE? THE CONTINUING SAGA OF THE NURSING SHORTAGE

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COMMITTEE IN CHARGE OF CANDIDACY

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100914

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ABSTRACT

This paper examines the issues which have encompassed the nursing profession for many years, thus making it a difficult career in which to attract and retain members. The nursing shortage, many say, has returned, but did it really go away? The shortage experienced in the 1970's was coupled with high admission rates and high employee turnover causing a shortage of nurses, particularly experienced ones. Then, hospitals faced the emergence of the federal government making major changes in reimbursement to hospitals. This caused a major shift in the cash flow system of hospitals. Also, costs were no longer reimbursed on a "fee for service" basis, but rather on a fixed rate. With the resulting shift of many services to an outpatient basis, the inpatient services have shown an increase in the acuity of illnesses seen and cared for by the nursing staff.

During this transition period, many hospitals laid off nursing staff because of the fear of declining occupancy rates. Inflation was high, jobs were scarce, so this resulted in a less mobile nursing society. People stayed in their jobs due to the economic climate. Many open nursing positions were not filled during this time.

Now, with expanding outpatient services, increased technology, more seriously ill patients to care for on an inpatient basis, and experience with the new reimbursement system, nursing positions are again open,but without applicants to fill them.

Nursing has faced many long-term problems with little resolution. These problems include: entry into practice, expanding roles for nursing, a lack of recognition from the public for nursing as a profession, and growing dissatisfaction and lack of professional growth on the job. The nursing profession has done little to remedy these issues. Declining enrollments in nursing schools, negative media attention, and women's increased access to other professions are just symptoms of the nursingshortage. These issues must be resolved in order for nursing to attract and retain its members.

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INTRODUCTION

CHAPTER 1: CYCLICAL NURSING SHORTAGES

Periodic nursing shortages have plagued this country for many years. Each time this cyclical pattern occurs, the same issues are discussed without solving the underlying problems or causes.

Nancy Higgins, President-elect of the American Organization of Nursing Executives says, "The pool of registered nurses is diminishing", (Gallivan, p. 152). Two years ago, 6,000.Minneapolis nurses went on strike with their biggest issue sited as job security during a year punctuated with healthcare worker layoffs, (Gallivan, p. 152). Today, Health care recruiter Rose Houston, head of the Chicago office of Medical Recruiters of America, Inc., says,"... the Midwest has experienced a growing shortage of registered nurses since last fall. Ironically, in three previous years, hospitals had waiting lists of nurses seeking positions", (Gallivan, p. 152). In 1985, more than 4,000 hospital workers had lost their jobs. Trending data shows, "....a deficiency of 619,100 nurses prepared at the baccalaureat and higher level; an excess of 296,900 prepared at the associate degree level; and an excess of 204,200 licensed vocational and practical nurses", (Fagin, p. 120). What has happened in so short a time span?

Professional nursing has been considered a shortage occupation since World War II. Since then, the demand and need for professional nurses has increased with population growth, the technology

explosion, increased hospitalization, a shift from primary to specialized care, expansion of the registered nurse role, an emphasis on preventative care, and the recent introduction of the prospective pricing system by the federal government for hospital reimbursement. Margretta Styles, President of the American Nurses Association, states, "The pressure on nurses in hospitals today is tremendous. They are caring for critically ill patients in technologically complex environments, preparing patients and their families for earlier discharge and coping with chronic staffing shortages", (Selby, p. 1).

Traditionally, a shortage exists when the demand exceeds the supply that is available at a specific market price. With today's nursing shortage, the issue includes not only having the right number of nurses, but also the right mix of staff possessing the right skills. The numbers of available nursing staff must be sufficient for every patient, on every unit, on every shift, every day of the year. These numbers must constantly match a fluctuating patient census and acuity level. Thus, a nursing shortage today means an insufficient number of qualified professional nurses to provide patient care on the days, at the times, and in the places required by patients (Beyers and Damore, p. 33). This includes matching nursing skills to patients' needs from the complex high technological world of intensive care units to the increased complexity of ambulatory and home care.

Historically, the nursing shortages of the past have demonstrated a similar cyclical pattern. Past nursing shortages have triggered increased nurses' salaries and benefits, increased nursing recognition, and increased perception of nursing as an attractive career. These events subsequently led to increased nursing school enrollments,

which led to an increased supply of nurses. Following the laws of supply and demand, as more nurses entered the work force, there was deterioration of nursing salaries, followed by a drop in enrollment in nursing schools which finally resulted in another nursing shortage. This was the scenario in the 1960's when hospitals reported an average of 23 RN vacancies per 100 budgeted positions (Prescott, p. 207). Subsequently, this shortage also produced increased salaries, followed by an increase in nursing school enrollments.

In the 1970's, the shortage appeared again when nurses' wages fell behind both the rate of inflation and comparable occupation groups. Hospitals reported nurse vacancy rates at 13% (Prescott, p. 207). This nursing shortage was studied by the National Commission on Nursing and the Institute of Medicine. Their report called for major changes in the organizational structure of nursing services and better RN/MD relationships. Consequently, the late 1970's and beginning of 1980 showed an increase in nursing salaries and a drop in nurse vacancy rates to 8% (Prescott, p. 207).

Early in 1980, problems again developed with nurse staffing,only this time the reverse took place. Facilities began to downsize. Between 1982 and 1983, hospitals and healthcare workers began feeling economic pressures and influences as the prospective pricing system began. Attempting to adjust and function within the guidelines of the new reimbursement environment, hospitals began to lay off staff in order to cope with a possibility of decreased census and revenues. As a result, when hospitals faced extreme fluctuations in patient census and acuity, they had difficulty staffing nursing divisions.

The prospective payment system also changed the patient population. Patients needing hospitalization were now sicker, but their hospital stay was much shorter. Many nursing experts argue this requires a higher concentration of professional nursing staff (Fralic, p. 209). Ironically, recruitment for nurses came to a halt at acute care hospitals because administrators were reluctant to hire due to the extreme fluctuations in patient census. Also, these administrations felt necessary recruits would be available from the pool of nurses previously laid off.

The increase in the severity of inpatients and the intensity of services needed by today's hospitalized patient is reflected in the changing ratio of nurses to patients. In 1975, 50 RNs were required for every 100 patients. In 1985, this ratio was 85 RNs to 100 patients. This ratio is complicated by a rising elderly population which requires more labor intensive nursing care. By the year 2040, the elderly will comprise 21% of the population as compared to the current 12% (Jenkins, p. 3-4).

The prospective pricing system has also led to the development of new services. Thus, lower hospital occupancy rates have not offset the nursing shortage as administrators were hoping. Other areas such as health maintenance organizations, ambulatory care centers and insurance companies have absorbed these nurses. Home care agencies are also successful in recruiting nurses trained in critical care because they can offer employees straight days which are more desirable than the shift work experienced in hospital settings. Their critical care skills are needed to take care of patients at home who's illness demands this type of training.

1980 to 1981, when the nursing shortage was most acute, salaries for nurses took a dramatic upward swing followed by an increase in nursing school enrollments. By 1983 to 1986, salaries for nurses again began to taper off. Salary increases were under 5%, and once again there was a drop in nursing school enrollments. By 1983, nursing school enrollments had declined 5.3%; by 1984, enrollment was down 8.1%; and, by 1985, enrollment was down 7.5% (Prescott, p. 206).

Along with salary trends, nursing school enrollments were higher when there was federal support for nursing education. However, this support had been cut in the 1980s (Prescott, p. 206). As a result, by 1986, vacancy rates for nurses in hospitals had doubled from 6.3% in 1985 to 13.6% while hospital occupancy rates were increasing (Beyers and Damore, p. 32). The National League for Nursing predicts a 15% decrease in the number of nursing graduates from 1986-1990. This is an estimated drop from 81,000 graduates to 70,000 graduates (Beyers and Damore, p. 34).

These historical shortages have other similarities. Action was traditionally not taken until crisis proportions were achieved. These crisises were usually defined as a disruption of patient services, poor quality of patient care delivered, and/or a loss of money. When this occurred, then cutthroat competition for nurses between hospitals began. Expensive gimmicks such as hiring bonuses, increased entry level salaries, recruiting abroad, and filling positions with less well-prepared nurses took place. As demonstrated, these have been short term solutions since shortages continue to occur.

Today, the scenario is different. These past strategies for reducing the nursing shortage will not be effective. In today's environment, a

nursing shortage which disrupts quality of care or the ability to provide service could lead to decreased market share for hospitals-a situation more difficult to recapture as competition for market share increases. The differences in today's nursing shortage are:

1. the prospective pricing structure, causing new management structures to develop as well as downsizing and closure of acute care hospital beds. Organizational structures are decentralizing around service/product lines;

2. development of alternate care delivery systems with the increased emphasis on outpatient services, home health, etc.;

3. changing roles and functions of health professionals;

4. poor public image of nursing coupled with increased choices of careers for women are no longer attracting large numbers of young people to the profession. Also, nursing is a 95% single gender profession, making it unattractive to members of the opposite sex;

5. confusion over the entry level requirements for beginning practitioners;

6. decreasing job satisfaction. Nursing is not adequately competing with careers offering dynamic, significant work coupled with autonomy of practice instead of subservience, especially when these other careers are accompanied by competitive salaries, not low-ceiling wages relative to the responsibility assumed;

7. an increasing emphasis on the prevention of illness in an environment that makes its money from sickness;

8. the change from a need-driven health care environment to one which is resource-driven ; and

9. the supply of nurses usually folllows the economy in an inverse pattern. Nurses tend to return to work when their spouses are laid off and quit when their spouses are rehired.

Since the 1970s, has the nursing shortage ever really gone away or did it go underground? Declining enrollments in nursing schools, hospital vacancy rates increasing with these openings remaining unfilled for longer periods of time, an increased use of agency nurses, increased use of regular staff for overtime, temporary closure of beds due to inadequate staffing, nurses leaving the profession for other careers, negative media attention, and college women's access to other professions are just the symptoms of more complex problems facing nursing today. The problems of entry into practice, expanding roles for nursing, a lack of recognition from the public as a profession, and a lack of satisfaction and professional growth have hurt the nursing profession for years. There has been little progress by nurses themselves to remedy these issues. As subsequent chapters will demonstrate, it is now critical to the future of nursing in order to attract and retain its members. Someone must care for patients. If nurses cannot resolve these issues, there are other professions willing to create their own answer to the nursing shortage.

CHAPTER 2: NURSING AND PROFESSIONALISM

"The nursing profession has had a long history of agreeing on our common goal: to provide high quality nursing care for all. We also have a long history of difficulty in working together to achieve the goal. Our debates are emotion-laden rather than logical. We experience and demonstrate the behaviors common to immature, insecure, oppressed groups. We lack a strong professional ethos and camaraderie. There are many reasons why this state exists; however, we can no longer accept the status quo. We must find a common shared interest that will challenge us to move beyond this stage of development" (Gioiella, p. 128).

As implied by this quotation, nursing today is struggling to be recognized as a profession. Classic professional groups recognized by the general public include lawyers, physicians, and theologians. The general public tends to accept the opinions of professionals as fact rather than just data to consider when they form their own opinions. Opinions and judgments of professionals are frequently sought and respected especially for public issues. When was the last time a registered nurse's opinion was sought? Nurses aren't asked to participate in political issues to the same degree as other professions and they aren't consulted on public issues of concern. Rarely are nurses members of community advisory boards nor do they sit on boards of directors. Why?

"Although organized nursing considers itself professional, and many individual nurses would say that nurses constitute a profession in

the classical sense, the general public has not acknowledged nursing as such in the same manner as they would, for example, medicine or law.....The traditional dominance of men and physicians has led to the assumption that nurses, as women and followers, think like physicians and thus have their views represented.....The fact that most nurses are women probably deserves the most credit for this public ignorance of nursing as a force in decision making. (Deloughery and Gebbie, p. 6)." "Nurses express resentment toward physician's telling them what to do in areas in which they feel competent.but are reluctant to accept in toto those areas of responsibility," (Deloughery and Gebbie, p. 9). As women enter domains traditionally dominated by males, men face a loss of power, a position not easily relinquished. This is demonstrated by the recent proposition of the American Medical Society to develop a new category of health care worker titled, "Registered Care Technologist", (Salahuddin, p. 1). Physician licensing boards would regulate their practice. Dr. James E. Davis, President-elect of the American Medical Association, states, "Organized nursing is cutting back...going all out for graduate nurses to get more supernurses, but we all know the real need is at the bedside." Nursing is currently seeking direct reimbursement from Medicare which has placed itself in direct opposition to organized medicine.

Nursing may be more preoccupied with what it might be rather than what it is. Helen Cohen states, "....for true professionalism is not about being well paid or climbing the hierarchial tree. It is about controlling one's own practice and making one's own decisions. But nurses simply talk about it; they do not have this control because they have never really fought for it", (Tiffany, p. 28).

The public continues to stereotype nursing as "Florence Nightengale" or the "angel in white" instead of the community leader capable of decision-making. There are two illustrations of this. The first is the National Commission on Manpower which was formed by the federal government. There were no nurses on this commission even though they constitute the largest pool of health care manpower. A report entitled, *U.S. Health Care: What's Wrong and What's Right,* discusses many views of physicians and layman, but nurses were excluded, (Deloughery, p. 6). Nurses are consulted more on an individual basis when friends, neighbors or acquaintances are afraid to ask the doctor, or when they feel a nurse will better understand their needs.

What constitutes a profession and why doesn't nursing fit? Mullard in 1980 quotes Wickenden in proposing six characteristics of a profession. They are:

> 1. a common body of knowledge;
>
> 2. an educational process based on that body of knowledge;
>
> 3. standards for admission to the group or profession are based on character, training, and proven competence;
>
> 4. conduct standards are developed based on courtesy, honor and ethics. These define relationships between practitioner, client, colleague, and public;
>
> 5. colleagues and the public formally recognize the group's status; and,

> 6. the professional group's organization is devoted to advancement and societal duty (Kinsey, p. 22).

Bixler and Bixler define a profession very similarly to Mullard and Wickenden. Their characteristics of a profession are defined as follows:

> 1. an explicit body of knowledge is utilized based on the level of higher learning;
>
> 2. the practice is constantly enlarged by expansion of this body of knowledge and improvements are made through scientific methods;
>
> 3. practitioners of the profession are educated in institutions of higher learning;
>
> 4. knowledge is applied to practical services which are vital to human welfare;
>
> 5. the group functions autonomously to formulate policies and control its professional activity;
>
> 6. individuals are attracted to the profession who place service above personal gain and recognize this chosen profession as its life work; and
>
> 7. members are provided the freedom of action, professional growth and economic security.

After examination of these criteria, ".....nursing touches each one, but fulfills only three-conduct standards, knowledge in services vital to human welfare, and formal recognition of status" (Kinsey, p. 22). Sleicher (1981) contends nursing is not a profession, but merely fulfills the role of "helper group". Stuart (1981) contends there are varying

degrees of professionalism and he approaches it as a continuum or scale along which an occupation moves. Thus, nursing is viewed as an emerging profession. Schein in 1972, described nursing as having trends of a maturing profession.

Nursing's possession of a specialized body of knowledge is argued on many fronts. The American Nurses' Association (ANA), argues that nursing,"....is unique in that it does not exist as part of another discipline but rather as a discipline in its own right as evidences by the following defining characteristics:

> 1. Phenomena-human responses to actual or potential health problems; nurses diagnose and treat those responses;
>
> 2. Theory application-nurses use theory in the form of concepts, principles, processes, and the like, to sharpen their observations and to understand the phenomena within the domain of nursing practice;
>
> 3. Nursing actions-aims of nursing actions are to ameliorate, improve, or correct conditions to which those practices are directed; to prevent illness and promote health; and
>
> 4. Evaluation of effects-nursing actions are intended to produce beneficial effects in relation to identified responses; research study provides scientific evidence of beneficial effects due to nursing actions (ANA, 1980; Hageman, p. 8)."

Opposing viewpoints are having difficulties defining responsibilities, tasks, and functions that are intrinsically nursing (Weissman, p. 36). "Throughout history, nursing has been marked by development through trial and error, education by apprenticeship, and practice based on empirical approaches"(Deloughery and Gebbie,

p.11). "Nursing care still continues to be equated with the performance of manual tasks and for the most part is not associated with the use of decision-making skills and independent thinking" (Pick, p. 7). Ms. O'Brien, CEO Hotel Dieu Medical Center, states, "(I have)...observed little change in the focus of nursing education since the early 1960s, when nursing process began to evolve. Nursing knowledge appears to be a discrete set of procedures, protocals, and traditions reflecting a standard of practice that has been handed down basically unchanged for the last 40 years", (O'Brien,et.al., p. 38). This indicates that nursing knowledge is limited and poses a conflict between nurses' role expectation of high interaction on a collaborative basis on multiple levels and the reality of rigid protocols and procedures directed by other disciplines-mainly physicians. Thus, nursing seems driven by regulations, self-evaluation, physicians, hospital policy, the law, and patient expectations.

Mavis McCarthy described in a recent paper the unclear definition of the nurses' role which leads to a road block to professional status. The work of nurses is characterized by routinization of work rather than innovative nursing practice. This results in nurses spending more time directing the work of others after going to school to become competent practitioners giving direct patient care. Standardization of care makes it easier to deal with staff turnover because new members need to "just learn the routines" and they enable nurses to negotiate from a position of weakness with physicians. "....such nursing organization cannot be considered to have any professional distinction. It bears all the hallmarks of an industrial model with the

emphasis placed on getting the job done according to prescribed methods directed by supervisory staff" (Tiffany, p. 29).

There is little evidence of nursing research to expand nursing knowledge. If nursing is defined as performing the acts of another profession, such as medicine, then it loses the characteristic of having its own unique body of knowledge. Lack of a clear definition of nursing knowledge creates confusion and disillusionment for those wanting to enter the field and for those practicing in the field.

A profession exercises the right to control its own work. This is a right granted by society and society is represented by the state. A Nurse Practice Act exists in all states to define and control the practice of nursing, thus nursing meets this criteria.

Another characteristic of professions is the community development which occurs ".....whereby the members have a permanent affiliation, an identity, commitment, specific interests, and general loyalties" (Goode, 1957;.Barber, 1963). Nursing does not have a permanent affiliation among its members. The American Nurses Association (ANA) and other specialty organizations jockey for position within the profession. This is due to the diversity and specialization which is occurring within the nursing ranks. Even though the ANA is trying to emerge as the professional organization for nurses, it is not comparable to the American Medical Association (AMA). The ANA has only 20% of working RNs belonging as members compared with the AMA having 75% of working physicians belonging (Schrader, p.380). Specialty nursing organizations are growing in numbers of members and in power, thus posing a threat to the ANA. These specialty organizations are aimed primarily at continuing education which

leaves the ANA with lobbying and collective bargaining activies. Collective bargaining activity is often associated with union activity and is therefore, not looked upon by its members as professional activity in which they want to associate. There is an overlap in areas of certification causing further confusion within the ranks of nursing.

Thus, by definition, nuring does not meet the criteria for a profession, nor is it fully recognized as such by the general public. Furtheremore, the entry into practice issue, which has long plagued the nursing profession, is further indication of a lack of professional status. (This subject is covered in Chapter 3). This lack of public recognition coupled with increased career opportunities for women make it extremely difficult to attract new recruits to nursing schools and to retain its current members.

CHAPTER 3: ENTRY INTO PRACTICE CONTROVERSY

Today's society partially equates education to career potential, status, salary, and autonomy. Education and licensure, thus, remain as two of the most critical issues in nursing. Yet, these two issues have been debated in the nursing profession for years without any solution to the problem.

In 1948, the Brown Report was published suggesting two levels of nursing: a professional level and a technical level, (Kinsey, p. 24). Other reports followed with no subsequent action to adapt this sytem.

In 1965, the American Nurses' Association published their first position report, (Kinsey, p. 24). In this report, a two tiered system of nursing practice based on the two year and four year academic programs was proposed. The only nurses holding the legal title, "registered nurse", would be the four year graduate. The two year graduate would be considered an associate or technical nurse. A grandfather clause was proposed to protect those currently practicing as professional nurses but who do not possess a baccalaureate degree. Following this statement, there was a tremendous outcry from nurses across the nation against such action being implemented. This same sentiment continued with no resolution.

In 1978, the ANA reaffirmed their position as published in 1965 and added the following stipulations:

> 1. The ANA would properly identify two levels of nursing practice by 1980 and the entry level for a professional nurse would be a Bachelor of Science in Nursing by 1985.

2. By 1980, the ANA would have a statement of competencies for the two categories of nursing.

3. The ANA would actively support accessibility for individuals seeking academic degrees in nursing.

A survey of all 50 state nurses' associations eliciting their opinion on the entry into practice issue was conducted by the ANA in 1979. This resulted in 43 responses with only 25 actively supporting this issue. During this same time frame, the National League for Nursing (NLN) endorsed the two tiered nursing system. Several large specialty organizations such as the National Student Nurse Association, Association of Operating Room Nurses, and NAACOG support the concept of a Bachelor's degree as the entry level for professional nursing. They argue that it will enhance the professional image of nursing since bachelor degrees are required of other recognized professions.

The deadlines outlined above have come and gone with the issue remaining every bit as controversial as when it was first published. Subsequently, the debate continues with little being accomplished in the way of resolution or implementation of this system. The difficulty seems to lie in defining technical and professional performance. This involves distinguishing performance based on specific repeatable tasks and differentiating performance based on a theoretical understanding of the goals of work. This further denotes a separation of tasks which can be standardized (technical) from those functions which cannot be standardized (professional).

Some experts argue nursing is not technically oriented and cannot be standardized due to the idiosyncrasies of individual patients being givencare. Therefore, nursing requires professional judgment and decision making ability. Still others believe it is possible to standardize some nursing tasks and identify attitudinal correlates of professional and technical practice. Ehrat's study in 1981 concluded no sound evidence existed to suggest that RNs from the various educational programs performed differently. Groenwald and associates in 1980 and Howell in 1978 proposed that professional advancement is due to individual performance, not educational background.

This distinction of technical and professional nurses is difficult for the general public to understand because of their belief "...a nurse is a nurse", (Deloughery and Gebbie, p.13). "Until most persons coming into contact with a nurse can identify practices that are consistent with that image, blocks will exist. As long as ex-patients say, 'I never saw a nurse ' or 'They just give pills,' the nurse will not be acknowledged as a change-inducing professional", (Deloughery and Gebbie, p.13). Legally, this distinction raises questions of differing employment benefits and practices, malpractice and negligence. These last two issues are rarely seen with technical people, yet increasingly, nurses are being held legally liable for their actions, (Deloughery and Gebbie, p.13).

The American Hospital Association and Assembly of Hospital Schools of Nursing oppose this 2-tiered structure. They feel this system would severely restrict pathways to nursing education and would cause the closing of diploma schools. This would, in turn, discourage prospective new people interested in nursing from entering this career

path. Distributions and shortages of trained nurses would subsequently increase if nursing schools would close. Associate degree nursing programs are most often found at community colleges in rural areas. Rural hospitals currently have a difficult time attracting RNs and rely on the community college nursing graduates to fill vacancies. This structural change would only add to the difficulty of RN recruitment especially for these rural hospitals. To date, there is only one state, North Dakota, which has adopted the ANA proposal.

Since the proposal, the folowing undergraduate schools of nursing have closed: American University, Boston University, Duke University, and Skidmore College. Closure of Georgetown University's program is under discussion. By 1990, predictions are that American colleges will award 14,500 BSN degrees and 16,000 MD degrees (Iglehart, p. 648).

As will be demonstrated in subsequent chapters, associate degreed and diploma nursing graduates comprise a major portion of the nursing work force and nursing school enrollments are declining. This unresolved issue of the uncertain entry level into practice issue negatively impacts the recruitment efforts and public image of nursing.

CHAPTER 4: NURSING AND PUBLIC OPINION

It is crucial for nurses to gain the respect of others including society in order to be recognized for their achievements. In the eyes of the public today, which includes parents, career counselors, and in many cases, nurses themselves, the nursing profession cannot offer the opportunities of a prestigious public image, a career instead of a job, competitive salaries instead of low-ceiling wages, and autonomy instead of dependency according to Gioiella (p. 127). The general public often views professional attitudes as cold, precise, and business-like, which contradicts the caring image they have of a nurse. Nursing is traditionally viewed as playing a mothering role.

Wages and salaries have been an issue with every nursing shortage and contribute to an inability to attract and retain nurses. "Salaries are directly related to the nursing shortage,"said Mary Foley, RN, Chairperson of the ANA Cabinet on Economic and General Welfare. "Salaries are a recognition of the value of the nurse and the nurse's contribution. The health care industry and society have been unwilling to provide adequate recognition for nursing services" (Selby, p. 11). As demonstrated in a 1986 survey conducted by the University of Texas Medical Branch of Galviston,the average starting salary for a hospital staff nurse is $20,340 and after years of experience the average maximum salary is $27,744 (Iglehart, p. 648). Nurses in practice five years or less average approximately $22,000 per year and staff nurses with 6-10 years of experience average $25,000. There is nothing

further for a staff nurse to achieve. If that nurse is a single parent, other professions look increasingly attractive due to higher salaries. Women comprise 90% of the nursing work force and are no longer willing to accept less for their efforts in terms of monetary rewards.

Price is inversely related to supply. Supply, demand, price and employment levels constantly adjust toward an equilibrium in a competitive market. According to Prescott, some argue that the operation of the nurse labor market is not well explained by economic models, (Prescott, p. 204). This is because nursing is not a fully competitive labor market due to monopsony or oligopsony. Monopsonistic or oligopsonistic conditions are labor market conditions which exist when there are too few employers to stimulate meaningful wage competition, (Prescott, p. 204). Under these conditions, wages are artificially restrained. Thus, they do not operate to balance supply and demand. In a competitive market, when demand increases, so do wages to attract the needed supply. In an oligopsonistic market, wages which are artificially set, do not rise in response to changes in demand. "As Yett (1975) has demonstrated, under these conditions employers will express demand in excess of the supply that the prevailing wage will purchase; that is, they would like to hire more nurses, but they are not willing to raise wages sufficiently to do so", (Prescott, p. 204).

When hospitals have vacant positions, there are two choices: 1. raise nursing salaries in hopes of attracting new nurses, and 2. hire per diem nurses at a higher salary on a temporary basis. Most often the second option is chosen because it costs less to hire some highly paid nurses than to raise salaries of all regular staff in order to hire new

recruits on a permanent basis. Career ladders have developed in some areas, but they are coupled with increased work and responsibility with insufficient financial rewards.

The public does not realize that high quality nursing care will cost money and the public will receive the type of care they are willing to pay for. To some, nurses are an expensive luxury. Some believe nurses aren't willing to deliver the service equal to the cost nurses are demanding. This feeling stems from patients and health care organizations where nurses work (Deloughery and Gebbie, p. 11). However, nurses have not marketed their services or attached clear costs to them to justify their existence. Nursing costs have traditionally been combined in room and board hospital charges. So, the general public does not know the cost of nursing. Combining this with a lack of knowledge of what nursing does, the public is reluctant to pay more for services which they do not understand.

Etzioni describes nursing as a semi-profession because of the different entry into practice routes and it is viewed by the public as a women's profession, (Deloughery and Gebbie, p. 11). Many women in nursing leave their jobs to raise families instead of rising into administrative ranks. Also according to Etzioni, professionals are viewed as being more concerned with humanitarian efforts for all rather than just themselves, yet nurses biggest complaints are over wages, hours, and working conditions. These complaints of long hours, heavy assignments, and shifts are common to all high status careers, (Deloughery and Gebbie, p. 11). So the general public has been shocked over nursing strikes and complaints.

The news media, including the nursing media, has emphasized the negative aspects of nursing as a career to the general public. Popular literature, television and movies portray nurses as sexual objects for patients and physicians. Although this is not unique to nursing, it hinders the public's perceptions.

A five year study was conducted by Phillip and Beatrice Kalisch from January 1979-December 1983 on nursing images and television coverage. An analysis of all network TV newscasts from ABC, NBC, and CBS as well as local newscasts from 18 cities nationwide was conducted. 844 newscasts pertaining to nursing fell into the following categories:

> Nurse strikes-54% with nurses portrayed the majority of the time as uncaring and greedy. The major focus was on harm to patient care.
>
> Crimes by nurses-28%
>
> Nursing shortage-7%
>
> Clinical Nursing-4%, which involved nurse midwives, practitioners, etc.
>
> Miscellaneous-4%, which included public service and human interest stories involving nurses.

"Agenda setting theory says that because of the news media, people are aware or not aware, pay attention to or neglect, play up or downgrade specific features of the health care world. People tend to include or exclude from their cognitions what the news media include or exclude from their content", (Kalisch and Kalisch, p. 48). The public assigns the same degree of importance to issues as the mass media. Physicians and other healthcare professionals assumed the role of spokesperson for all television news media coverage of health care

including nursing. Based on this study, the public's views of nursing are more negative than positive.

Nursing's image was further hindered by Otis R. Bowen, MD, Head of the Department of Health and Human Services announcing on September 10, 1987, that,"...the current and projected supply of nurses appears adequate. (and)...the fiscal 1988 executive budget proposes to discontinue support for the nursing education authorities" (Mitchell, p. 7). Dr. Bowen's statement was in direct contradiction from the statments made by the nursing profession to the general public. Action was subsequently taken by Senator Kennedy (Democrat from MA) by introducing a Nursing Shortage Reduction Act in June, 1987, and Senators Bordick (Democrat from North Dakota) and Inouye (Democrat from Hawaii) by urging the Senate Appropriations Committee, "to add $5 million to the FY'88 spending bill for projects demonstrating ways of solving recruitment problems and stepping up enrolments" (AJN, Aug. 1987, p. 1094). However, the public image of nursing continues to be more negative than positive.

METHODOLOGY AND RESULTS

This section will analyze studies and secondary data which demonstrate the existance and severity of the nursing shortage, support many of the claims made in the previous section, and offer some solutions to this dilemma. The majority of solutions will be addressed in the conclusions section.

As indicated previously, the current nursing shortage is particularly serious as it impacts all types of nurses, hospitals, and regions of the country. "According to a survey conducted by the American Journal of Nursing, (Cunningham, 1979), the nursing shortage has reached epidemic proportions with virtually every type of agency and every region of the country affected 'from the Atlantic Coast to the Mid-Pacific, from the Great Lakes to the Gulf of Mexico,'" (Silva, p. 469). There are three elements contributing to this shortage:

1. a decreasing nursing applicant pool
2. increasing hospital staff turnover, and
3. an increased demand for nurses as a result of higher patient acuity.

These elements are only clues to the underlying issues of nursing as a true profession, the entry into practice controversy, a poor public image, and nusing autonomy which need to be addressed in order to reverse these trends.

CHAPTER 5: SEVERITY OF THE NURSING SHORTAGE

In 1978-1979, the U.S. Department of Labor's Occupational Handbook projected 83,000 openings annually for registered nurses and stated, ".....50% of job openings in health occupations during the next ten years will be for nursing personnel", (Illinois Nurses' Association, p. 2).

In the 1970s, high admission rates and high employee turnover caused the chronic shortage in nursing at that time. Hospitals were particularly lacking the experienced practitioner. At that time, the *American Journal of Nursing* predicted a nationwide nurse shortage of 100,000 nurses by 1982 because of low pay and burnout. In today's environment, decreased occupancy rates have forced hospitals to demand higher productivity levels from their employees. This has led to the increased job stress and burnout predicted, as well as the current nursing shortage, (Sepic, p. 72). Hospitals have employed the use of hiring bonuses, 12-hour shifts, job sharing, cash incentives, part-time benefits, etc. in order to attract new nurses. Recruiters are looking abroad to bring new nurses into this country. "In a September survey of nursing directors and recruiters, *AJN* was told that shortages are spreading from critical care to medical-surgical floors at hospitals that only recently were turning away applicants by the hundreds. Others said they had stalled off critical care shortages by 'growing their own'- then had to run massive ads to fill the vacancies left by medical-surgical nurses who took the intensive care courses", (*AJN*, p. 1285).

The nursing shortage of the 1980s is not a myth, but a reality. According to a study of the National Association of Nurse Recruiters,

an average United States hospital with 450 beds has 72 fulltime nursing positions open, (Donovan, p. 21). A study by *RN* magazine revealed, "40% of the nation's licensed RNs drop out of active nursing at some point in their professional lives", (Donovan, p. 21). ANA estimates this number at 30% of 1.4 million qualified nonretired RNs who are not working in the field by choice, (Donovan, p. 21).

The supply of nurses depends on 3 factors:

1. the rate of production of new RNs;

2. the retention of those nurses currently employed; and

3. the return of inactive nurses to the work force.

CHAPTER 6: RATE OF PRODUCTION OF NEW RNs

The nursing shortage of today is coupled with a downward trend of nursing school enrollments.

A study by the University of California, Los Angeles, reported that women entering U.S. colleges today prefer careers as physicians over careers as nurses by a 3-to-1 margin and, the major reason sited for this choice is economics, (Barker, p. 294). Women can enjoy greater salary potential, increased social prestige, and professional autonomy as physicians.

Between nurses leaving the profession and nursing schools closing, the NLN has predicted a shortage of 390,000 BSN prepared nurses by 1990, (Barker, p. 294). In the two year period ending on October 31, 1979, 23 diploma schools closed, according to NLN, (Donovan, p. 21).

For the academic year 1985-1986, nursing schools are demonstrating a 30-50% decrease in enrollment, (*AJN*, p. 1178). *Nursing Job Fair*, a publishing and recruiting firm in Weston, Massachusetts, published a report, demonstrating nursing school enrollment declines since 1984. Fall enrollments for 1986 were down 7.8% and fall enrollments for 1985 were down 14.6%, (*AJN*, p. 1178). In 1986, nursing enrollments fell below 200,000. This represents a loss of more than 50,000 students since 1983, (Rosenfeld, p.39).

NLN reported a steady decline in nursing school enrollments since 1983. During the 1983-1984 academic year, enrollments were down 4% in BSN and AD programs, and 11% in diploma programs, (*AJN*, p. 1178). Enrollment drops continued in the academic year 1984-1985 when figures showed a decline of 4% in BSN programs, 8% decline in

AD programs, and a 19% decline in diploma programs, (*AJN*, p. 1178). This has a tremendous long range effect. The shortage may be considered detrimental now, but with fewer people currently enrolled, the future seems bleak as there will be even fewer graduates in three to four years.

As indicated from the figures above, many schools are suffering. Washington D.C.'s American University School of Nursing admitted no new first and second year freshman in the fall of 1986. This prestigious school alone is suffering from a 40% enrollment drop since 1983.

St. Louis University's School of Nursing's undergraduate enrollment is down 45% over the past six years. Likewise, the University of Missouri is expecting a fall class of only 40 undergraduate nurses as compared to 60 from the year previous.

The University of San Fransisco in past years admitted 160 freshman each fall into the nursing program. Now, enrollment is approximately 50. Maryland reports associate degree programs in the state are suffering two year losses ranging from 11-45%, (*AJN*, p. 1178).

Reasons for these drastic declines include:

1. a decreasing pool of high school graduates from which to attract candidates;

2. increasing tuition and decreasing federal assistance;

3. some students express concern over the uncertainty in the health care environment in light of the recent hospital layoffs;

4. the unsettled issue of the correct entry into practice educational level ;

5. poor public image of nursing;

6. low pay;

7. "hard work under conditions not tolerated in other professions", (*AJN*, p. 1189).

What kind of candidates are nursing schools attracting these days? Indications are that admission requirements to nursing schools are being lowered. "..... as *AJN* surveyed program heads around the country, the consensus was that some schools are accepting students who would not have made the grade a few years ago", (*AJN*, p. 1189). Also, two year nursing programs in California have lowered the grade averages required for admission. This will have a profound effect on the type of nurse which will be produced in the years to come.

New graduates complain of culture shock after they leave the safety of their nursing schools. They experience: 1. practicing at the bottom of a rigid hierarchical structure which is dominated by physicians and administrators; 2. no voice in health care planning decisions; 3. inflexible hours and shifts; 4. under utilization of skills learned; 5. a lack of administrative support; 6. physician expectations of subservient handmaidens; and, 7. little opportunity for professional growth and development/advancement, (Illinois Nurses' Association, p. 3).

One Dean of Nursing stated, "It's not an attractive field for people who have options. Why should young women want to be nurses when they can get a better return on their investment and enjoy more independence in medicine, law, or engineering?", (*AJN*, p. 1189).

At the same time, government aid for nursing education is currently threatened with cutbacks as the Secretary of Health, Education and Welfare states it is unjustified, (Donovan, p. 21)! This is despite the downward trends just demonstrated. Dr. Bowen, Head of the Department of Health and Human Services, announced on September 10. 1988, ".....the fiscal 1988 executive budget proposes to discontinue support for the nursing education authorities", (Mitchell, p. 7). He claimed, in an interview with *Nursing Economic$*,that there was a question of a true shortage of nurses. Yet, hospitals have high vacancy rates, nursing school enrollments are on the decline, and future graduate nurses will be fewer in number, making the potential applicant pool smaller. In addition, the government now proposes the withdrawal of financial educational support!

CHAPTER 7: RETENTION OF NURSES CURRENTLY EMPLOYED

20% of the two million nurses in the United States are leaving the profession for careers with higher salaries, less stress, and more respect, (Barker, p. 294). Many of the retention issues are related to competitive salaries with comparable professions which have the same or similar responsibilities and societal contributions. From 1972-1977, nursing salaries fell in relation to the cost of living (Illinois Nurses' Association, p. 3). There is a prevailing lack of monetary incentives for longevity and career advancement. A *USA Today* editorial reported that nurses were, ".....sick of low pay, lousy hours, limited opportunity for advancement, and lack of respect", (Barker, p. 294).

Due to the cost conscious health care environment, salary raises are in jeopardy. In 1980, the American Hospital Association's President, Alex McMahon, urged hospital administrators to hold down the cost of salaries and cut back on employing new personnel for voluntary cost containment in order to avoid mandatory cost control legislation, (Illinois Nurses' Association, p. 3). Hospitals have continued to follow these recommendations.

A national survey of randomly selected community hospitals was conducted by the American Organization of Nurse Executives. The purpose of the survey was to gather national data about the supply of nursing personnel in hospitals. One-third or approximately 2,316 hospitals received the survey and 44% returned it. The data is based on the vacancy rate for RNs for the week of December 1, 1986. During this timeframe, only 17.6% of the hospitals had zero vacancies; and 13.6% of RN fulltime equivalents were vacant. Hospital size seemed to

be associated with vacancies as 54.3% of the hospitals with less than 50 inpatient beds reported any RN vacancies, while 97.1% of the hospitals over 500 beds reported vacancies.

Another major study,the *AHA NURSING PERSONNEL SURVEY* was conducted in March, 1981, by the American Hospital Association. This random sample survey of 1,222 community hospitals nationwide achieved an overall response rate of 59.9%, (Beyers et. al., p. 34). The survey dealt with topics pertaining to the nursing shortage.

Vacancy rates for nurses in the AHA study were examined for the week of March 22-28, 1981. This study examined the ratio of the number of vacant RN positions being actively recruited for to the number of RNs employed by the hospital. Turnover was defined as the number of staff nurses who left during the first quarter of the year to the total number of staff RNs actively employed for the same time period. The results are shown in Table 1 with both figures expressed as percentiles.

Table 1: Vacancy and Turnover Rates

PERSONNEL	VACANCY RATES	TURNOVER RATES
Fulltime RNs	16.6%	7.9%
Parttime RNs	17.3%	11.0%
Fulltime LPNs	7.6%	7.5%
Parttime LPNs	11.8%	11.6%
Fulltime Nurse aides/orderlies	2.7%	7.4%
Parttime Nurse aides/orderlies	5.4%	10.7%

Source: Beyers, Marjorie, et. al., Journal of Nursing Administration, May 1983, p. 27.

The major reason sited for turnover in this table was voluntary resignation. This reason accounted for 65.4% of the fulltime turnover rates and 67.3% of the parttime turnover rates, (Beyer, et. al., p. 28).This has serious implications for quality care, since a lack of nurses could close units leading to hospital revenue losses.

Also, the recruitment and orientation costs are very expensive. The average recruitment costs of a staff nurse is $874 and the average orientation costs are $1563, (Beyer, et. al., p. 36). The National Association of Healthcare Recruitment Nurses estimates the cost of replacing nurses at $20,000 per nurse hired and the rate of attrition is 31.7% annually, (Donovan, p. 21). Hospitals are paying an average of $3.2 million annually to replace vacant positions, (Jenkins, p. 5). There are no guarantees the nurses hired will have the appropriate education or experience needed, especially if nursing school admission requirements are lowered.

The composition of nursing personnel who staff hospitals has changed since 1984. There is an increased demand for registered nurses. Statistics show a 36% decline in LPNs employed and a 38% decrease in aides/orderlies employed. The reasons for this relate to increased patient acuity and a greater cost savings to hospitals when they can continue to care for the same number of patients with a smaller nucleus of more highly skilled nurses. These reasons alone make it imperative for the nursing profession itself to accurately assess the causes for the shortage and take appropriate steps to correct it.

The AHA survey also examined hospitals with varying career/promotional levels of nursing staff. 48.2% of the hospitals had only one level of nursing with no promotional plan. The average

hourly salary range for these institutions was $7.46 per hour, minimum, to $9.50 per hour, maximum. The average difference between minimum and maximum is $2.04 per hour. The average difference between the minimum and maximum in hospitals with four promotional levels is $3.77, (Beyer, et. al., p. 19). So, hospitals with these career programs do offer higher earning potential and career advancement, but is it significant for the added work and responsibility which accompanies a higher level? ".....one must question whether an increase of $0.85 to $0.90 per hour-about $300 per year in salary-provides the staff RN with sufficient incentive to remain in a position for six years", (Beyer, et. al., p. 19).

Another major salary issue is : ".....many hospital managers as well as RNs perceive that nurses are hourly wage earners rather than salaried professionals", (Beyer, et. al., p. 20). Lawyers and doctors do not punch a time card when they work, but nurses and nursing managers continue to do so. This certainly interferes with the image of a professional nurse in the eyes of the public.

Salary is obviously not the sole solution to the nursing shortage problem, but salary accompanies respect and recognition as a tangible symbol of these items. Compensation is also indirectly linked to job satisfaction, but it is not the most important factor. Structure of nursing care, working conditions, commitment to the organization, promotional opportunities, and pressures of work are all related to nursing job satisfaction, (Beyer, et. al., p. 19). A study by Weisman, Alexander and Chase found that satisfaction with pay was ranked fifth, behind such factors as work, promotion, supervision, and people on the job, (Beyer, et. al., p. 19). These issues must be addressed

collectively in order to break the nursing shortage cycle.

CHAPTER 8: RETURN OF INACTIVE NURSES TO THE WORK FORCE

In 1977, (the most recent year for which data is available), Walter Johnson, Director of the NLN's Division for Research compiled the following national employment activity statistics of nurses:

1. 988,000 nurses were actively working in the profession.

2. 422,000 licensed RNs were not employed in nursing.

3. 81,000 newly licensed nurses entered practice.

4. 58,200 nurses changed from inactive to active employment status.

5. 73,800 nurses left the profession, (Illinois Nurses' Association, p. 3).

Focusing efforts on the return of inactive nurses to the profession does not seem to be the solution as some might suggest. During this time, the survey demonstrated 50% of the 422,00 inactive nurses were unlikely to return to the work force because:

a. 97,250 were aged 60 or older;

b. 56,780 were employed in another profession; and,

c. 42,028 were in the process of seeking active nursing employment, (Illinois Nurses' Association, p. 3).

Of the remaining 228,000 inactive nurses, more than 100,000 were under 40 years of age and were responsible for young children. The 125,000 candidates remaining from this inactive pool are 40 years of age and older, and have been away from nursing for 10-30 years. Their skills would need significant improvement (Illinois Nurses' Association, p. 3).

As demonstrated, efforts must be focused on the retention of nurses currently in practice. This includes the professional recognition of the nurses' role as an essential member of the health care team.

CHAPTER 9: JOB SATISFACTION

The editors of Nursing '88 conducted a poll on the nursing shortage. There were 8023 responses from nurses across the nation. A similar survey was mailed to 500 nursing executives simultaneously. The results are as follows:

TABLE 2: SURVEY DEMOGRAPHICS

DEMOGRAPHICS OF RESPONDENTS	PERCENTILES
RNs working in hospitals	90%
RNs working on Medical/Surgical floors	39%
RNs working in Intensive Care Units	25%
RNs working in the city	61%
RNs working in the suburbs	25%
RNs working fulltime	74%
RNs possessing a BSN	37%
RNs possessing a diploma in nursing	25%
RNs possessing an associate degree	25%

Source: Editors of Nursing '88. *Nursing '88*, Feb. 1988, p. 39.

All regions of the United States were represented in this survey.

KEY FINDINGS:

1. 47% of the respondents were very worried and 43% were moderately worried about the nursing shortage. This compared to 64% of the nursing executives were very worried, and 35% were moderately worried.

2. 75% of all respondents described difficulty with hiring and retaining nurses.

3. 51% reported hiring more new graduates in Intensive Care Units and Emergency Rooms.

4. 48% reported utilizing more agency nurses.

5. 59% reported increases in salaries and benefits while 58% of the nursing executives stated there had been increases.

6. Respondents stated 72% of the hospitals were not giving priority to BSN nurses. 67% of the nursing executives confirmed this stating the reason was, "you take what you can get".

Respondents were asked about job satisfaction on a scale of 1 to 5. The numerical rating of 1 corresponded to "very dissatisfied" and the rating of 5 corresponded to "very satisfied". The average rating for this question was 3.1, with 9% being very satisfied and 9% being very dissatisfied. A significant result was 15% of the very satisfied nurses stated they would definitely not choose nursing again as their career if given a second opportunity. This magazine had conducted a similar survey in 1978. The results then were drastically different. 79% of the respondents in 1978 stated they were moderately or very satisfied with their jobs. This 1987 survey had only 34% stating the same.

The survey questioned nurses about the opportunity for alternative career choices in relation to choosing nursing again. The results showed 31% would choose nursing again; 35% might choose nursing again; and, 33% would not choose nursing a second time. Only 38% of all respondents have encouraged others to enter nursing as their profession, while 60% have not encouraged others to join.

This survey further demonstrated that the average nursing job is held for seven years, but 55% had changed jobs within the last five years. A total of 61% stated they had not stayed at their current job long enough to become vested in a pension plan.

The respondents further described the following staffing situations:

1. parttime nurses who were hired to work 5 days in two weeks, were actually working 8-10 days in the same time period;

2. new graduates were being used as regular staff during orientation;

3. two new graduate nurses were left alone on a medical/surgical unit in charge of 39 patients;

4. acuity levels have increased 36% with no changes in nurse manpower budgets;

5. nurses described their typical day as a full one with overtime, no breaks, no lunch, and leaving with a feeling of letting their patients down; and,

6. typical staff-to-patient ratios on a medical /surgical floor is 1:14.

Typical written comments on this survey were: "Nursing salaries are a joke. I have a friend whose only job is emptying mail bags off a truck at a post office, and he gets $2.00 more an hour than me. After 13 years, I make only $11.50 an hour. And I'm suppose to be grateful. Any day I could do something wrong, kill somebody, and lose my license." (Editors of Nursing '88, p. 39).

Many nurses complained via the survey that ANA's position on entry level was not helping matters. "Granted, we need educated nurses, but having a BSN does not a nurse make", (Editors of Nursing '88, p. 39). It was clearly demonstrated that nurses want professional recognition and every professional group requires a basic college education, but the survey indicated they want the same status with a two year program.

Implications of this study reveal that:

> 1. nursing salaries for new recruits are rising, but salaries are staying the same for veterans;
>
> 2. the entry into practice issue still prevails today with little resolution; and
>
> 3. new graduate nurses are receiving insufficient orientation leading to early burnout, while their experienced colleagues have increased fear because of them due to their lack of training. (Editors of Nursing '88, p. 33-41).

CHAPTER 10: PROFESSIONAL AUTONOMY

There are approximately 100,000 available nursing positions across the United States resulting in severe staffing shortages (Aiken, 1981). This is complicated by a high turnover rate. Three to four nurses out of every ten, quit their job annually, (Wolf, 1981). "Nurses leave nursing or seek employment elsewhere because they feel they are not free to practice their chosen profession", (Silva, p. 36).

The principles of autonomy are based on a respect for others. These principles suggest little or no restraints for the autonomous practitioner if that practitioner is legally competent. Other persons' rights are not infringed upon with professional autonomy. Applying this concept to nursing, then, autonomy means granting respect to nurses for matters over, ".....which society has not only granted us this privilege but also mandated this duty", (Silva, p. 36). Nursing's duty is further defined as, ".....a duty to ensure the safety, comfort and protection of those in our care, as well as a duty to assist persons to cope holistically with states of dying, illness, chronicity, disability, recovery and wellness", (Silva, p. 36). These concepts are intrinsically connected with professionalism and subsequently, job satisfaction.

If an individual or others diminish in any way the principles of professional autonomy, then there is a corresponding inability to carry out professional responsibilities to society. This leads to frustration, burnout, and a subsequent exodus of nurses from the profession. They begin to seek ethical and professional autonomy in other careers. This has a disastrous effect on the individual nurse who decides to leave, the nursing educational system which cannot replace them fast

enough, the institutions employing nurses because vacancies exist leaving nursing units uncovered, the entire health care team, and the patients seeking nursing care.

Silva lists four major constraints placed on nursing autonomy. The first constraint is a dispute over occupational territory. Yet, as indicated in Chapter 2, nurses may resent being told what to do by physicians. At the same time they resent this, they are reluctant to take total responsibility for their areas of expertise.

Territorial disputes are well documented in the literature. The most well-known dispute was the highly publicized Tuma Case (Bell, 1981; Tuma, 1977). In this legal case, a patient requested Nurse Tuma to explain alternative cancer treatments. Tuma felt it was her responsibility to ensure this patient's right was met and so informed her of alternative measures of treatment. The Idaho State Board of Nursing suspended Tuma's license for interfering with a patient/physician relationship. In 1977, Lewis explained the ruling as unusual because it seemed to indicate, "That a major component of professionalism may be *not* to interfere with the physician-patient relationship", (Silva, p. 37). The major focus of the case was the nurse intervening in the situation at all while the issue of patient's rights was lost in the turf battle between doctor and nurse.

The second major constraint is a lack of institutional support for autonomy. As indicated previously, the ANA Code for Nurses states the primary responsibility of nurses is one of patient advocate. This creates the basis for the turf battles with the medical staff. The administrative group will listen to the medical group before nursing is heard.

Yet, the literature (Aiken, 1981; Davis & Aroskar, 1978; Wolf, 1981) suggests that , ".....professional autonomy and formal bureaucratic institutions may be incompatible", (Silva, p. 37). Health care organizations are very paternalistic (Fromer, 1981). In order to increase authority and autonomy in this hierarchical arrangement, restriction of freedom from less powerful groups is essential. Therefore, ".....most health care systems cannot or choose not to respect or grant professional autonomy to nurses", (SIlva, p. 37). The reason is quite evident. These other groups within the health care system are unwilling to relinquish any of their power in order to enhance nursing's power.

The third major constraint on nursing autonomy is societal expectations. Society must grant a profession the power of autonomy. In exchange for this, the profession must safeguard the public's trust in the profession. For nursing, competition exists between the nursing group and other health care professions and special interest groups for this social recognition. Whenever there are competing claims, those groups with the most power win.

Newton, in 1981, claimed the public rejection of nursing autonomy was because the public would not accept it, (Silva, p. 37). Society is still looking for the sympathetic, nurturing "angel in white". Therefore, the autonomous nurse practitioner does not fit this old public image. Newton further claims nurses have an ethical obligation to provide this nurturing image because this type of person makes, ".....the health care system morally tolerable", (Silva, p. 37).

The final major constraint is nurses' own attitude toward autonomy. While some nurses seek this autonomous role, others are

afraid of it, and still others prefer the traditional nurturing role. For those individual nurses who seek professional autonomy, this leads to frustration and abandonment by those nurses who are opposed to this role. Adding all four constraints together, the result is a tremendous lack of support for professionally autonomous nurses both inside and outside the realm of nursing. This lack of support forces those individuals to seek other career opportunities where professional constraints are reduced or are more tolerable.

Autonomy for nurses is one of the central issues which must be rectified. These four major constraints to nursing autonomy must be addressed and resolved in order to maintain and attract nurses to the profession. The decision making role of the professional nurse must be clearly defined, especially in its relationship to physicians. Solving this central issue is paramount in the fight to break the continuing cycle of the nursing shortage.

SUMMARY

In summary, nursing shortages are nothing new to the health care industry. They have occurred and recurred since World War II. Each time this cyclical problem reappeared, employers of nurses took steps to solve the shortage only when staffing crises were reached and the economic effects of closed divisions were felt. This was accomplished by these same employers increasing salaries, offering attractive hiring incentives, enhancing benefits, etc.in order to attract enough new nurses to fill vital vacancies. As a result of these actions, nursing school enrollments temporarily increased and the outcome was an increase in the supply of available nurses for hire.

Today, the health care environment is different. This nursing shortage will not be solved in the same manner because there are new issues to contend with in the health care environment. Also, the emphasis, in the past, has been on recruitment without retention. The issues surrounding this shortage are different for the following reasons:

1. the supply of nurses is different and is affected by nursing school enrollments, entry level into practice requirements, etc.;

2. nurse demands are different as evidenced in changes within the health care delivery system;

3. health care regulations and reimbursements have changed; and,

4. there are inter-professional factors which contribute to the shortage, mainly turf issues with physicians.

As indicated in previous chapters, the supply of nurses and the demand for nurses is changing. A three year National Commission on Nursing Implementation Project predicts the following about the supply of professional nurses:

1. more nurses will be needed outside acute care organizations;

2. the traditional health care setting will need nurses with advanced preparation;

3. there will be an increased need for technically skilled nurses;

4. nurses will move with patients across various health care settings as needed;

5. the nurses' role will become one of managing, coordinating, advocating, teaching, directing, etc. There will be more involvement with self-help groups;

6. the trend is toward higher education;

7. organized nursing will seek practice changes and direct reimbursement through legislative action;

8. there will be an organized effort to restrict the practice of nurses;

9. a shortage of BSN nurses and an oversupply of associate degree nurses will exist;

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> 10. health care organizations will contract with organized nursing services to provide nursing services; and,
>
> 11. nursing costs and revenues will be identified clearly in all areas of health care which delivers nursing care, (Fagin, p. 120).

Changes in the delivery system have resulted in: 1. increased technology, 2. an increased need for independent decision making, 3. an appreciation of financial ramifications, and 4. a recognition of special needs of an aging population. In the early 1980's. Congress asked the Institute of Medicine to study and report on the future nursing supply and demand. The report was published in 1983 and indicated a strong need for more nurses by 1990 in areas such as management, education and clinical specialty practices. With an aging population, the report further identified that more nurses would be needed to provide services to the elderly. The report went on to note the positive effects good nursing care has on patient outcomes, (Fagin, p. 122).

Inter-professional tensions between doctors and nurses have existed for many years. These territorial issues recently came to light in 1986 when Congressman Richard Gephardt of Missouri proposed a bill to establish community based nursing organizations to provide Medicare Part B benefits on a prepaid, capitated basis. These organizations would be managed by nurses and function similarly to health maintenance organizations. This would enable nurses to receive direct payment for care rendered and would be a cost effective alternative. While this direct reimbursement would certainly enhance the public image of nursing and increase its autonomy, it is viewed as a

direct threat to physicians. The result has stimulated under-funded nursing organizations desiring this direct reimbursement to launch campaigns in Washington against well funded medical societies who want to prevent these changes. Surprisingly, there has been some progress for nurses on this issue, (Fagin, p. 123).

Conflicts with physicians continue on other issues. By 1990, there will be a surplus of physicians. This will cause increased competition among physicians, between physicians and hospitals, and between physicians and nurses. Will doctors move into nursing areas in an effort to protect their income? It has been noted that, ".....nurses neither control their labor supply nor hold a monopoly over any set of socially significant, or even insignificant roles", (Fagin, p. 124). This means nursing can be manipulated both internally and externally, a position Fagin describes as dangerous. There have been reports of physicians applying for management positions in nursing and residents assuming some services nurses have been traditionally responsible for, (Fagin, p. 124). The nursing shortage will only enhance this threat as indicated by the AMA attempting to develop the "registered care technologist" as an answer to the nursing shortage problem. Further controversy with physicians is evidenced by the recent withdrawal of AMA representation on the National Commission on Nursing Implementation Project.

As a result , for this nursing shortage, employers of nurses will not fill vacancies solely on increased salaries and benefits alone as they did in the past. There are too many new issues affecting this shortage as indicated above. Also, as demonstrated in previous chapters, nursing school enrollments are declining rapidly; women are choosing other

careers now available to them; there is a decreasing applicant pool for nursing schools to even draw from; and there is a failure to retain nurses currently employed in the field. These issues are caused from problems inherent to the profession of nursing itself. These include: 1. nursing is not recognized as a true profession, 2. entry level into practice is unresolved, 3. poor public image of nursing, and 4. little autonomy within the practice of nursing. These inherent nursing problems added to the changes in demands for nurses, as well as, changes in the health care delivery system, must force the profession of nursing into action. According to an article by Gail Stuart in the 1981 issue of *Image,* "....nurses disagree on the uniqueness of their contribution as health care practitioners, their educational programs, and their legal rights and responsibilities", (Pollack, p. 87). Now is the time for nurses to get their act together and solve these issues.

There are several pitfalls occurring with this shortage. First, there is a decreased selectivity of job applicants occurring. Due to the urgency to fill needed positions, items such as employment history and references are being overlooked. Hiring less qualified personnel to perform RN duties will result in further nursing recruitment problems, since direct care is an attraction for many nurses. Relaxation of hiring standards will only dilute the quality of patient care provided or needed. Second, providing the opportunity for current staff nurses to attend classes in order to advance their education is becoming increasingly difficult. Hospitals are advertising improved tuition reimbursement, but the shortage makes it difficult for senior nurses to take advantage of this. These senior nurses are working long hours, overtime, double shifts, etc. Scheduling the time off for class

attendance is almost impossible. Third and last, there is further damage by the media as it details low pay, stressful working conditions, shift work, nursing strikes for more money, etc. There is no publicity for the nurses who stay in the profession or for those who truly like nursing. The media portrayal does not encourage anyone to enter nursing, and it certainly causes many who stay to question "why?", (Woolley, p. 75, 76).

Efforts must be focused, not just on attracting new recruits to nursing, but on retaining members currently in practice. The solution to these issues rests with nursing and no one else. Nursing must solve this crisis or others will solve it for them. With suggestions being made to hire medical technicians, critical care paramedics, etc., the question is raised of the need for nurses at all! The bottom line is: someone must take care of patients. So, if nursing chooses not to solve its own issues, then some other group, probably physicians, will solve the problem for them and it will cause the end of nursing as it is known today, (Nornhold, p. 49).

Is the nursing profession ready to give up professional practice models that patients need? "Today's patients, more than any other patient population in history, need professional nurses who can promptly detect and obviate complications, plan and initiate appropriate interventions, and generally guide them through their episode of illness-to their own level of optimal wellness-in the shortest period of time with the best clinical outcomes", (Fralic, p. 210). Nursing cannot afford a "business as usual "attitude. Fralic states that nursing, "must develop nontraditional and new systems for organizing patient care delivery in a way which is consistent and workable in

today's health care environment", (Fralic, p. 210). As demonstrated in the previous section, the human resources are no longer available.

Yet, the new cost effective health care environment should favor nurses from the viewpoint of consumers, third party payers and employers. Nursing must separate the cost of their services, price them, demonstrate their value, and market these aspects. Nursing must demonstrate their cost effective worth.

"The physician oversupply, nursing's own licensing and titling controversy, and creation of positions for nurses in peripheral health care businesses, such as retail health and ambulatory services, have damaged the public's perception of nursing", (Beyers and Damore, p. 33). Rebuilding an image is costly in terms of time and time is running out for the nursing profession.

For years, nursing literature has stressed the need for nursing to change. So, why have the necessary changes not taken place? The nursing profession is still fragmented which causes an inability for nurses as a whole to implement changes which would improve health services and public support. There are numerous nursing organizations, none of which have the majority of nurses as its members. This is attributable to the size and diversity of nursing. This diversity, including different skill levels required of nurses, different scopes of practice in a variety of settings, different educational preparations, and differences in the organization of nursing services demonstrates an inability for nursing to get its act together.

Does nursing have any long range plans? This is crucial to the survival of this profession. It is imperative that nursing as an organization of professionals must:

> 1. control the definition of professional practice;
>
> 2. initiate, participate, and influence public policy affecting health and nursing. This will enhance the public image of nursing and contribute to nursing autonomy;
>
> 3. take social and political action on behalf of nursing and health care, (Hageman, p. 9).

A long range strategic plan among all nursing organizations must be developed and these three areas in particular must be included. First, focus must be placed on the issues of recruitment of new people into nursing which is vital to accommodate for the many shifts experienced in the supply and demand for nurses, but a strong emphasis must also be made to retain these people.

Second, in order to retain current practitioners, professional nurses must be recognized by the public and by their colleagues for their ability to utilize their knowledge, valued for their skills, and rewarded for their significant contributions to meeting the needs of their patients. Job satisfaction is intimately related to this recognition.

Herzberg's theory identified both satisfiers and dissatisfiers as they relate to workers. Job dissatisfiers in the job environment which cause worker unhappiness are physical working conditions, coworker relations, salary, administrative practices, etc. Dissatisfiers are not associated with the job itself, but with conditions surrounding the performance of the job. When dissatisfiers fall below a certain level which a worker considers acceptable, then job dissatisfaction is present. Satisfiers are positive job attitudes which contribute to attaining self actualization. They satisfy a need. These are

recognition, responsibility, the work itself, advancement, and possibilities for career growth. Removal of dissatisfiers do not make an employee satisfied because they are not capable of providing basic satisfaction. Therefore, dissatisfiers must be kept low, while satisfiers are enhanced in order to produce job satisfaction, (Carroll and Dwyer, p. 17-18). This is why issues such as career mobility, advancement, autonomy and inter-professional collaboration must be addressed in order to solve the cyclical pattern of the nursing shortage. It also explains why previous attempts of raising salaries, offering hiring bonuses, etc. were only temporary solutions.

In 1982, the *Annual Report of the Kaiser-Permanente Medical Care Program* identified status as a top dissatisfier in nurse attitude surveys, (Pollack, p. 79). Status and public image were the third area. Status is closely linked to professional image, an area discussed earlier as needing improvement for nursing. Status is defined as a lack of respect, authority, and autonomy. *RN Magazine's* 1979 survey found 3 out of 4 physicians regard nurses as their assistants, ".....and nothing more", (Pollack, p. 79). Physicians have a profound affect on public opinion.

Media campaigns alone are not enough to market the esteem required to surround nursing with the respect it seeks. Nursing needs to launch two types of media campaigns. First, it is,necessary to study media agendas, including what the public will watch, listen, or read. Second, nursing must find out what the general public utilizes the media for and how the public feels about nursing, (Pollack, p. 80).

There are problems with media campaigns. First, they are expensive. Sustained funding is required to maintain viewer and

producer interest. The ruling of the Federal Communications Commission does not force stations to air public service announcements during prime time television. So, they are usually aired at 2 or 3 a.m. This is not considered a viable option. Second, there are problems of convincing producers to make programs concerning nurses and problems of convincing viewers to watch them.

Pollack suggests nursing become a part of media agendas in order to achieve recognition by utilizing contemporary issues such as wellness. Nurses traditionally have been more concerned with lifestyles and the total person than doctors who treat disease entities. Nurses can thus gain attention by being spokespersons on diet, nutrition, cost effectiveness of nursing, and nursing's skills at saving health care dollars, (Pollack, p. 86). These are areas which will attract media attention and serve as a vehicle for nursing to gain positive public recognition.

A large scale attitude survey of public opinions on nursing is another possible solution in order to develop strategies for increasing public opinion and professional recognition. This will enable the nursing profession to focus on areas where the public needs further education about nursing. This would help determine inaccurate and accurate impressions. As it stands now, nursing is unaware of how they are viewed by the public.

Marketing efforts must also be geared toward attracting more young people to the profession. Nursing has done little to market the positive aspects of a nursing career to perspective students. The American Association for Critical Care Nurses has launched a campaign for critical care nursing to high school students. Nursing should

combine efforts to demonstrate the vast number of choices students would have in choosing nursing as a career. Advertising in such young people's magazines as *Seventeen* could appeal to the challenge and excitement of being a nursing in similar fashion to the armed forces' advertisement of, "being all that you can be".

Other marketing ideas include:

1. "Future Nurses of America" high school clubs;

2. High school presentations on nursing career opportunities for men and women;

3. Workshops for high school students about nursing career opportunities;

4. Nursing scholarships through local hospitals, businesses, civic organizations, etc.; and,

5. Nursing actively participating in high school career days. (Barker, p. 295)

Salaries must also increase along with these other changes. Salary increases alone will not solve the situation. Nurses are expected to increase their clinical expertise, demonstrate advanced theoretical knowledge, write individualized care plans, provide family support and teaching, and take care of patients who are sicker and are discharged earlier without increased salaries. According to the AJN survey in 1979, staff nurses were paid approximately the same wages as executive secretaries, and less wages than grocery clerks or starting policemen in many cities, (Pollack, p. 79). Salary changes must keep up with current responsibilities.

The educational dilemma of the entry into practice issue could aid the recruitment effort if a decision can be reached. The longer the delay, the more damage is done to the profession. Solving this issue will strengthen nursing's image as a viable professional career.

Riesler and Sproull report that past nursing crises have been remembered, but not utilized for organizational policy and planning. Congress has recently sponsored the "Nursing Shortage Act". This will grant nursing $5 million to eliminate the shortage. Nursing needs to use this money wisely to develop strategies which will put a permanent end to this cyclical pattern through long range planning.

REFERENCES

Aiken, Linda and Mullinix, Connie Flynt. "The Nurse Shortage, Myth or Reality?" New England Journal of Medicine, Vol. 317, No. 10, September 3, 1987, p. 641-645.

American Hospital Association. "AONE Takes Lead on Nursing Shortage Issue." The Nurse Executive, Vol. 12, No. 2, March-April 1987, p. 1-3.

Barker, Elaine. "The Nursing Shortage: Enough Talk." Journal of NeuroscienceNursing, Vol. 19, No. 6, December 1987, p. 294-295.

Beyers, Marjorie and Damore, Joseph. "Nursing Shortage Requires Lasting Solution,Not A Quick Fix." Health Progress, May 1987, p. 32-35.

Beyers, Marjorie; Mullner, Ross; Byre, Calvin;and Whitehead, Suzanne. "Results of the Nursing Personnel Survey, Part 1: RN Recruitment and Orientation." Journal of Nursing Administration, April 1983, p. 34-37.

Beyers, Marjorie; Mullner, Ross; Byre, Calvin;and Whitehead, Suzanne. "Results of the Nursing Personnel Survey, Part 2: RN Vacancies and Turnover." Journal of Nursing Administration, May 1983, p. 26-30.

Beyers, Marjorie; Mullner, Ross; Byre, Calvin;and Whitehead, Suzanne. "Results of the Nursing Personnel Survey, Part 3: Salary and Fringe Benefits." Journal of Nursing Administration, June 1983, p. 16-20.

Carroll, Elizabeth and Dwyer, Dr. Larry. "Causes of the Nursing Shortage in NSW: A Framework for Discussion." The Lamp, Vol. 44, No. 6, August 1987, p. 17-21.

Castledine, George. "The Shortage: Can We Prevent It?" Geriatric Nursing and Home Care, Vol. 7, No.2, February 1987, p. 8.

Davis, Gail C. "Nursing Shortage An Issue of Quality." Texas Nursing, Vol. 54, No. 8, September 1980, p. 12-13.

Deloughery, Grace and Gebbie, Kristine. Political Dynamics Impact on Nurses and Nursing. St. Louis: C.V. Mosby Co.,1975.

Diers, Donna. "To Profess-To Be a Professional." Journal of Nursing Administration, Vol. 16, No. 3, March 1986, p. 25-30.

Donnaho, Barbara. "Reasons For Today's Nursing Shortage Sound Familiar." Health Progress, May 1987, p. 31.

Donovan, Lynn. "The Shortage: Good Jobs Are Going Begging These Days, So WhyNot Be Choosy?" RN, Vol. 43, No. 6, June 1980, p. 21-27.

Dubuque, Susan and Harvey, James. "The Nurse Shortage, A Brief Opinion Survey." AORN Journal, Vol. 46, No. 4, October 1987, p. 653-660.

Editors of Nursing '88. "Nursing Shortage Poll Report." Nursing '88, Vol. 18, No. 2, February 1988, p. 33-41.

Everlye II, George and Schabdach, Gayle May. "Specialization: The Road to Professionalism." Supervisor Nurse, Vol. 6, No. 10, October 1975, p. 38-41.

Fagin, Claire. "The Visible Problems of an Invisible Profession: The Crisis and Challenge for Nursing." Inquiry, Vol. 24, Summer 1987, p. 119-126.

Fralic, Maryann. "Again So Soon? Thoughts on the Nurse Shortage." Nursing and Health Care, Vol. 8, No. 4, April 1987, p. 209-210.

Gallivan, Mary. "Nursing Forces Rally Under Role-change Flag." Hospitals, Vol. 60, No. 5, March 5, 1986, p. 93-94.

Gallivan, Mary. "Debate Heats Up Over Two-Tiered Nursing System." Hospitals, Vol. 60, No. 5, March 5, 1986, p. 94-95.

Gallivan, Mary. "Signs Indicate A Nursing Shortage Isn't Far Off." Hospitals, May 5, 1986, p. 152.

Gioiella, Evelynn. Editorial. "The Nursing Shortage-A Potentially Unifying Challenge." Journal of Professional Nursing, Vol. 3, No. 3, May-June 1987, p. 127-128.

Hageman, Paul T. "Goals, Autonomy and Professionalism." Journal N.Y.S.N.A. Vol. 18, No. 1, March 1987, p. 7-11.

Iglehart, John. "Problems Facing the Nursing Profession." New England Journal of Medicine, Vol. 317, No. 10, September 3, 1987, p. 646-651.

Illinois Nurses' Association. "INA Presents Views On The Nursing Shortage." Chart, Vol. 77, No. 9, November 1980, p.1-5.

Jenkins, Charles. Summary. "Statement of the American Hospital Association Before the Subcommittee on Finance of the United States Senate." October 30, 1987, p.1-10.

Kalisch, Beatrice and Kalisch, Phillip. "Nursing Images: The TV News Picture." Nursing Management, Vol. 16, No. 4, April 1985, p. 39-48.

Kelly, Lucie. Editorial. "Ignorance, Ineptitude, Indifference: The Roots of the Nursing Shortage." Nursing Outlook, March/April 1988, p. 61.

Kinsey, Kathy. "Professional/Technical Today's Nurses Are Making Their Choice." Nursing Success Today, Vol. 2, No. 11, 1985, p. 22-30.

Mahaffy, Perry. "Clarification of Nursing Activities and the Nurse Shortage." Hospital Topics, Vol. 50, No. 5, September/October 1980, p. 34-35.

McCarty, Patricia. "House Acts on Shortage, AIDs, Liability." The American Nurse, Vol. 19, No. 7, July/August 1987, p. 1, 12.

Mitchell, Karen. "Nursing Shortage and Insurance Problems: The Long-Term Focus of DHHS' Otis Bowen." Nursing Economics, Vol. 6, No. 1, p.7-9, 47.

Nornhold, Patricia. "Why You Are The Answer To The Nursing Shortage." Nursing '87, November 1987, p. 48-50.

O'Brien, Beth; Knutson, Kristine; and Welch, Lynn. "Nursing Shortage or Transition? Three Perspectives." Health Progress, May 1987, p. 36-40, 79.

Pick, Jeanette. "Professionalism in Nursing Today." AARN Newsletter, Vol. 11, No. 36, December 1980, p. 7-8.

Pollock, John Crothers. "Professionalism In Nursing: A Bottom-Up Strategy For Generating Public Recognition." Presentations at 16th NLN Biennial Convention 1983-1985, National League for Nursing, New York, p. 79-87.

Prescott, Patricia. "Another Round of Nurse Shortages." Image: Journal of Nursing Scholarship, Vol. 19, No. 4, Winter 1987, p. 204-209.

Rosenfeld, Peri. "Gender Roles and the Nursing Shortage: Where Have All the Nurses Gone?" NSNA/Imprint, Vol. 34, No. 4, p.39, 41.

Salahuddin, Mobashir. "AMA Seeks New Nursing Job Category." Health Week, Vol. 2, No. 10, May 9, 1988, p. 1, 28.

Schoettle, Marlene. "Nursing Shortage; Nursing Crisis-National Problem." NSNA/Imprint, Vol. 34, No. 4, November 1987, p. 27-31.

Schrader, Elinor. "Will the Real Voice for Nursing Shout a Little Louder?" AORN Journal, Vol. 38, No. 3, September 1983, p. 380-382.

Selby, Terry. "RN Shortage Threatens Quality of Care." The American

Nurse, Vol. 19, No. 3, March 1987, p. 1,11,14.

Sepic, F. Thomas. "Do You Know a Quitter When You See One?" Health Care Supervisor, July 1986, p. 65-74.

Silva, Mary Cipriano. "The Nursing Shortage: Ethical and Professional Issues of Autonomy." Virginia Nurse, Vol. 49, No. 4, Winter 1981, p. 36-39.

Simpson, Irene. "Professionalism: Can We Afford Not To Pay For It?" RN ABC News, Vol. 15, No. 4, May-June 1983, p. 30.

Steck, Ann. "The Nursing Shortage: An Optimistic View." Nursing Outlook, Vol. 29, No. 5, May 1981, p. 302-304.

Stucki, Kathryn. "The Nursing Shortage From the Recruiters Viewpoint." Imprint, Vol. 34, No. 4, November 1987, p. 42.

Tiffany, Robert. "Striving To Be More Than Cinderella." Nursing Mirror, December 16, 1981, p. 28-30.

Weissman, Gail Kuhn and Siegel, Patricia. "The Impact of the Nursing Shortage on Clinical Practice Challenges and Opportunities." NSNA/Imprint, Vol. 4, No. 34, November 1987, p. 36-37.

Wells, Maryann Papanier. "One Nurse's View of the Nurse Shortage." AORN Journal, Vol. 46, No. 4, October 1987, p. 662-670.

Woolley, Alma. Editorial. "Shortage Fallout." Journal of Professional Nursing, Vol. 3, No. 2, March-April 1987, p. 75-76.

"RN Shortages Sprout in Reagan's Backyard." American Journal of Nursing, November 1986, p. 1285, 1294-1295.

"Nursing Enrollments, Applications Fall Again; Closures Seen, But Some Schools Hold Their Own." American Journal of Nursing, October 1986, p. 1178, 1189.

"Changes in Health Care Trigger Nursing Shortages." The Missouri Nurse, Vol. 56. No. 2, March-April 1987, p. 5.