

# THE NURSE SHORTAGE AND OUR MINISTRY

**H**ow can Catholic schools of nursing and the Catholic health establishment creatively approach the nursing shortage that is seriously affecting access to health care? Believing as I do that the shortage's resolution will require a fundamental transformation of nursing practice and education, I have organized this article around a model of change called "Four Requirements for Change." This planning framework, which is used by the Catholic Health Association (CHA):

- Analyzes pressure for change.
- Analyzes capacity for change
- Develops a clear, shared vision
- Presents a plan of action.<sup>1</sup>

## THE CONTEXT

The contemporary nursing shortage has stimulated discussion of the issues that face the nursing profession. Various authors—using the language of recruitment and retention, supply and demand, feminism and workplace culture—have tried to explain the disenchantment of practicing nurses with their discipline and the lack of interest among young people in it.<sup>2</sup> Other writers argue that nursing has failed to reinvent itself to appeal to a new generation of young people, that it must learn to present the profession in ways that will attract men or minorities.<sup>3</sup> Such experts express the commonly held belief that, if it is to compete for talented people, nursing must create

*Catholic  
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new images and better marketing plans. One writer goes so far as to argue that nursing's future is uncertain because it represents only one of many contemporary claims on the shrinking health care dollar.<sup>4</sup>

Whatever theory best explains the nursing profession's current status, there is ample evidence that it faces problems: declining enrollments in nursing schools, an aging workforce, the inability of health care organizations to fill vacant nursing positions, the reliance by those organizations on temporary staffing arrangements to provide care for very sick patients, and the early retirement of experienced nurses. These are not encouraging life signs.<sup>5</sup>

Many analysts of the crisis fault nursing's business plan. Few economic incentives exist to encourage young people to seek baccalaureate or graduate education to prepare for nursing careers. Today, almost 40 years after the discipline's leaders endorsed baccalaureate education as the desired preparation for entry into the practice of nursing, no more than a third of nursing school graduates enter the workforce each year with a baccalaureate degree.<sup>6</sup> A study recently conducted by the American Association of Colleges of Nursing revealed that fewer nurses with associate degrees are returning to school to earn baccalaureate degrees.<sup>7</sup>

New graduates find that, when it comes to assigning titles, responsibilities, and salaries, employers rarely discriminate among graduates with baccalaureate degrees, associate degrees, or diplomas from a hospital nursing program—as long as all the graduates have passed the registered nurse licensing examination. The scope of responsibility for nursing practice is shaped not by educational preparation but rather by possession of the license. As time goes by, new graduates learn that experience is not valued in the



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marketplace either. In most professions, experience and tenure ensure better working conditions, more interesting assignments, higher salaries, and preferential treatment. In hospitals, however, shift rotation policies and mandatory overtime affect *all* staff members. When a floor must operate shorthanded, informal scheduling practices (which may at other times reflect seniority) are not honored.

Moreover, the clinical career ladders that do exist for nurses have only a limited number of rungs. Career-oriented staff nurses soon hit glass ceilings. Those who seek more control of the scope of their work and schedules leave nursing altogether, seek positions in other institutions, earn graduate degrees, or seek positions in management. The physical, intellectual, and emotional demands of nursing require energy and endurance. Most staff nurses retire at age 55 because there is no tradition in the work culture to make adjustments in work demands as nurses age.<sup>8</sup> A nurse is a nurse is a nurse.

Workforce development is not valued in health care as it is in other industries. Writers on the topic have noted that, especially in hospitals, health care workplace and compensation policies are tailored to attract new graduates, not to retain experienced staff. Although hospitals do tend to emphasize the development of innovative recruitment policies during times of staff shortage, they usually shape their staff nursing roles, staffing patterns, and compensation packages around new graduates.

Since this practice does not make sense in the contemporary climate, it should be reexamined. Approximately 10 percent of the contemporary nurse force is under 30 years old.<sup>9</sup> The coming of managed care and the emergence of ambulatory and community-based delivery systems have changed irrevocably the practice of nursing and health care delivery. Inpatient acuity levels and the complexity of tertiary care delivery have increased. There are fewer new graduates, and, of course, those graduates are unprepared to assume immediate responsibility for patients in emergency rooms, intensive care units, operating rooms, neonatal nurseries, delivery rooms, and coronary care units. The high costs of recruitment, orientation, and turnover tend to support this observation.

The Catholic health care ministry is not exempt from the nursing crisis. Last year, CHA's Nurse Workforce Initiative Committee held a contest in which a \$10,000 prize was offered to the nurse in Catholic health care or nursing education who came up with the most innovative solution to the nursing shortage. In response, 350 nurses submitted thoughtful ideas, all based on their personal experiences.<sup>10</sup> These nurses

graphically described the shrinking of nursing staffs in their institutions, the increase in the use of temporary staffing agencies, and the ubiquitousness of mandatory overtime, concerns about quality of care, delays in nurse's ability to provide patient care, loss of morale, and significant communication problems. They also discussed the value of their work and their profession. Many likened nursing to a religious calling, describing their work as "ministry." Others said it was their commitment to meet the spiritual needs of their patients, even in periods of inadequate staffing, that helped them through difficult days. They wished for an environment that would nurture and enhance their spirituality.

### PRESSURES FOR CHANGE

No one denies that the current nursing shortage is a source of concern. The fact of the shortage has been fully documented, discussed, and disseminated by nursing and health care organizations, labor unions, and the federal government.<sup>11</sup> A sizable body of evidence documents the state of professional nursing in the United States.<sup>12</sup> Even those writers who question the use of the term "shortage," or find nurse shortages to exist only in certain specialized areas, or, if they do see a general shortage, disagree about its causes, acknowledge that *something* is wrong.<sup>13</sup> The aging of society, the graying of the baby boomers, and newer concerns engendered by terrorism and the threat of war increase the pressure to address problems—in both the nursing profession and society at large—that contribute to the nurse shortage.

Amazingly, a consensus is growing concerning the definition of the shortage itself. The Nurse Reinvestment Act of 2002 captures this sense of agreement in the titles "Nurse Recruitment" and "Nurse Retention."<sup>14</sup> Pressure for change can be experienced in both nursing schools and the places where nurses practice. An analysis of recruitment efforts yields descriptions of the general population and the people who select nursing as a career pathway. Nursing schools are at the center of discussions of recruitment because such institutions are the gateway to the profession. On the other hand, discussions of retention tend to focus on the workplace and the conditions of nursing practice; they rely heavily on studies of hospital nursing practice because 60 percent of the nation's 2.7 million nurses work in hospitals.<sup>15</sup>

Nursing schools in Catholic hospitals, colleges, and universities feel pressured to change because their enrollments have fallen dramatically over the past six years.<sup>16</sup> In the past, the public responded to recruitment methods that included financial assistance, but this is no longer the case. Cuts in

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academic budgets have increased faculty workloads and reduced morale.<sup>17</sup> A shortage of nursing school faculty contributes to the tension.<sup>18</sup>

Inadequate and unstable staffing patterns can be found in all systems, hospitals, and long-term care institutions, even those under Catholic auspices. This is a concern because the nurse supply affects the delivery and the quality of care.<sup>19</sup> Supplementing the workforce with staff from agencies negatively affects continuity of care and strains budgets. No one thinks that hiring temporary staff correctly addresses the nursing crisis; and most employers would like to be out of the business of hiring temporary nurses.

Most hospitals and long-term care centers have—either alone, in concert with, or in competition with other area providers—changed *something* in an effort to attract or retain nurses: salaries, bonuses, work hours, child care arrangements, scheduling, educational benefits, or parking privileges. Labor unions have increased their efforts to organize nurses, using issues such as mandatory overtime and the increased use of non-licensed persons in care delivery roles.<sup>20</sup> CHA has responded to the nurse shortage by engaging its board of trustees and membership in dialogue, by publicizing successful efforts in addressing the problem, by forming coalitions with the deans of Catholic colleges and universities, and by joining with nursing organizations and other health care groups to support passage and funding of the Nurse Reinvestment Act. The nursing shortage is a source of pressure.

#### CAPACITY FOR CHANGE

If our ministry is to create a capacity for change, it must look beyond the data and examine the culture of nursing in Catholic health and educational environments. Analysis of this kind will require a rethinking of assumptions and beliefs, as well as a willingness to take risks concerning the recruitment and education of nurses. Analysis may lead Catholic health care systems to examine the roles nurses play in the delivery of care.

The *Harvard Business Review*, several years ago, published a provocative article on the use of “problem solving” and “adaptive change” methodologies in complex organizations that compete for scarce resources.<sup>21</sup> The article’s authors observed that administrators—and particularly those in health care organizations—are more comfortable with problem solving than with adaptive change approaches and, therefore, tend to use them in most situations. However, the history of nursing seems to indicate that the contemporary nursing shortage calls for adaptive thinking, not problem solving.

Ample contemporary evidence indicates that

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technical adjustments and problem solving have not worked. The cyclic history of nursing shortages, on the other hand, suggests that the issues surrounding nursing education and practice are deeply rooted in society, in the economy and in the profession itself. Nursing education and practice, having developed over long periods of time, are rich with cherished rituals linked to professional and institutional cultures, beliefs, and values. The curriculum and systems of nursing care delivery are also influenced by external norms, standards, and regulations. Discussion of the shortage crisis among those affected by it—administrators, faculty, students, physicians, nurses, patients, regulators, accreditation agencies, and third-party payers—reveals the complexity and interdependence of modern educational systems and health care delivery. Although such discussion facilitates value clarification and new ways of thinking and operating, it also intensifies stress. Merely talking about familiar patterns does not itself change things for the better; indeed, it usually evokes anxiety because all involved fear that new realities will require talent, skill, or attitudes that they may not possess. Change processes often dissolve when participants are afraid to let go of something they value. Faculty may hesitate to commit themselves to an untested curriculum, for example, or nurses may be wary of a novel health care delivery system or staffing program.

Creating capacity for change takes more time and more participant engagement than problem solving. Health care administrators and clinicians place economic value on the use of time. The pace of contemporary health care, especially in managed care environments, often requires that decisions be made before all data are available. The application of adaptive methodologies calls for effort and sacrifice because changing the system of nursing education and the models of nursing care delivery will affect the identity of the delivery system, the quality of patient care, and the mission. However, the systems are broken, and leaders and nurses must investigate their capacities to change.

The *Harvard Business Review* writers cited earlier suggest that the first step in assessing capacity for change is to go, metaphorically, “up on the balcony and look at the field.” Patterns emerge when seen from such a viewpoint. What might happen, for example, if emergency room nurses and critical care coordinators were to view ER waiting rooms “from the balcony”? What if deans and faculty of nursing schools viewed the entire curriculum “from the balcony”? The *Harvard Business Review* writers advise those who use adaptive processes to pay attention to

the conflicts that emerge during discussions. "Disputes over seemingly technical issues such as procedures, schedules, and lines of authority were in fact proxies for underlying conflicts about values and norms."<sup>22</sup> If conflict and competing perspectives can be tolerated, managed, and integrated by the group, they can often provide the creative force for dialogue. Many of the nurses who responded to CHA's call for innovative ideas discussed these conflicts and the ways they affected nursing education and patient care in Catholic health care.

Perhaps it is obvious from this discussion that adaptive methodologies are not "top-down" management. Adaptive methodologies give voice to the people who are at the foundation of the organization—in this case nurses. Elaine Hlopick, RN, MSN, the nurse selected as the winner of CHA's competition for the best idea to solve the nursing shortage, proposed that CHA and each Catholic health care facility institute a nurse advocacy program. (See Julie Minda, "Making the Difference in Patient Care," pp. 43-44, 66.) Hlopick believes that health care would be enhanced if nurses were at the policy tables.

#### A CLEAR, SHARED VISION

Dialogues concerning the nurse shortage should result in the development of a clear, shared vision of nursing for the new millennium. This stage of the process will lead to the writing of goals, objectives, and initiatives that describe new patterns and modes of nursing education, as well as new roles and responsibilities for nurses in practice. However, such a vision cannot by itself bring into being the new reality of nursing education and nursing practice. If the vision is to be implemented, it must be clear not only to nurses but also to all those who work with them in nursing schools and clinical environments. The vision statements arrived at should not require complex explanations. If the vision is not clear, it cannot motivate, inspire, or be shared.

Catholic schools of nursing and health care organizations have the potential to inform their vision statements with new meaning. Many of the nurses who responded to CHA's request for ideas spoke of nursing as a "calling," a "vocation," a "ministry," or the "work of the Spirit." These ideas about the nature of nursing have implications for nursing education and practice. People preparing to engage in a ministry approach their studies differently than those preparing for careers. Faculty members who teach their students to express a calling look to the Catholic tradition as well as to the body of nursing science for inspiration, values, and seminal ideas. Nurses with a vocation bring a different

level of meaning to the work of nursing. For them, nursing is always more than a job.

In the Catholic tradition, caring for the sick and comforting the dying are works of mercy, rooted in the Scripture narratives of the healing ministry of Christ. More than half of the miracles recorded in the Gospels are stories of healing. Jesus is often described as restoring sight, enabling the crippled to walk, and freeing those troubled by "unclean spirits"—the biblical term for mental illness and addiction. Jesus also ensured that the hungry were fed, that people were instructed and inspired to change their lives, and that unjust social structures were identified and overcome. The Catholic tradition teaches nurses, physicians, and other members of the helping professions to see Christ in their patients. Healing in this tradition is holistic, seeking to alleviate suffering in its physical, psychological, and spiritual dimensions. The healing is also social because it works to overcome the causes of suffering, which are rooted in unjust social and economic structures.

The values flowing from the Judeo-Christian view of the person are relevant for nursing practice. These values, not always embraced by U.S. society at large, flow from a belief in the dignity of the human person. The ethic of Catholic nursing is an ethic of respect for life from conception to natural death. Illness, disfigurement, vulnerability, pain, aging, addiction, and disability are conditions that evoke understanding, compassion, care, and advocacy. Education for ministry transcends the study of physiology, nursing, psychology, and public health. In Catholic settings, both faculty and students learn how Christian anthropology, philosophy, theology, social and biomedical ethics, economics, and the social encyclicals contribute to the understanding of people's needs, one of which is health care. These studies also address the dignity and rights of workers and the quality of the workplace.<sup>23</sup> Embedded in this understanding is a special recognition of the poor. In the Catholic tradition, the poor have a unique claim on the resources of the community. For nurses who espouse this tradition, acting as advocates for national health insurance and working to achieve access to care for all are more than good business strategies. Advocating justice for all, choosing the fundamental option for the poor, is at the core of Catholic health care ministry.

Catholic health care and nursing education are carried out in the 21st century as part of the U.S. health care and educational establishments. Like their secular counterparts, Catholic institutions and programs struggle to reduce costs and balance operating budgets. Adaptation to secular

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values, competitive business and managed care practices, and mergers and acquisitions to gain larger shares of the market confront and may even erode fundamental values and Catholic identity. In the health care field, becoming comfortable with such terms as "product lines" and "covered lives" as metaphors for the care of sick people is also evidence of this corruption of values.

Some experts trace the origins of the current nursing shortage to the business-driven downsizing of the 1980s and '90s.<sup>24</sup> There is little doubt that public recognition of nurses and their contribution to patient care has been diminished by downsizing, devolution, and the increased focus on profit-oriented business strategies. Physicians and other clinicians have also seen diminishment of their roles and authority. Although the Catholic tradition encourages Catholic institutions to be accountable, transparent, and good stewards of the resources under their care, it also challenges Catholic health care to "balance margin with mission."

#### A PLAN OF ACTION

While a plan of action must come from local stakeholders, certain themes from the Catholic tradition can help nurses find or rediscover meaning in their work. These values include respect for the dignity of persons (patients and workers), humanistic applications of scientific knowledge and technology, special attention to the poor and their access to health care and other human goods, compassion, stewardship of resources, justice, and concern for the common good. These elements contribute to a culture of life and create a healing environment.

The women and men religious who founded Catholic hospitals and nursing schools in the United States also established school systems and social service agencies. Each of these organizations strives to create a better world and seeks to enhance the lives of the people it serves. When St. Paul discusses the coordination of body parts and employs the metaphor of gifts given for the good of the community, he is describing a model for today's Catholic health ministry. What if Catholic hospitals were to actively collaborate with Catholic universities and colleges to educate nurses for the ministry? Imagine Catholic parishes, schools, hospitals, long-term care institutions, and charitable agencies consciously working together to build up the body of Christ. Suppose the importance of nursing as a vocation was emphasized not only in Catholic colleges but also in grade and high schools and religious education programs. What if parishes and dioceses assisted nurses in their studies and their practices? Scholarships to encourage nursing students to

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work in Catholic health care and nursing schools; continuing education programs that explore moral and social issues from a Catholic perspective; and retreats, days of recollection, and support groups that foster the spiritual development of nurses—all these illustrate the point.

In the immigrant church, a natural continuum linked parishes, Catholic charities, Catholic hospitals, and schools. Business partnerships are common in contemporary health care. Catholic health care organizations could, by partnering with other church institutions, create new avenues for cooperation, collaboration, and transformation. More than a decade ago, the late Cardinal Joseph Bernardin was wont to describe Catholic health care as "a work of the Church." If this insight is true, a true solution to the nursing shortage will transcend the profession, the schools, and the hospitals and tap into the hearts and the resourcefulness of the Catholic community. □

#### NOTES

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2. See, for example, L. H. Aiken, et al., "Nurses' Reports on Hospital Care in Five Countries," *Health Affairs*, vol. 20, no. 3, pp. 43-53; AHA Commission on Workforce for Hospitals and Health Systems, *In Our Hands: How Hospital Leaders Can Build a Thriving Workforce*, American Hospital Association, Chicago, 2002; N. Betz, "Women's Career Development," in F. L. Denmark and M. A. Paludi, eds., *Psychology of Women: A Handbook of Issues and Theories*, Greenwood Press, Westport, CT, 1993, pp. 627-684; and C. Fagin, *When Care Becomes a Burden: Diminishing Access to Adequate Nursing*, Milbank Memorial Fund, 2001, available at [www.milbank.org/reports/010216fagin.html](http://www.milbank.org/reports/010216fagin.html).
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5. See, besides the sources already cited, G. Bednash, "The Decreasing Supply of Registered Nurses: Inevitable Future or Call to Action," *JAMA*, vol. 283, no. 22, pp. 2,948-2,954; and P. Buerhaus, D. Staiger, and D. Auerbach, "Implications of an Aging Nurse Workforce," *JAMA*, vol. 283, no. 22, pp. 2,948-2,954.
6. E. Spratley, et al., *The Registered Nurse Population, March 2000*, U.S. Health Resources and Services Administration, Washington, DC, September 2001, chart 17.
7. American Association of Colleges of Nursing, "Though Enrollments Rise at U.S. Nursing Colleges and Universities, Increase Is Insufficient to Meet the Demand," December 20, 2002, available at [www.aacn.nche.edu/media/newsrelease/enr102.htm](http://www.aacn.nche.edu/media/newsrelease/enr102.htm).
8. Kimball and O'Neill.

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