Where's That Nurse?

By BEN OLDS and DAN HERR

Short between 65,000 and 75,000 nurses, America is faced with a major crisis in care of the sick. Here's what can happen to you should you require hospitalization today.

BECAUSE of the nurse shortage, more Americans every day are finding out that while it is tough to be sick and have to go to a hospital, it is far tougher to need hospital care and not be able to get it.

Dr. Donald C. Smelzer, ex-president of the American Hospital Association, warns that the current lack of nurses threatens to bring on this country's worst crisis in the care of the sick. Nine out of ten hospitals need nurses badly—so badly in many cases that patients are being turned away because there aren't enough nurses to look after them. In New York City, for example, voluntary and municipal hospitals, short 6000 nurses, have had to close more than 2100 beds. In hundreds of hospitals whole wards have been shut. A small Indiana hospital sent all its patients home or to other institutions recently because it did not have enough nurses and other workers left to stay in operation. Some nurse-shy hospitals in Cleveland are discharging new mothers in three days instead of the usual ten, and a New York hospital often cuts it to one day. The situation is as bad, or worse, in Boston, Los Angeles, Baltimore, New Orleans and Des Moines.

Even if you are seriously ill, you may not be able to find a hospital that will take you today, and if you are lucky enough to find one, your chances of receiving good, old-fashioned hospital care are poor. On occasion, depending upon circumstances, you will not receive a daily bath. Your temperature is not apt to be taken oftener than once a day unless you are very sick. If your medicine is ordered for eight A.M., don't expect it before eleven. Your meals will probably be late . . . and maybe cold. The nurses will never seem to be around when you want them. The pleasant, dependent feeling a patient used to get from their solicitude and cheery conversation as they bustled about, fluffing pillows and rearranging flowers, is a thing of the past.

Your nurse will be missing the old days even more than you will. If you asked her what happened to them, and she had time to give you an explanation, it would be something like this one from Judith Walter, a Brooklyn nurse: "I'm doing the work of at least three nurses. Before the war we had five graduate nurses, two attendants and one or two students for the thirty-three ward patients that two graduates and three attendants take care of now. My work is just too much for one person, but the job has to be done, no matter how few people there are to do it. I'm so exhausted when I go off duty that I fall into bed and sleep for two or three hours before I can even eat. I'm tired all the time, and always in dread of the next day. The human relationship between patients and nurses is gone, and most of the satisfaction of nursing just isn't there any more. We don't have time for it."

Other nurses are even harder pressed. In one New York City hospital where there used to be a nurse for every five or six patients, a single nurse today is sometimes responsible for as many as 150. Not long ago a night supervisor, ordinarily in charge of one building for eight hours, had to manage three buildings all night and all the next day and night without a break. In many state psychiatric hospitals, one graduate nurse serves several thousand patients.

With nurses as overburdened as that, it is not surprising that some patients have suffered more serious shortage effects than cold meals and unfluffed pillows. Hospital accidents have mounted. In a private institution recently a woman had a brain operation. Her overworked nurse forgot to tell her not to leave her wheel chair. When she did, she fell over backward and suffered severe shock, which kept her in the hospital an extra two weeks. Another patient was recovering after a thyroidectomy. Ordinarily, nurses would have been at her bedside constantly for *(Continued on Page 81)*

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Student-nurse enrollment in 1946 totaled only 24,000, less than two thirds of the number wanted to combat the serious shortage.

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the first day or two following the operation, watching for signs of hemorrhage or shock. The hospital does not have enough nurses for that now, though, and before anyone noticed, the woman had died of a collapsed trachea.

The most generally quoted figure on the shortage of nurses today is 41,700. It first appeared in a National Nursing Council report, which assumed that all of the 37,900 nurses discharged by the military services since September, 1945, and all 35,600 of last year's nursing-school graduates would be nursing by now. Since this has not happened and was not in the least likely to, the figure, despite its wide circulation, is not very helpful.

The best guess available on the shortage of hospital nurses—the number who could start working tomorrow—is between 65,000 and 75,000. Dr. Hugo V. Hullerman, assistant director of the American Hospital Association, offers it after talks with hospital administrators all over the country.

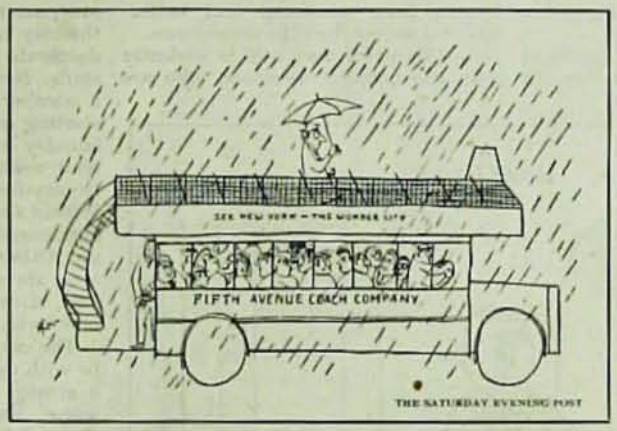
In the face of this, it is hard to believe, but it is nevertheless true, that there is a registered nurse for every 400 people in the United States. We have between 300,000 and 400,000 of them, half of the world total. The catch is that although there are more nurses now than there were in 1940, the number working has dropped by 27,000. Only 244,300 are currently active. Then, too, while Federal hospitals have nearly three times as many nurses as they had before the war, non-Federal hospitals, with only 114,300 today, have lost about 10,000.

At the same time, something else has happened to make the effect of that loss many times as bad as it would have been otherwise. The demand for nurses has skyrocketed.

Sixteen and a quarter million people—4,500,000 more than in 1941—managed to squeeze into hospitals in 1945, and it looks as if the 1946 record will top that. From coast to coast, hospitals are bulging with patients. Private rooms, sunrooms, corridors and service areas are crammed with extra beds. The congestion is so bad in some institutions that fire departments have threatened to close them. In cities, and in many smaller suburban hospitals, too, admissions are on a strict priority basis.

All this is not an indication that America's health has hit an all-time low. For one thing, the public is losing its fear of hospitals and is discovering the importance of health. Nonemergency surgery has increased tremendously. Prepayment hospitalization and medical-care plans have boomed, and their millions of members are going to hospitals for treatment which they would once have had at home. The birth rate has gone up, the death rate down, and the population includes a greater proportion of old people, among whom sickness is more prevalent. The Government, continuing a practice begun during the war, is subsidizing the maternity care of wives of enlisted men of the four lowest grades. Recent medical advances demand equipment and procedures that make hospitalization necessary now where it was not necessary before. Busy doctors are putting their patients in hospitals to avoid time-wasting rounds of homes.

Most of these trends started before the war and grew with it. So did the nurse shortage. In 1941, after fourteen years of more nurses than jobs, the situation was reversed. The Chicago Nurse Placement Service, for example, reported a hundred hospital openings for every nurse available that year. When the war came, nursing gave more generously to it than any other profession. Nearly 77,000 volunteers, almost a third of all active nurses in the country, were accepted for service with the Army and Navy. A majority of these came from hospitals, and



the hospitals expected to get them back.

It hasn't worked out that way. Of the 63,000 nurse veterans released so far, an unprecedented number have married and eliminated themselves from the nursing field. About 22,000 are going to school under the G. I. Bill of Rights, either learning new professions or preparing themselves for supervisory or specialized work in nursing. Some have taken non-nursing jobs and others are using the money they did not have a chance to spend overseas and buying themselves a good rest. A large segment of the younger-nurse group who saw war service are as restless and undecided as some of the ex-servicemen are; they lose a lot of work days while shopping around from hospital to hospital, looking for the kind of pay and working conditions they think they have earned.

Several additional developments have contributed to the present hospital crisis—some directly, by removing nurses, and others indirectly, by heightening the effect of their absence. Among these are the return to retirement after V-J Day of thousands of older and married nurses who had helped out during the war; the movement of nurses into specialized and administrative jobs and into better-paying, pleasanter nursing work in public health, industry, the Federal Government and private duty; the loss of hundreds of thousands of wartime volunteers; the shortage of practical nurses, attendants, orderlies, maids and other workers, which has shifted much of their work onto nurses.

The 1946 nursing-school enrollment was only a little more than 24,000. That this was far smaller than the number entering nursing in 1945 is not alarming, because most 1945 enrollees were members of the Government-financed Cadet Nurse Corps, which stopped recruiting in the fall of that year. What is alarming is that it fell 14,000 short of the 1940 figure and was less than two thirds of the number wanted. Many classes are less than half filled, and some schools have no new students at all.

The most serious shortage today, because it most directly affects patients, is that of general-duty nurses, the ones who hurry in and out of rooms and up and down corridors, giving medicine and treatments, taking temperatures, preparing trays and doing all the hundreds of other nursing chores that contribute beyond measure to the comfort and recovery of the sick.

Except when there was work to be done, the general-duty nurse has been the forgotten nurse. Professional leaders have exalted administrative and teaching nurses, but have done little for her. She feels that doctors regard her as a servant rather than as the collaborator she wants to be. Many hospital directors admit that her salary is unreasonably low, considering the training and responsibility required of her. In 1945, the average monthly salary for general-duty nurses was $155, and as low as that was, it wasn't all cash. Part of it—probably at least a third—was the estimated value of room, board and laundry service furnished by the hospital and, in many cases, taken out of a nurse's pay whether she used them or not.

The forty-hour week is rare in hospitals. In most of them nurses work forty-eight hours; in too many, as high as fifty-four and even sixty. In most hospitals night and evening duty brings no extra pay. Even those nurses who work an eight-hour day are often tied up for twelve hours or more because it is convenient for hospitals to take them off duty for several hours in the afternoon. The on-call-for-emergencies system confines surgical and obstetrical nurses to the nurses' home two or three nights a week without extra pay. Overtime is taken for granted, almost never paid for or compensated for in time off.

"This seems even worse when you compare it with other jobs," Elizabeth Brooks, the St. Louis girl recently chosen by nurses as The Typical American Nurse of 1946, points out. "My roommate took a short business course, and now she works forty hours a week for more than I earn in forty-eight hours—and I have a college degree, three years of nursing school and nearly seven years' experience. It's no wonder that there was a lot of griping among Army Nurses overseas about coming back to civilian hospitals."

Nurses are showing an increasing inclination to take matters into their own hands. A few have joined the nurses' unions. The CIO claims 6500 of these, and the AFL 5000. Both organizations are seekng a minimum salary of around $3000 a year, a forty-hour week and improved working conditions and personnel policies. Since the idea of abandoning their patients is abhorrent to most nurses, the unions have had to disclaim the strike as a bargaining instrument. They admit that the situation is difficult without it, but insist that they can win their objectives by arousing public interest in nurses' problems.

A newcomer to collective bargaining for nurses is the American Nurses Association, the largest of the nurses' professional organizations. After a fifty-year record of studies and vague recommendations on the subject of pay and

working conditions, the ANA startled the profession several months ago by urging its local units to begin at once a vigorous program of wage-hour negotiation. This could be a death blow to the unions, whose membership looks puny beside the ANA's 175,000, because the ANA units will probably insist on closed-shop contracts with hospitals.

The big question raised by this activity in the direction of higher wages is: Who's going to pay for them? Hospitals are already staggering under mounting costs. Since 1939 the operating expenses of hospitals in New York City have gone up at least 40 per cent, and probably much more, and information from other parts of the country indicates that a similar increase has taken place everywhere.

Most hospitals are not operated for profit. They are supported in part by philanthropy and government payments for care of the poor, but patients' fees are their major source of revenue, and at the moment they are meeting as much as possible of the rise in their expenses by charging patients more.

Both hospitals and nurses agree, however, that the limit to what patients can pay has nearly been reached and that some other way to cover cost rises must be found. The majority of hospital directors feel that, in the long run, increased government support of one kind or another—preferably more adequate reimbursement for the care of the indigent—is the solution. John H. Hayes, president of the American Hospital Association, complains that while charity cases cost his hospital, the Lenox Hill in New York, at least eleven dollars a day and sometimes as much as sixty dollars, the city pays him only four dollars and a half. If some branch of government would compensate hospitals in full for this work, administrators contend, they could pay as good salaries as any industry.

Another idea, in favor with both hospitals and nurses, is that higher salaries and other increases could be met, without overtaxing the individual patient's ability to pay, by higher hospitalization-insurance rates. With almost a third of the population enrolled in various hospital and medical-care plans, insurance has become a major factor in hospital finance. In 1945, Blue Cross alone paid hospitals more than $100,000,000. Proponents of higher rates argue that the 45,000,000 plan members could easily afford the few cents apiece necessary to raise hospital salaries all over the country.

One young woman, whose attitude might become more general among nurses if action is delayed much longer, takes this hard-boiled view of the financing of better salaries: "I don't care where the hospitals get the money to pay me a decent wage. They can hold a lottery or rob a bank, for all I care. Hospital boards have been taking credit for the charity of nurses for too long. If they can't pay me, I'll go somewhere else."

Positive as nurses are that better pay and hours will go most of the way toward ending the shortage, they insist with equal firmness that the profession will remain unattractive and fundamentally out of order until something is done about nursing education. Many of them look back on their three years of training with feelings ranging from regret to rage.

"I knew it wouldn't be a picnic," a recent graduate says, "but I didn't think it would be as bad as it turned out. We had to work so hard and were so worn out that two girls in my class got tuberculosis. We were on the run from seven in the morning until seven at night, except for a couple of hours off during the afternoon. We had only one class a day on hospital time and the other three on our off time. There was no social life. We never got a full day off; just one morning and one afternoon a week. The instructors ruled us with an iron hand. If we came in one minute late at night, we were restricted for a whole month, no matter what our excuse. The food was awful. In our first year, without enough training to help us meet even minor emergencies, we were put in charge of wards of forty or fifty patients. In our second and third years we had only three or four classes a week and spent all the rest of our time working in the wards."

This may explain why a portion of every class quits before graduation. In the words of one embittered nurse, "They find the realities of student life totally at variance with the ideals that caused them to join."

The charge that hospitals, which operate almost all nursing schools, overwork and underteach students is widespread. Some of them require fifty-three hours a week of practice—actual work in the hospital—beyond the time spent in classes. In a pamphlet it sends to prospective students, one of the best schools of nursing tells them that 5590 hours of their 6785-hour course will be spent in practice. Much of the blame for this condition may be placed on state regulatory boards, which set curriculums.

Hospitals assert that this is essential to proper nurse training, but nurses call it exploitation, holding that practice is required of students long after they have mastered their procedures and is a direct income to the hospital. They offer as evidence that the training itself is inferior the fact that although requirements for the Cadet Nurse program were set at the lowest practicable level, one out of every fourteen schools was judged unfit to participate.

The basic weakness in the system of instruction is, as Surgeon General Thomas Parran notes, "that most nurse-training schools are not primarily educational institutions, but merely apprentice-training adjuncts to hospitals." The resulting conflict between education and the care of the sick can be as bad for patients as for students when first and second year trainees, who have only a smattering of theoretical background, are put in sole charge of critical cases.

Nurses advocate Federal support of nursing education as the best way to achieve separation of schools and hospitals. Once that is accomplished, they hope that nurse training can be elevated to the college level, with a longer, more advanced and better-rounded course than the present one.

At this point they collide violently with the hospital directors, who are hell-bent in the opposite direction—toward less nursing education. The directors blame too much schooling for what they consider the contemptuous attitude of nurses toward bedside nursing.

The Greater New York Hospital Association is planning a campaign to lower the educational requirements in its state. It is confident that, besides turning out nurses who would be happy at the bedside, a shorter, more utilitarian course would attract a greater number of girls to nursing. If the campaign succeeds, similar efforts by other hospital groups may follow.

An alternate plan for filling out the thinned ranks of bedside nurses is the wider use of practical nurses—women whose training ranges from taking care of a sick relative to a year in an accredited school. Hospital directors are generally eager to try it, but nursing opinion is divided. Nurse leaders have professed some enthusiasm for the idea and even more for further and stricter licensing legislation. Working nurses are not so eager to embrace their less-qualified sisters. At the moment, however, any discussion of the subject is on a strictly hypothetical basis, because practical nurses who want hospital work are as hard or harder to find than professional nurses.

To date, no one has made much of an effort to lick the shortage on a national scale. Individual institutions are trying in various ways to recruit nurses, many of them by raising salaries, but the only raises big enough to have any considerable effect have been in California and New York City. California's progress is the result of a five-year uphill fight by the California State Nurses Association, which is presently signing contracts for minimum monthly salaries of $200, a forty-hour week and other long-sought improvements. Even these terms, however, are not so attractive as the ones the city of New York is offering in a desperate effort to rebuild its nursing staffs. New York now provides, among a number of unusual inducements, a starting salary of $2400 a year, plus laundry and two meals a day, a forty-hour week, automatic pay raises and twenty-five days of vacation with pay. Within a month after the program was announced, 500 new nurses had signed up. Other hospitals in the New York area are already following the city's lead, if only to hold the nurses they now have.

The national shortage will probably be with us for some time, and there is a strong possibility that it will get worse. Every sign points to a greater demand for nurses in the future. Increasing concern of the Federal Government with our health will create a large part of it. More than 100 bills on health and welfare were introduced in the last session of Congress, and those which have become law—the program of grants in aid for the care of mothers and children, the Mental-Health Act and the Hill-Burton Hospital Construction Act—will eventually require the services of many thousands of nurses.

It is estimated that 195,000 more hospital beds—a 39 per cent increase over the existing number—are needed right now, and the Hospital Construction Act authorizes the Government to help provide them by subsidizing the building of new hospitals, health centers and clinics to the extent of $75,000,000 a year for the next five years. This alone would almost double the need for nurses.

Industry is learning that good health among its employees is not only desirable but has a dollars-and-cents value, and unions are insisting on medical care for their members on an ever-wider scale, so the demand for industrial nurses will continue to mount. The Veterans Administration, although its nurse rolls have grown more than 100 per cent already, does not expect to reach its peak until 1975. Country-wide adoption of the forty-hour week in nursing, which seems inevitable, will drastically increase the need for nurses.

Along with these prospects for a towering demand has come the drop in enrollment in 1946. There is no indication at the moment that the enrollment this year will be any larger, and many hospital directors look for little help from the Cadet Nurses who will form the bulk of the 1947 and 1948 graduating classes. They doubt that a great many Cadet Nurses will go into active nursing.

Collaboration of nurses and hospital directors in a determined effort to clear up their problems and misunderstandings appears to be long overdue.

THE END

"A bully ship and a bully crew, Dooda! Dooda! A bully mate and a captain too, Dooda Dooda Day!"