



‘Do we really need all these nurses?’

Time to stop the ‘surge-and-cut’ approach

By Dean Sioban Nelson, RN, PhD

If there’s one thing nurses know, it’s that tough economic times tend to mean cuts to the profession. This has been the pattern over the decades, where nursing from Toronto to Manchester, from Madrid to Sydney, from Los Angeles to Sao Paulo, has all too frequently been the health-care service sector that takes the hardest and deepest cuts when the economy, and our health-care budgets, take a nose dive.

There is an obvious reason for this. Nursing salaries account for a major percentage of health-service budgets. As CEOs and CFOs are driven to reduce spending and create efficiencies, the first question that comes to mind is usually: ‘Do we really need all these nurses?’

This is at one level a legitimate question. The drive to answer it has spawned an entire science that measures workload and efficiency, examines the relationship between number and skill level of nurses on patient outcomes, and analyzes the relationship between staffing profile turnover and burnout. The Lawrence S. Bloomberg Faculty of Nursing, through its nursing research unit, has made this Faculty one of the top sites in the world for health-services research in nursing and health care. This unit was founded in 1990 by Dr. Linda O’Brien Pallas and is now co-led by Dr. Diane Doran, along with colleagues in health-services research such as Dr. Ann Tourangeau and Dr. Linda McGillis Hall. Like-wise Dr. Sean Clarke, the RBC chair in cardiovascular nursing research, has been a major contributor to the field of outcome studies, researching nursing and workforce characteristics and examining their effect on patient outcomes.

But the question ‘Do we really need all these nurses?’ is not only an empirical one that good research can answer. It is also a rhetorical question and as such it reflects a worrying attitude to nursing that has bedevilled the profession for more than a century. Even today, when we finally have the data to show quality nursing staff is strongly correlated with patient outcomes—including mortality—the ability to answer that question remains one of nursing’s great challenges. I would suggest the tradition of seeing nursing as resource to be built up in good times and trimmed back in lean ones comes from the very beginning of professional nursing, and the development of hospitals across the world staffed by nursing students.

For a full three-quarters of the 20th century (and more in many parts of the world), nursing student labour fuelled the engines of the modern hospital. Hospitals hummed with industrious nurses cleaning

and washing patients, bed-making and military order and cleanliness ensuring everyone was combed, tucked and compliant, sitting up for inspection during medical rounds and visiting hours. Behind the scenes reminiscent of the hospital in medieval and early modern times, where nurses wove the linen to make the bedding and robes of the patients, student nurses rolled bandages, mended surgical gloves, sterilized and packaged all the sterile materials and packs, sorted laundry items, stocked and restocked drugs and supplies, cooked special diet meals in ward kitchens, distributed all meals and fed all patients. At the same time the hospital was humming with feminine industry (and they were all women), nurses managed the wards, their patients, the operating room, the hospital budgets and overall operations.

In addition to this, there was clinical work, and it was no less challenging or cutting edge than it is today. Early transfusions involved a team of six nurses managing the two patients, careful handling of the delicate glass equipment and ensuring constant flow to prevent clotting. What is a simple dipstick reading today in the past involved a chemistry kit in the scullery or treatment room. Here nurses boiled urine briefly on a Bunsen burner to assess proteinuria (excess protein), and conducted a battery of other chemical tests (involving Condies Crystals or Fryer’s Balsam) to measure each element. Hypodermic injections involved oil lamp heating of solutions and nurses did a great deal of dispensing work in the everyday course of caring for their patients. Pre-antibiotic era nursing meant lengthy and complex irrigations of wounds and douchings. Nurses also possessed a skill set largely unknown today. Fever nursing was a speciality and the complex pattern of peaks and lows and crises that were the natural and distinctive trajectory of specific fevers required great skill to manage. In fact, typhoid nursing was a sub-speciality all of its own and a good nurse’s ability to manage the fever and prevent the often fatal complication of gut perforation was highly lauded by colleagues and patients alike.

When students graduated from their programs and completed their staff nurse year, they made their way into the few senior roles that existed within the hospital sector or moved into the community, public health and home nursing sectors. In the first half of the 20th century it was in these non-acute domains that experienced nurses held their own. As public health or school nurses, or working in the long lost fields

of industrial nursing and private duty nursing, these experienced and educated nurses were linked to their communities and provided education and leadership from the mother and baby clinic to the factory floor. Back in the hospitals, the priority was often volume rather than quality. High attrition rates were considered a normal part of nursing as young girls were worked hard and long, with poor remuneration and little respect for their contribution to patient care. As one colleague of mine was informed in the 1970s at the ‘welcome’ address by the director of nursing at an Australian hospital school, ‘No-one asked you come and you are free to leave if you don’t like it’. This ‘take-it-or-leave-it’ attitude to staffing has left a heavy legacy on nurses over the years. High burnout, workplace injuries and poor health status have been the norm for hospital-based nurses around the world for far too long.

It also has led to the idea that nurses are in a sense a disposable resource, replaceable and interchangeable like frontline soldiers in early 20th century warfare—a necessary expenditure with supply being the critical element for success. But the military is certainly ahead of the health-care sector in its 21st century realization that soldiers are an investment—and a costly one to replace. Despite clear advances in nursing’s position in many parts of the world, including Canada, with each turn of the economic screw nurses feel the vulnerability of the sector and the anxiety that once again we may not have learned the lessons of history. As my colleague and friend, journalist Suzanne Gordon says, “Nurses are not a faucet to turn on when you need them and turn off when you need the budget to balance.” It is this kind of thinking that has created desperate shortages in successive waves over the 20th century. Every time we cut nurses, we hit a pipeline. It is not today’s nurses we affect but the next 10 years’ worth of nurses. In five years time, with normal attrition and the retirement of the boomers, there will inevitably be more panicked calls for more nurses once more—but where will they be? Every time nursing jobs are cut, smart young high school students watch, learn and choose other careers, nursing schools don’t fill quotas and have to cut staff or move into graduate programs or other areas, and lose the capacity to take more undergraduate students. Meanwhile, health-service providers cut services (along with nurses) and pressured acute care units, and community providers functioning with fewer nurses and busier services, can’t cope with the extra demands of students. So they cut places. It then becomes impossible to increase the number of nursing seats and we create a vicious cycle. Meanwhile, entrepreneurial governments and private providers scour the world for nurses, causing more inequity and suffering in their wake as they contract large numbers of nurses from countries that can ill afford to lose them.

It’s inefficient and unethical to continue this surge-and-cut approach to nursing that is so much the norm around the world. But sadly, if there is one thing we must learn from history, it is that we don’t learn from history. In the 1930s, the prime role for a well-educated nurse was in the community, in public health and private duty nursing. When the Great Depression hit in 1929, one of the things it swept away was the domestic sector of the economy. People simply did not have the money to pay for private duty nurses. This failure led to great hardship among nurses, but it also led to a major shift in the structures of our health-care system, where finally the middle classes embraced the hospital system as the provider of their health care. Home surgery ceased, home deliveries of babies declined and hospital care became the core of all health care. It is worth reflecting on this outcome. When the cuts of the

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’80s and ’90s happened in most parts of the world and in-patient care days dropped dramatically over the following decade, it was to the homecare sector that much of cost burden shifted, to patients and their families directly. The growth of personal support workers (PSWs) and a variety of aides working in homecare and in the community has been to a great extent financed, directly and indirectly, out of the private purse.

What are the implications for health care with today’s economic crisis? There is no doubt that despite the widespread pain, the cuts of the ’80s or the ’90s created enormous efficiencies. There was generally capacity to reduce length of stay without affecting quality or outcomes, there were opportunities to advance ambulatory care and important opportunities to be seized in the support of chronic illness at home. On the other hand, the scenario facing us today is that we have ‘lean and mean’ health-care systems with virtually no ‘fat’ to trim, the homecare sector is overwhelmed by increased service demand without corresponding increased funding, and the private capacity of citizens to fill in the gaps through PSW employment or other private means has been drastically reduced. Meanwhile, the rise in chronic illness that is accompanying the demographic shift, and the gloomy retirement projections of our RN workforce, makes this a critical juncture for the future of our health-care system’s capacity to deliver care over the next 20 years. If we cut off nurses now, we will feel it for the next decade—and it will be bad.

Once again we face the critical question: ‘Do we really need all these nurses?’ We do. We need new graduates developing their skills and knowledge in a safe and supportive environment so they do not burn out and leave. We need advanced practice nurses bringing creative and cost-effective solutions to complex system problems. We need nurse practitioners to provide access and keep costs down to the great number of people the system currently fails. We need them to prevent illness, manage chronic disease and to keep people well and safe in the community. We need them to track us through the highly dangerous space of the acute inpatient sector and ensure that we avoid life-threatening complications, are well informed and educated about our treatment and its consequences, and go home in the best position possible to undertake self-management of chronic conditions. To cut nurses is to cut the system’s capacity to do this now and into the future. It is in everyone’s interest to make sure our decision-makers understand this and are held accountable for the consequences of their actions. As members of the profession and members of the public, it is our job to ensure this. ✚

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