Where have all the nurses gone?

RONALD W. DWORdIN

The nursing shortage in the United States has turned into a full-blown crisis. Because fewer young people go into nursing, one-third of registered nurses in the United States are now over 50 years of age, and that proportion is expected to rise to 40 percent over the next decade. Nurses currently practicing report high rates of job dissatisfaction, with one in five seriously considering leaving the profession within the next five years. In Baltimore, where I practice medicine, hospitals routinely cancel or delay surgical cases because of a lack of nursing staff.

Conventional wisdom blames managed care for the problem. In the early 1990s, managed care cut reimbursement and curtailed hospital admissions, and in response, hospitals relied on unlicensed assistant personnel instead of nurses to perform routine tasks. Fewer people went into nursing as a result. By the time demand for nurses had increased in other areas like home and ambulatory care, and administrators began noticing an upsurge in medical errors stemming from a greater reli-
ance on non-nursing personnel, it was too late—young people had come to look upon nursing as a profession in decline.

Yet the managed-care explanation fails to explain the global nursing shortage. In Canada, Germany, and Great Britain, the nursing shortage is as severe as in the United States, even though these countries have health-care systems based on very different economic models.

The new career opportunities open to women provide a second explanation for the nursing shortage. When nursing was one of the few career paths available, it had a captive labor pool. Now that other, more lucrative opportunities beckon—for example, medical school—women are less likely to choose nursing. Yet this theory fails to explain why other, traditionally female-dominated professions like teaching maintain enough applicants. In Baltimore, for example, registered nurses make more money than teachers. The starting annual salary for a nurse is approximately $35,000; for a teacher, it is closer to $27,000. Teaching should be the more vulnerable profession, yet in reality nursing is the one that suffers.

There is some truth to the managed-care and open-career theories, but they do not tell the whole story. Nursing’s troubles are more profound and alarming than even nurses themselves realize. The nursing profession is being whittled down in size and stature as a result of three overarching trends: the decline of the professional ideal, the worsening social predicament of nurses, and the evolution in the spirit of caring.

**Florence Nightingale dethroned**

The modern nursing profession evolved, to some degree, in reaction to its past. In the eighteenth and early nineteenth centuries, nursing ranked low in the public’s estimation, and for good reason. During this time, nurses were often poorly trained and sometimes disreputable or drunken. The public’s attitude toward nursing changed almost overnight with the activities of Florence Nightingale during the Crimean War. Known as the “lady with the lamp,” Nightingale combined saintliness with hygienic knowledge to produce the ideal of the modern nurse.

Yet it was not inevitable that nursing would become a largely
female profession. Shortly after the establishment of the first school of nursing, British authorities continued to emphasize the benefits of physical strength that males might bring to the profession. And there was certainly nothing in hygienic science that kept men from becoming nurses. Not the expertise, but the virtues associated with nursing were the impediment: They were seen as distinctively feminine, and are still to this day.

What does the nurse ideal conjure up in the public mind? People imagine a nurse’s tenderness, sweetness, and kindness; the softness of her hands in contrast to the doctor’s cold and sharp instruments; a nurse’s graceful pride and light step; the delicacy and understanding with which she mops a patient’s brow with cool compresses. In the hospital, subliminal reminders of domesticity abound: Shining washbasins recall the rules not just of hygiene but also of a well-kept home, and a nurse’s dedication and selflessness recall a mother’s sacrifice for her children.

The link between nursing and feminine virtue is a major reason why only 6 percent of nurses in the United States are men, a number that has not significantly changed in over 40 years. In contrast, almost 30 percent of U.S. teachers are men, as are a large number of airline-service workers. Men are comfortable entering these other, traditionally female-dominated careers because they do not see them as inherently feminine. To attract men to airline service, management needed only to change the job title from “stewardess” to the more sex-neutral term, “flight attendant.” What makes nursing seem inherently feminine is not its service orientation but the virtues of compassion and empathy that go with it.

Since the era of Florence Nightingale, nursing has stood on two pillars—virtue and good science. However, starting in the late 1970s, the nursing profession, both in the United States and in Western Europe, began to emphasize science at the expense of virtue. According to progressive thought, virtue was a personal, not a professional, concern. Feminists especially fought to expunge the ideal of virtue from nursing, since not only were nurses’ traditional virtues biased toward one sex but they had long been associated with a woman’s timidity and subjugation.
It was the aim of nursing activists to turn nursing into a knowledge-based profession. Hospital nursing programs that award noncollege diplomas have largely been discontinued. Nursing education is now firmly on a university track. Only those who earn a B.S.N. (Bachelor of Science in Nursing) receive the title, "professional nurse." An A.A. (Associate Arts) degree earns the lesser title, "technical nurse." In truth, however, nursing lacks an independent knowledge base. Nurses are taught the same material as physicians, only less of it. Nursing textbooks, for example, differ from physician textbooks only in being less rigorous. When nursing tries to distinguish itself on the basis of scientific knowledge alone, nursing loses status among doctors and para-professionals who have knowledge bases of their own. Thus, the professionalization of nursing and the lingering sense that it is a women's profession have had devastating consequences for nurses.

**Equivocal professional status**

Nursing practice at the highest levels can be extremely frustrating. Aspiring to the modern professional ideal in this setting is like going to the well but not being able to drink. In terms of salary and education, nurse anesthetists and advanced-practice nurses sit in nursing's upper ranks. Nurse anesthesia, for example, is extremely technical, and one of the few nursing specialties that is popular among men, since, to some degree, it is where knowledge matters more than bedside manner. But while nurse anesthetists and advanced-practice nurses train for years, they know that their sphere of knowledge is limited. They remain under the control of doctors, since doctors have more education than they do and receive higher renumeration. I once overheard a nurse tell a patient that the difference between a nurse anesthetist and an anesthesiologist is "about $200,000 dollars a year."

Young people who envision careers in the upper ranks of nursing quickly decide to go to medical school instead. If they want to be thought of as full professionals in an era that equates professionalism with expertise—and nothing else—they probably should.

For nurses in the middle and lower ranks, life is no less frustrating. They are called professionals by virtue of their
education. Yet when nurses with B.S.N. degrees look around, they see nurses with A.A. degrees, and even older nurses with noncollege diplomas who have been “grandfathered” into the system, performing the same tasks as they and getting paid roughly the same salary. The B.S.N. graduates conclude that the fine gradations in nursing competence established by nursing boards exist only to raise self-esteem and have little clinical significance.

Every day, nurses are reminded of the weakness inherent in a professional ideal of nursing based on expertise alone. If the hospital has a shortage of assistant personnel, nurses are called upon to fill in. Emptying out the garbage and changing beds—duties that supposedly stand on the other side of the great professional divide—quickly become a nurse’s duties whenever orderlies go on strike or call in sick. Even nurse anesthetists are occasionally drafted to perform such duties, for, when all is said and done, hospitals see them just as nurses, without a monopoly on any one skill. Nurses quickly learn that they are not professionals so much as the middle ground between the hospital’s professional and nonprofessional classes.

Nursing’s equivocal position has now been formally institutionalized. For example, registered nurse first assistants (RNFAs) are trained as surgical assistants and frequently help with operations. But their role is not distinctive. RNFAs know that surgeons ask for them only when insurance companies refuse to reimburse for a second surgeon (e.g., when the case is a breast biopsy as opposed to a gall bladder operation). Their special training is only honored when it is convenient.

Similarly, hospitals often employ nonlicensed technicians to scrub floors, circulate in the operating rooms, and prepare patients for operations, thereby freeing RNs to perform duties commensurate with their level of education. Yet in neighboring outpatient surgery centers, nurses perform these tasks to save the centers money.

Nursing’s image is in limbo during an era that equates professionalism solely with knowledge. Because nursing lacks an independent scientific base, young women must weigh years of education and hard work against the prospects of tenuous professional status at best. And since the nursing leadership
repudiates the older ideal of nursing as a career well-suited to a woman's special attributes, young women see little in nursing that is honorable or distinctive. Young men also spot the weakness in nursing's claim to professional status. They consider nursing a distinctively feminine vocation, despite the public-relations effort to the contrary. Thus, they too turn away from careers in nursing.

These problems play out in other ways. Bright young people see a nursing career as relatively undistinguished, since nurses wear a professional's hat one day and an orderly's the next. People for whom nursing school would be a major challenge forego the effort, since becoming a nursing assistant allows them to check vital signs and perform other nursing activities without actually having to become a nurse. Ironically, by shedding nursing's mundane tasks in the effort to boost the profession's status, nursing advocates have made the job of nursing assistant seem more attractive to borderline applicants.

The nursing profession's weakness is especially vivid when juxtaposed with the emerging order of physician assistants (PAs). PAs form a class of employees known as "physician extenders." Generally employed by doctors, they perform quasi-nursing duties, which is why nurses look upon them as rivals. Additionally, because PAs have a different heritage from nurses, their numbers are swelling rather than declining. The first PAs were ex-corpsmen who served in Vietnam, and so, unlike nurses, they lack an historical tie with feminine virtue. Men who are PAs perform nursing duties without any stigma. Nor do PAs try to professionalize their status on the basis of an independent science, since by definition, they are attached to doctors.

When the professional ideal of nursing combined knowledge with a noble sensibility, doctors saw nurses as simultaneously beneath them and adjacent to them. Nurses had more limited knowledge than doctors, but they displayed admirable qualities that doctors lacked. When this unique spirit died, and nursing tried to distinguish itself on the basis of scientific knowledge alone, it lost status in the eyes of doctors and those para-professionals who operated within their own spheres of influence. Suddenly, nursing was beneath everyone.
The subjection of women

The history of nursing is bound up not only with the evolution of the professional idea but also with women's marital aspirations and the changing status of women in society. Many years ago, I asked my mother why she became a nurse. She replied, "That's silly. To marry a doctor, of course." Many of my mother's friends would have answered the same way.

The high number of marriages between male doctors and female nurses during the 1950s and 1960s is perfectly understandable. If you place a handful of young male interns with a handful of young female nurses, then work both groups so hard that they rarely leave the hospital building, romance will inevitably result. In those days, the image of the ideal nurse was in full force, and it catered to men's fantasies of caring and selfless women.

The attack in the 1960s on the traditional female ideal and the promotion of sex-neutral professionalism made these feminine virtues seem out of date. This change was accompanied by a coarsening of doctors' attitudes. To many male doctors, nurses became only women to have fun with. The idealized image of the nurse lost its virtue component, but retained its sexual component. Such attitudes toward nurses are well-captured in an experience I had as an intern in the 1980s. Asked by an elderly doctor (who himself was young in the 1960s) if I was playing around with the nurses, I replied, "Not really." He shrugged, then said, "Well, that's what they're there for."

The nursing profession's response to this abusive behavior was to rid itself of even the trappings of womanliness. During the 1980s, for example, some of the older nurses still wore skirts, which is how most nurses once dressed. The younger nurses switched to unisex pantsuits. In the operating room, both doctors and nurses began wearing the same scrubs—blue trousers and smocks—giving the whole theater an androgynous feel. All sense of "otherness" was eliminated, and young male doctors eventually learned to treat nurses as co-professionals rather than as sex objects.

Among the older generation of doctors who trained in the 1960s, there were still those who saw nurses as people to be pinched and squeezed. And many nurses simply took these men in stride, and let them pinch and squeeze, even though
such behavior was considered unacceptable among younger doctors. The nurses jokingly concluded, "That's their way." All they could do was wait for this generation of doctors, and their abusive sensibility, to die off.

The effort to "de-sex" nurses has contributed to a phenomenon rarely analyzed in books, but much discussed among nurses in casual conversation. When asked if doctors are still marrying nurses, many nurses shrug and say, "No, they marry other doctors." If first-year nursing students admit that a major reason they went into nursing was to marry a doctor, the older nurses warn them that such a match is probably beyond their grasp.

Why are male doctors no longer marrying nurses? Male doctors confess that the more nurses lose their feminine markings, the more they lose their allure. Doctors see nurses as austere, almost mechanical beings who pull the levers of the enormous hospital engine. By expunging the nursing ideal of both its virtue and its sexual components, and training male doctors to think that any sexual attraction felt toward nurses is a degrading emotion, the nursing leadership has erected a barrier in their imaginations.

The increasing number of women doctors has certainly contributed to this trend. Almost half the medical students in the United States are now women. Young male doctors can meet women who understand the trials of a medical education, and who can also bring home a large paycheck. Social class probably also plays a role insofar as male doctors seek to wed someone of a similar background. Female doctors have another advantage over female nurses: They are not hobbled to the degree that nurses are by the commandment to sanitize their sexuality. They feel free to wear more feminine clothing in their rounds, and occasionally send attractive photos along with their job applications. Few nurses would feel confident enough in their professional status to do likewise.

The most tense relationship in medicine now is in fact not between male doctors and female nurses, but between female doctors and female nurses. Reports of insubordination are legion, as female nurses sometimes refuse to take orders from female doctors, and female doctors and nurses accuse one another of disrespect. Among some female nurses, there is a
fear of being thought of as redundant personally and professionally, a dread that betrays itself in sarcasm and obduracy. The irritation and contempt that some female doctors show toward nurses only exacerbates this despair. To some female doctors, it is as if nursing signified an earlier, more primitive stage in women's evolution. The nursing leadership adds to a young woman's confusion and self-doubt, telling her that she has no need for any special feminine qualities. It is thus no surprise that few women enter this arena with enthusiasm.

Class division

Many women once looked upon nursing as the perfect part-time job. They worked a few days a week to help their families, while their husbands remained the primary wage earners. Nursing is still a convenient part-time job. But the economic status of women has dramatically changed over the last 50 years, such that what was once a great advantage is now less so.

Convenient, part-time work for women was popular during an age when over half the families in the United States (and in Western Europe) were two-parent families with children. Now less than 25 percent of families are. Many women either live by themselves or raise children alone. Today's nurses often must extract an entire family's income from their jobs. And they can, but only by working the worst shifts—nights, holidays, and weekends. Most hospitals reimburse for such hardship posts, but for many nurses—especially those who are single mothers—these time shifts can be physically painful and psychologically grueling. Women need to work these shifts to provide for their families, but, as a consequence, they find they have little time to spend with their children.

Nursing itself is becoming divided as a profession because of this desperate situation. Many nurses have signed up with independent agencies to regain a flexible life style. A nurse lets the agency know when she can work, and the agency assigns her to one of the local hospitals, often reimbursing her at a higher rate than the hospital would if it employed her directly. In some hospitals, almost 40 percent of nurses are now with an agency. But because not all agencies provide
benefits like health insurance, and most are unable to guarantee a nurse 40 hours of work per week, single mothers with children find it too risky to leave their permanent staff positions. Middle-aged divorced women seem equally hesitant.

Today, one hospital, even one operating room, can have two nursing populations. Agency nurses are often young women without children who may be attending school in their spare time. Another subset includes older women close to retirement, with grown children, who simply want to keep a hand in nursing. Staff nurses are frequently single women with young children, or middle-aged divorced women living on their own, who see before them 20 years of exhausting toil. They are tired, and envy the agency nurses. A staff nurse who leaves the hospital one day and returns an agency nurse the next is often treated like someone who has just won the lottery.

When nurses flee to the agencies, those who remain must pick up the slack, which means even more mandatory “volunteering” on nights and weekends. Staff nurses become increasingly demoralized, despite being well-paid, for they know that their good pay comes from doing the work that no one else wants to do. To make up for the labor shortage, hospitals sponsor visiting nurses from the Philippines and Ireland, which depresses staff nurses even more. They feel that they are working in jobs that no self-respecting American would consider.

The hospitals are not completely at fault. In most jobs, the troubles of single women with children, or divorced women living on their own, can be diluted in a sea of male co-workers. But nursing is the one job that is overwhelmingly female, causing a large number of women in difficult situations to be concentrated in one profession. Hospitals have an enormous problem, and limited flexibility to manage it. Tight health-care budgets prevent them from paying nurses more. Hospital services are essential, and so cannot be cut back. In addition to causing many nurses to leave the profession, such conditions inevitably affect prospective applicants. Young women see unhappy nurses leading difficult lives, and choose to pursue other careers.
The new spirit of caring

Many nurses experience what is described as “burnout.” The three components of burnout are emotional exhaustion, depersonalization (i.e., a lack of sympathy for one’s patients), and the absence of a feeling of personal accomplishment. The problem is most serious among intensive-care-unit and emergency-room nurses, but it is increasingly common among ward nurses.

The causes of emotional exhaustion are self-evident: long hours, inadequate resources, demanding patients, and mediocre pay. While nursing has always been a difficult job, several new factors make it even more so. Because managed care demands that healthy patients be discharged quickly from the hospital, the patients remaining are generally sicker and older, and more difficult to care for. At the same time, today’s nurses face an incredible amount of paperwork. Having to fill out time sheets, medication sheets, administrative records, clothing lists, and checklists (just for starters), all while taking care of extremely sick patients, is very stressful. One nurse complained to me, “I have just enough time to choke some pills down their throats, and throw a tray of food into their rooms.”

The causes of depersonalization and a lack of fulfillment among nurses are more complex. They are tied up with the evolution of the caring professions. Before caring became a secular profession, it was a religious calling in which everyone took some part. Caring for the sick was not parcelled out to specialists but was the responsibility of the entire community. With the emergence of psychology, social work, and psychopharmacology, caring became an area of study and eventually a technique. Methods were devised to teach it, and schools sprang up to promulgate it.

But true caring depends on the caregiver’s possession of certain kindly feelings—feelings that no amount of schooling can evoke. Fortunately, psychologists and social workers understand this. Over many years, I have asked caring professionals if the connection they make with their patients is grounded in scientific theory and the methods they learned in school, or in their natural instincts for service and friendship. Every one of them said that this connection, along with the
advice and wisdom they offer patients, originates in the latter. Theory is only a useful guide.

The health-care system allows psychologists and social workers enough time to develop a true caring relationship with their patients, and to gain fulfillment through such relationships. Doctors also have time for this, though less so now under managed care. In any case, most doctors consider themselves scientists, not caring professionals, and thus the response they feel toward patients depends less on feelings of friendship than a sense of technical accomplishment. This protects them against feelings of guilt and inadequacy when they fail to make an emotional connection with their patients.

Sadly, neither of these scenarios is true for nurses. Although they are caring professionals, nurses increasingly lack the time to forge real relationships with their patients, especially in critical care. Unlike social workers and psychologists, they also have strenuous physical duties to perform. At the same time, nurses lack the scientific background of doctors which might allow them to interact with patients more extensively.

Nurses are now often limited to the theory of caring rather than the practice. When a patient is admitted, a nurse performs a rapid psycho-social assessment, which is basically a checklist of how the patient is feeling. She then spends time chasing down lab numbers, managing the patient's drugs, running from monitor to monitor, and filling out forms—all while managing the most intimate aspects of a patient's existence. When signing out to another nurse at the end of her shift, she sums up the patient's state of mind in two or three sentences, despite the fact that she has not had the time to adequately assess it.

In this work environment, the nurse feels tremendously conflicted. She bathes, feeds, and medicates a patient, yet she does not really know the patient. She lacks any feeling of closeness or familiarity with the patient, although such things are expected of her as a caring professional. She has just enough time to care for the patient according to the theory of caring—for example, to use psychological terms in her daily progress note—but the whole enterprise is more like a counterfeit of true caring. She experiences guilt, embarrassment, and a sense of failure in her work. Oftentimes she quits.
The third component of nursing burnout—a lack of personal accomplishment—is also rooted in the evolution of the caring professions. When caring had a closer tie to religion, it relied on ideals of self-sacrifice. Feelings of compassion were yoked to a belief that one should not think or worry too much about one’s own happiness. Christian doctrine told people that if they cared for others without fearing for themselves, they would be able to endure the greatest privations.

In contrast, a degree of egoism penetrates the spirit of modern professional caring. Health-care professionals go into the business in part to feel good about themselves. But what happens when their profession no longer provides them with such a sense of self-satisfaction? The dean of my medical school once told me that those who go to medical school with the goal of saving humanity rarely make it through. To endure the long hours and exhausting toil, medical professionals need something more tangible to sustain them—for example, an intellectual interest in medicine or the dream of becoming wealthy.

Many nurses today are torn because they want to dedicate themselves to their patients yet find caring for them so burdensome. Inadequate resources, time constraints, and bureaucratic inflexibility infuriate nurses, partly because they are concerned about their patients, but also because these things rob nurses of a sense of fulfillment. The link between the profession of caring and a nurse’s sense of self-worth is well-captured by those who have burned out. Poor work conditions “prevented me from accomplishing what I wanted to accomplish,” or kept me from “being true to myself.” One nurse told me, “I’m a perfectionist. If I can’t do what I’ve been trained to do, I don’t want to do it.” She looked at caring as a form of self-improvement. She wanted to achieve her personal best as much as to help others.

According to one nursing journal, “The prime candidate for burnout is the nurse who strives for excellence in a toxic environment.” Nurses have little control over their professional lives, since they are usually under the authority of doctors or hospital administrators. Lacking tangible work benefits, whether it be money, autonomy, or prestige, they may try to see caring itself as the way to happiness. When the
system refuses to cooperate, the caring ethos turns from a source of personal accomplishment into one of frustration. Many nurses reach the end of their tether and resign.

No quick fixes

The crisis in nursing is fundamentally one of identity. It is captured in the problem of how to address a nurse. Take a hypothetical nurse named Anne Smith. Decades ago, physicians would have addressed her as "Nurse Smith," while ancillary hospital personnel might have called her "Miss Anne." Today, few doctors would call her Nurse Smith, since the formality creates a sense of distance. Both the nursing and medical professions prefer today’s more easygoing relations between doctors and nurses, in part because the new friendliness conceals a more fundamental inequality that both find embarrassing. Better for a nurse to present herself to a doctor as a distinct individual and a potential friend. So the doctors address Nurse Smith just as plain "Anne." Yet the doctors are still addressed by their title of "Dr." Meanwhile, few hospital workers would address our hypothetical nurse as "Miss Anne," since "Miss" directly refers to her gender and violates the spirit of sex-neutral professionalism. Nurses thus go from having a different rank than doctors to having no rank at all. They go from being colleagues to nobodies, increasing the precariousness of their professional status.

To some degree, nursing is the victim of social forces beyond its control. The influence of individuals on the fate of nursing is weak while the power exercised by the new professional ideal, the changing status of women, and the evolution of caring is great. The nursing profession has been swept up in a cultural avalanche. Today’s nurses are understandably weary, discouraged, and demoralized, and their leadership is looking for solutions. But to improve matters, nurses must first realize what has happened to their profession. At the present time, changes in public and health policy will have no great effect on the profession’s fortunes. A new vision is needed.