Hospital Speedups and the Fiction of a Nursing Shortage

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Abstract

In recent years, hospital managers and public policy makers alike have focused considerable energy on the prospect of an imminent national shortage of hospital nurses. In response, officials have urged both increased funding for nursing schools and increased importation of foreign nurses from the Philippines and other developing countries. The study below documents that this policy direction is fundamentally misguided. There is no shortage of nurses in the United States. The number of licensed registered nurses in the country who are choosing not to work in the hospital industry due to stagnant wages and deteriorating working conditions is larger than the entire size of the imagined "shortage." Thus, there is no shortage of qualified personnel—there is simply a shortage of nurses willing to work under the current conditions created by hospital managers. Extensive survey data among both currently working nurses and those who have left the profession indicate a very strong consensus regarding the causes and potential solutions to this problem. Nurses will return to hospital work if the wages are improved and, above all, if nurse-to-patient ratios are restored to a level at which RNs believe they can provide professional care. If conditions are improved, enough nurses will be drawn back into the hospital industry to solve the alleged shortage. If, on the other hand, conditions remain stagnant or deteriorate further, new graduates of nursing schools will continue to abandon the profession in large numbers, and no increase in new graduates will suffice to keep hospitals adequately staffed. In a final section of the paper, a survey of magnet hospitals indicates that the industry can afford to implement improved staffing levels while remaining economically competitive.

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In the past few years, the hospital industry has seen an increasingly desperate shortage of nurses across the country. Management seminars and academic journals alike are clogged with accounts of short-staffing and strategies for recruiting more nurses.

Hospital managers and government officials have focused on a series of strategies for expanding the supply of nurses coming into the profession. New resources have been devoted to increasing enrollments in nursing schools. Public relations campaigns have been launched to improve the public perception of nursing as a prestigious occupation. The industry has redoubled efforts to recruit nurses from developing countries, or from poorer parts of the U.S. population. And finally, hospital administrators have looked to loosen licensing requirements so that more of nursing work might be done by less-trained staff who are cheaper and available in greater supply. In addition, many hospitals have sought to attract or retain existing nurses by creating more flexible and attractive work conditions within the limits permitted by current staffing levels. Unfortunately, all these strategies seem doomed to failure.

By contrast, nurses themselves have called for more dramatic efforts to improve working conditions-both to make their own lives more manageable and to attract more nurses into the hospital industry. These concerns focus above all on the need for increased wages, improved nurse-to-patient staffing ratios, and greater respect on the job. Unless these problems are fixed, nurses and their unions argue, no amount of increased nursing students or recruitment from abroad will ultimately solve the hospital industry's staffing problems.

In the essay that follows, I argue that the nurses' views are essentially correct, and that management solutions that fail to significantly improve both wages and staffing levels will have little or no impact on the national problem. I begin by documenting the surprising fact that the number of working-aged registered nurses who are choosing not to work in the profession they trained for-that is, who have left the hospital industry in frustration over job conditions-is significantly larger than the entire national "shortage." Thus, if-job conditions were sufficiently improved, the shortage could be entirely solved without any increase in nursing students or foreign relations campaign recruitment. Conversely, if job conditions remain as they are no public relations campaign can lure enough recruits into the profession, or prevent those in it from leaving.

The current nursing shortage is the result of management practices adopted in the 1990s, including significant cutbacks in nurse staffing, increases in patient loads, and a near-freeze in average wages. The solution to the current crisis can only come through revising the management practices that caused it. This conclusion is based on an extensive analysis of nurse surveys, man-

agement surveys, hospital work conditions, and patient outcomes. In what follows, I track the recent changes in nurses' working conditions and reasons for staying in or leaving the profession. I also identify a set of best practices as embodied in the "magnet hospitals" cited by the American Academy of Nursing (AAN) as models for recruitment and retention of RNs. For the past twenty years, the AAN has employed extensive measures of working conditions, nurse satisfaction, and vacancy and turnover rates in order to identify a small group of elite hospitals whose nursing practices serve as "magnets" for recruitment and retention. The impact of these practices is measured through a number of studies, as well as a 2002 survey of magnet hospitals carried out by the University of Oregon's Labor Education and Research Center. Finally, I present evidence suggesting that adopting better practices is an affordable strategy for most hospitals. Thus, there is a clear, if difficult, path forward out of the nursing crisis. And it must begin with recognizing that the crisis is not an insufficient supply of trained nurses, but that working conditions have become so degraded as to drive hundreds of thousands of trained professionals out of their chosen careers.

The Scope of the Nursing Shortage

On and' off for the past twenty years, hospitals across the U.S. have struggled to attract and retain an adequate nursing workforce. Recently, however, the nation's hospitals have faced a more pronounced staffing crisis. Fully 89 percent of hospital CEOs reported "significant workforce shortages" in 2001 (American Hospital Association 2002, 6). On this basis, U.S. Secretary of Health and Human Services Tommy Thompson has warned that the country faces "a severe nursing shortage" (U.S. Department of Health and Human Services 2002).

The total number of RN positions that currently stand vacant is estimated at between 126,000 and 153,000 (American Hospital Association and the Lewin Group 2001, 1; O'Leary 2002; First Consulting Group 2001, 29). One in seven American hospitals is already reporting a severe nurse shortage, with vacancy rates exceeding 20 percent (First Consulting Group 2001, 14-15). The shortage of RNs has already debilitated hospitals' ability to provide quality health care. For instance, in 2001 (American Organization of Nurse Executives 2002, 11; First Consulting Group 2001, 24-25):

- 25 percent of hospitals were forced to close beds due to insufficient nursing staff.
- 19 percent of hospitals increased waiting time for surgeries, and 10 percent were forced to cancel surgeries.

- Over one-third (34 percent) of hospitals reported increased patient complaints or decreased patient satisfaction due to nurse shortages.

The failure to recruit new nurses also means that the RN population is aging rapidly. Between 2010 and 2020, tens of thousands of RNs will retire, and the single largest group of RNs remaining in the workforce will be those aged 50-60 (Buerhaus 2002, 5; Buerhaus, Staiger and Auerbach 2000, 2948-2954; Spratley et al. 2000, 7). This wave of retirees comes at exactly the worst time—as the aging baby boom generation enters its own retirement years, creating a massive increase in demand for nursing care. The collision between greatly increased demand and greatly decreased supply of nurses portends a shortage of crisis proportions. According to widely accepted projections, by the year 2020 the nation will face a 20 percent gap between supply and demand of nurses, representing a shortfall of approximately 300,000-400,000 RNs (O'Leary 2002, 1; Nursing Executive Center 2001, 11; American Organization of Nurse Executives 2000, 59).

What caused the nursing shortage?

The current shortage is a direct result of hospital management policies originated during the 1990s. The American Organization of Nurse Executives itself has given one of the best concise histories of the crisis (American Organization of Nurse Executives 2000, 6):

> In the early 1990s, managed care penetration increased dramatically across the country. Capitated payment systems drove decreases in the length of inpatient stays.... Many of the decisions made at that time, including those which responded to decreasing patient days, resulted in nurse layoffs or unusually low rates of nurse hires. New graduates had difficulty finding employment in hospitals, and schools of nursing subsequently experienced declining enrollments. In an additional strategy to slow health care cost growth, many hospitals instituted restructuring and redesign of their care deliver systems, reintroducing non-RN caregivers to their skill mixes, including unlicensed assistive personnel... As recruitment needs declined, the commitment of resources by facilities and educational institutions to the infrastructure that supported the nursing workforce, such as specialty training programs and investments in mentoring new graduates, declined proportionately.

As a result, the nursing profession faces a crisis on multiple fronts: shortages of hospital nurses, cuts in faculty and infrastructure limiting enrollment in nursing schools, and continuing high numbers of RNs who are choosing

not to work in the profession. The solution to these problems must come from changes in the same management practices that created the crisis in the first place, and that alone can improve work conditions and enhance the attractiveness of nursing as a profession.

A Nursing Shortage? Or a Shortage of Nurses Willing to Work Under Current Conditions?

Despite the dire projections, there is not an actual shortage of nurses at this point. Instead, there is a shortage of nurses willing to work under the conditions currently offered by the hospital industry. In the year 2000, there were nearly 500,000 registered nurses in the U.S. who were choosing not to work in the profession for which they trained. This number includes 136,000 nurses employed in non-nursing occupations. There is reason to believe that many of these nurses might return to the profession if conditions on the job were improved, as their reasons for having left nursing work are primarily to do with deteriorating conditions on the job. Over one-third (35.4 percent) left for better salaries; 45.7 percent cited more convenient hours in their new jobs; 19.7 percent were concerned about workplace safety in nursing, and 8.4 percent (or over 11,000 RNs) reported that they left the profession because they felt they were unable to practice nursing on a professional level (Spratley et al. 2000, 71). An additional 120,000 nurses are entirely unemployed, but under the age of 60 and have no children living at home. Together, these two groups constitute a reserve of over 250,000 licensed registered nurses who would be potentially available for work if the conditions were right—well more than the total size of the current nurse "shortage" (Spratley et al. 2000, 72). At the most conservative measure—assuming that the only realistically available RNs are those currently working in other occupations who are not disabled and have up-to-date nursing skills—if nursing were made more attractive as an occupation, the country could immediately fill two-thirds of the needed positions. Under very realistic scenarios, an improvement in working conditions for hospital RNs could, in and of itself, enable hospitals to fill every one of the vacant nursing positions in the country, more or less immediately.

In brief, the health care industry has created its own Catch-22 conditions worsen, more nurses opt out of the profession, creating shortages on hospital floors and resulting in even greater speedups, stress, safety worries, and similar conditions that drive additional nurses out of the industry. As long as work conditions do not improve, the industry will fail to retain qualified RNs. On the other hand, if conditions improve, there are enough qualified RNs in the country who are most likely prepared to return to work that the so-called "shortage" could evaporate in little time.

Table 1
Registered Nurses Not Working **in** Nursing, 2000

RN's Employed in Non-Nursing Occupations	135,696
Nursing skills out of date	23,578
Disability/Illness	9,438
Total, Employed in Other Occupations But Potentially Available	102,680
As % of 126,000 vacant RN positions	81.5%
As % of 153,000 vacant RN positions	67.1%
Unemployed RN's	323,453
Under Age 60, No Young Children	118,210
10% of Those Over Age 60	10,210
50% of Those With Young Children	15,206
Total, Unemployed But Potentially Available	143,626
As % of 126,000 vacant RN positions	195%
As % of 153,000 vacant RN position	161%

Source: Author's calculations based on The Registered Nurse Population, March 2000, Tables 33-34, pp. 71-72 .
Note: Employed RN's with out of date nursing skills and those with disability or illness may overlap. They are counted here as if there is no overlap, for the sake of conservative estimates.

Listening to Nurses: Dissatisfaction and Burnout on the Job

Nurses may constitute the single most dissatisfied profession in the U.S. According to the Department of Health and Human Services, only two-thirds of registered nurses (69.5 percent) reported being even "moderately satisfied" with their jobs (Spratley et al. 2000, 30-31). Moreover, nurse dissatisfaction is surprisingly consistent across age, salary, years of experience, and education. The problem is not in the person; it is in the job. When one recent survey asked nurses to describe how they felt at the end of a day, nearly 50 percent reported feeling "exhausted and discouraged." Forty percent felt "powerless to affect change necessary for safe, quality patient care"; 26 percent felt "frightened for [their] patients," and 24 percent felt frightened for themselves. Perhaps most disturbingly, 55 percent of nurses reported that they would not recommend a nursing career to a child or friend (American Nurses Association 2001).

While nurse dissatisfaction is endemic, survey after survey reports that nurses would like to continue working as nurses—if only the job conditions

were improved. The American Organization of Nurse Executives, for instance, reported that four out of ten working RNs (43 percent) say that they plan to leave their current positions within the next three years. However, the authors observe that

> many RNs who plan to leave their present jobs in the next few years say they would consider staying—and many others who have left nursing altogether say they would consider returning—if certain conditions were met. Among these conditions are better compensation, an improved work environment, better hours, and more respect from management. Nurses with no plans to leave echo many of these same sentiments. (American Organization of Nurse Executives 2002)

Mistaken Focus on the Pipeline

In recent years, more than half the states in the country have enacted laws to address the nursing shortage; two-thirds of these are designed to encourage more students to go into nursing programs (Norris 2002, 1). Similarly, the federal government announced a program that expanded its financial support for nursing schools (U.S. Department of Health and Human Services 2002). "It's absolutely critical that we encourage more of our nation's students to choose careers in nursing," Secretary of Health and Human Services Tommy Thompson has explained. "[We] want students to realize that nursing is an exciting and satisfying career that makes a difference in people's lives."

While perhaps well-intentioned, these initiatives are misguided. As long as the conditions on the job are not improved, expanding nursing schools amounts to little more than a bait-and-switch strategy , hoping that student nurses will not discover the downside of their profession until it is too late. Inevitably, however, even beginning nurses will start thinking about getting out once they confront the realities of their chosen occupation. "Nurses leave nursing after one year because it is so hard and too fast paced," explained one hospital's Human Resources director (First Consulting Group 2001,
16). Under these conditions, a strategy of expanding the pipeline is akin to pouring water into a bucket that has a gaping hole in its bottom, wondering why it never seems to fill up.

Key Factors and Best Practices

There is little mystery as to which factors are most central to recruitment and retention of nurses. While nurses express dissatisfaction regarding a wide range of work conditions, there is a short list of just a few key issues that are consistently ranked as the most important for nurses deciding whether to

take, or remain at, a job. Compensation and staffing levels are far and away the most important. Hospitals that have adopted policies that effectively address these issues enjoy lower turnover, higher job satisfaction, and improved patient care.

Table 2
Views of Nurses Considering Leaving the Profession:
Most Effective Strategies for Recruiting and Retaining Quality Nurses

Better Staffing Ratios	**87 percent**
Input in Decisions	**79 percent**
Flexible Schedules	**69 percent**
More Part-Time Options	**63 percent**
Continuing Education	**61 percent**
Better Health Coverage	**60 percent**

Source: Federation of Nurse and Health Professionals, The Nurse Shortage

One of the most comprehensive recent surveys focused on both practicing and non-practicing licensed nurses. It is striking that both groups identified the same improvements as critical to enabling them to continue working in nursing: a raise in pay, more time for patient care, and more understanding from administrators and supervisors regarding burnout issues (Foundation for Healthy Communities 2001, 2). It is important to note that staffing levels are often a prerequisite for other best practices. For example, it is difficult to adopt reasonable scheduling policies, or to maintain high standards of professional practice, if a hospital is understaffed. Thus, when these issues are promoted as best practices, they often entail a prior commitment to guaranteeing adequate staffing levels. These issues mug be addressed if current nurses are to be drawn back into the hospital workforce and new students are to be drawn into the profession.

Compensation

Inadequate wages and benefits are one of the most important factors driving nurses out of the profession, and with good reason. One recent survey found that only 36 percent of nurses feel they are being paid a fair wage (Foundation for Healthy Communities 2001, 2). Real wages for the nation's RNs stagnated over the course of the 1990s, with inflation-adjusted earnings in the year 2000 virtually identical to where they were in 1990 (Buerhaus and Staiger 1999, 216; Spratley et al. 2001, 20; U.S. General Accounting Office 2001, 10-11). Declining RN wages are directly related to the institution of

managed care. During the 1980s, when many hospitals sought to expand their nursing staffs, RN wages rose modestly but steadily. They flattened during the early 1990s, and then declined significantly in 1994-1997, the years when managed care swept the nation (American Organization of Nurse Executives 2000). The most important proposal for compensation is also the simplest: pay more. The "magnet hospitals" that have been documented to have the greatest success with recruitment and retention of nurses consistently pay wages at or above the level of area competitors.

Staffing

Asked to name the organizational changes implemented in their workplaces over the previous two years, nurses most commonly cite an increased patient care load. Fully 64 percent of nurses report that they have less time available for direct patient care than they had just two years earlier (American Nurses Association 2001, appendix). While hospitals were cutting nursing staffs during the 1990s, they were simultaneously increasing patient loads: the median number of inpatient admissions increased by 17.5 percent over the last five years of the 1990s (Nursing Executive Center 2001, 9). Moreover, the concerted effort to cut patients' length of stay means that the average patient is sicker than in' the past, thus increasing the nursing demand for any given patient (Buerhaus 2002, 4-6). The U.S. General Accounting Office (2001, 5) reports that "when adjusted to reflect the rise in acuity levels, the number of hospital employees on staff for each patient discharged, including nurses, declined by more than 13 percent between 1990 and 1999."

The combination of nursing staff cuts, rising patient loads, and increased acuity has been disastrous. When nurses rate the seriousness of selected problems, staffing levels are at the top of the charts. Nurses report making huge personal sacrifices in an effort to provide decent care to their patients. According to one large-scale survey (American Nurses Association 2001):

- 78 percent of nurses skip meals and breaks to care for patients.
- 58 percent work voluntary overtime.
- 33 percent work involuntary overtime.
- 51 percent experience stress-related illness.
- 42 percent stay late (off the clock) to finish charting and patient care.

Despite these heroic efforts, nurses are simply unable to scramble fast enough to make up for the cuts in hospital staffing. Fully three-quarters of nurses believe the quality of care provided in their hospital has declined in

the past two years, citing a troubling array of problems caused by short-staffing (American Nurses Association 2001):

- 58 percent cite delays in providing basic patient care such as feeding and bathing.
- 50 percent believe patients have been discharged without adequate preparation.
- 38 percent cite treatment errors such as patients put on the wrong diet or delays in lab testing.
- 36 percent cite increased medication errors.

Understaffing not only leads to nurse burnout and poorer patient care—it also makes hospitals more dangerous places to work. In one recent study, 40 percent of RNs reported that they had been injured on the job. Seventy-five percent said unsafe working conditions interfered with their ability to provide quality care. Eighteen percent of nurses report that their hospitals do not have safe needle devices, and patient lifting devices are often not available—and with an aging RN workforce, such ergonomic issues are becoming more important than ever (O'Leary 2002, 5).

Staffing Ratios: The Solution to Burnout and Nurse Retention

The stress, danger, exhaustion, and frustration that have become built into the normal daily routine of hospital nurses constitute of single biggest factor driving nurses out of the industry. Unfortunately, it is also the factor that hospital administrators are most reticent to address. The single most important policy for solving these problems is the establishment of staffing ratios, mandating a minimum ratio of RNs to patients in each unit of the hospital. While such ratios have been controversial, there is strong evidence that they have proven effective in the recruitment and retention of nurses. Linda Aiken, founder of the Magnet Hospital program and perhaps the most widely respected author in the field, argues that unless "a floor for staffing is established, we are not going to be able to stop the flight of nurses from hospitals" (Steinbrook 2002, 1757-66). While management generally opposes mandatory staffing ratios, these are by far the most promising means for solving the staffing problem. Indeed, management in hospitals that have adopted such ratios has come to appreciate them. Cape Cod Hospital in Massachusetts, which signed a collective bargaining agreement in. 1997 mandating a 1:5 staffing ratio for medical-surgical units (with a skill mix of 85 percent RNs), initially resisted the proposal but now hails it as a cornerstone of recruitment strategies. "It definitely does help with recruitment," stated Human Resources director Molly O'Connor. "I've won some candidates over that way." As of

2002, the hospital—in a relatively isolated part of the state—had achieved a vacancy rate of just 8.9 percent (New Jersey Nurse 1997, 11).2

In 1999, California adopted the first law in the country mandating specific staffing ratios.' Where such legislation is feasible, it will likely do more to solve the shortage than negotiating staffing language at individual hospitals. The latter may lure nurses from one hospital to another; the former will help draw currently non-working RNs back into the health care industry. Indeed, the attraction of mandated staffing ratios is so powerful that, in the wake of California's law, one Nevada legislator bemoaned the likelihood that that state would see a mass exodus of nurses heading across the border for the promise of a more adequately staffed hospital unit (Richmond 2002).

Staffing ratios often seem like the elephant in the corner of nursing research. Many reports—particularly those funded by management—define the problem in terms that seem to intentionally skirt the central issue of staffing. One typical such study surveyed nurses regarding their perception of "(a) autonomy, control, and physician relationships, (b) faith and confidence in peers and managers, (c) emotional exhaustion, (d) job satisfaction, and (e) the quality of patient care" (Laschinger et al. 2001, 209). Every one of these five aspects is significantly dependent on hospitals' staffing ratios. However, this study, like others, seems engrossed in measuring the symptoms of staffing levels rather than addressing the root cause. In this sense, establishing adequate staffing ratios is the prerequisite to pursuing best practices in these other areas.

Specific Proposals For Staffing Levels

In January 2002, California Governor Gray Davis announced the long-awaited nurse-patient ratios called for by legislation, establishing an initial 1:6 ratio for general medical-surgical units, moving to 1:5 within twelve to eighteen months. This legislation is an important and encouraging step toward solving the nursing shortage. However, several key issues make it difficult to determine exactly how such a mandate should be framed. First is the debate over the proper ratio of RNs to patients. The California Nurses Association, for instance, proposed ratios based on a massive study that examined 22 million patient records over a five-year period. Since California already had established a mandate requiring one RN for every two patients in the ICU, the ICU's acuity level was used as a baseline of comparison for establishing reasonable staffing ratios for other departments. Using this method, the C.N.A. called for a staffing ratio of 1:3 in medical/surgical units—twice as intensive as the standard set by state regulation (Institute for Health & SocioEconomic Policy 2001, 9011).

Beyond the question of establishing correct ratios, any staffing ratio is inevitably a crude measure of the quality of care needed; it does not take into account patient acuity, size, and physical layout of units, or other factors that influence the demand for nursing in a given unit. The most effective means for developing more fine-tuned staffing levels is to combine mandated minimum ratios with truly joint committees, in which nurses in each hospital unit use their knowledge to adjust the staffing levels above the minimum needed. Where true labor-management partnerships have been undertaken, agreements on staffing levels are impressive. Kaiser Permanents, among the largest of California's health care employers, has agreed to a staffing ratio proposed by its unions of one medical-surgical nurse to four patients—a goal more stringent than the California state mandate.'

Voice at work

The combination of stagnant wages, increased workloads, and policies that seem to reflect a disregard for patient's well-being have left many nurses with a generalized sense of frustration, distrust, and powerlessness. Multiple studies point to the importance of nurses having a meaningful say in crafting hospital policies. One study found that 22 percent of the variance in job satisfaction was explained by powerlessness (Bush 1998). Indeed, even management has come to promote the importance of nurses' participation in hospital governance. The American Hospital Association (AHA), for instance, calls for hospital staff to have "a sustained voice in shaping institutional policies" (American Hospital Association 2002, 5).

There is nothing that effectively meets nurses' desire for a voice at work as well as a union. In a survey of RNs conducted by American Federation of State, County, and Municipal Employees (AFSCME), nurses overwhelmingly pointed to their union as a ma¡or positive influence on work environment. One nurse explained that "the union brings reason to unreasonable expectations" (AFSCME Nurses Survey 2001) While man agement sponsored studies do not, of course, call for unionization, it is hard to imagine what mechanism apart from a collectively bargained contract or genuinely joint labor-management committees (with equal decision-making power) could satisfy the call for employee voice found in the literature.

Curtailing Worst Practices: Mandatory Overtime

Unfortunately, while some hospitals have moved to adopt best practices for improving recruitment and retention, others have moved in the opposite direction. Perhaps the most troubling development is the prevalence of hospitals that use mandatory overtime as a staffing solution. Multiple studies have

shown mandatory overtime to be perhaps the single worst of the practices that emerged from the era of downsizing and managed care; it discourages nurses from accepting employment, and encourages existing nurses to think about leaving. In addition, the evidence suggests that mandatory overtime is likely linked to a host of patient problems. Partly as a result, while mandatory overtime may be thought of as a cost-saving measure, it actually generates substantial new costs in the form of increased turnover, lower productivity, longer lengths of stay, and higher rates of treatment error that in turn necessitate more extended and costly solutions.

The severity of the burdens imposed by mandatory overtime is reflected in the growing incidence of strikes related to this practice. In recent years, nurses in Michigan, Ohio, and Pennsylvania (all represented by AFSCME) have all been out on strike over the issue of mandatory overtime. Both nurses and hospital administrators recognize mandatory overtime as a leading cause of turnover. Joint Commission on Accreditation of Healthcare Organizations JCAHO) president Dennis O'Leary notes that 22 percent of nurses who leave direct care work do so in search of "more regular hours." He warns that "health care organizations face competition from employers who offer nurses the chance to work a regular business week. No nights. No weekends. No mandatory overtime" (O'Leary 2002, 3).

By contrast, those hospitals that have succeeded in boosting their recruitment and retention rates have almost universally shunned the practice of mandatory overtime. When the AONE asked human resource directors and chief nurses to identify "the most effective methods of recruitment and retention," they specifically identified "low/no mandatory overtime" as one of their most effective policies (American Organization of Nurse Executives 2002, 67). Unsurprisingly, among the current magnet hospitals participating in the University of Oregon Labor Education and Research Center (LERC) survey, seventeen out of twenty-one maintained a complete ban on mandatory overtime, and the others restricted it to limited needs such as snow days. At St. Mary's Hospital and Medical Center, where the vacancy rate is just 3 percent, the human resources director explained that "no mandatory overtime is our promise to the staff."'

Do Magnet Hospitals Really Work?

The Magnet Hospital program, certified by the American Academy of Nursing, seeks to identify hospitals embodying the best practices for recruitment and retention of nurses. As described by the American Academy of Nursing,

> In magnet hospitals there is a low patient-to-registered nurse ratio, with adequate staff to provide total nursing care to all patients. Furthermore, the quality and complexity of patient care needs are taken into consideration when the staffing is planned; this is important in minimizing stress. The nurse does not feel overworked and has an opportunity to meet all of the patient's needs—psychological, interpersonal, and physical. There is also time for interaction among nurses so that continuity of care is insured and nurse-to-nurse consultation is encouraged. The nurses express great satisfaction in their opportunity to provide good care and in administration's support for it. (American Academy of Nursing 1983, 21)

Multiple studies confirm that the improved staffing ratios and more humane policies of magnet hospitals continue to make an important difference in the work environment. Nurses in magnet hospitals have less burnout and greater job satisfaction than those elsewhere (Laschinger et al. 2001, 210; Aiken et al. 2000, 26-35). Ultimately, the proof of magnets' success is in their significantly lower turnover. In the year 2000, the median turnover rate for RNs employed at magnet hospitals was 7.6 percent, compared to 14 percent for non-magnet hospitals (Frusti 2001). Perhaps for this reason, the AHA's most recent strategy document recommends that all its member hospitals "embrace the characteristics of the Magnet Hospital program and incorporate them in work innovations" (American Hospital Association 2002, 18).

The source of the magnets' success is clear. Magnet hospitals maintain competitive salaries, flexible scheduling, support for continuing education, and little or no use of agency nurses. In July 2002, the University of Oregon's Labor Education and Research Center conducted a telephone survey of magnet hospitals. Of forty-one currently designated magnet hospitals, slightly more than half provided information on their staffing levels, vacancy rates, and turnover. The average vacancy rate reported by magnet hospitals is 8.3 percent, significantly better than the national average of 13.4 percent. Similarly, the average RN turnover among magnet hospitals was 9.9 percent, compared with a national average of 17.1 percent.' Perhaps most importantly, the staffing ratios in medical/surgical and intensive care units—the two types of unit suffering the greatest national shortages—reflect a commitment to controlling workloads (American Organization of Nurse Executives 2000, 23). Nine of the twelve hospitals that provided this data maintain medical-surgical staffing ratios that are at or below the California mandate of one RN for every six patients. Indeed, it is striking that the hospitals with the best staffing ratios are consistently also those with the lowest vacancy rates.

Best Practices for Nurses are also Best Practices for Patients

> *I estimate that hundreds or, perhaps, thousands of deaths each year are due to. low staffing.... [Nurses are] the eyes and ears of the hospital.... If something is going wrong, they can catch the signs early, before the problem gets worse.... There were some hospitals, that if I were going to them as a patient, I would be very concerned (Needleman, in Grady 2002).*

While the issues of staffing levels, compensation, and stress on the job are central to solving the nursing shortage, they also significantly impact the health of hospital patients. A recent national survey found that an astounding 75 percent of RNs believe that the quality of nursing care at their facility has declined over the past two years, with 68 percent of RNs citing staffing levels as a major contributing factor to this problem. Shockingly, over 40 percent of current nurses report that they would not feel comfortable having a family member under care in their hospital (Foley 2002).

The single most comprehensive study linking staffing levels to patient outcomes was conducted by the Harvard School of Public Health (Needleman et al. 2001). The researchers found a strong and consistent relationship between nurse staffing and five outcomes in medical patients: length of stay, urinary infections, gastrointestinal bleeding, pneumonia, and shock or cardiac arrest. In addition, the authors report that "the death rate was 2.5 percent higher for 'failure to rescue,' meaning that the patients died from conditions that might have been reversed if they had been treated in time" (Grady 2002).

Looking solely at medication issues, the Institute of Medicine estimates that over 7,000 Americans die every year as a result of preventable medication errors. The majority of these errors occur in the administration of medication—i.e., predominantly in nursing work—caused primarily by "distractions and workload increases" (Foley 2002). Similarly, in Aiken's survey (see Table 3), nurses reported workplace stress leading to patient endangerment at disturbing levels of frequency (Aiken et al. 2001, 50).

Overall, the Institute of Medicine estimates that at least 44,000 Americans—and possibly as many as 98,000—die each year as a result of hospital medical errors (Institute of Medicine 2000). The IOM notes that human error in hospital treatment is not a random event, and calls for clear-cut policies establishing "reasonable work schedules" and "well designed jobs" as "preconditions for safe production processes" (Institute of Medicine 2000, 60). On the positive side, a series of studies by Linda Aiken found that magnet hospitals improve patient outcomes due to a combination of better staffing ratios and less stress. Comparing magnets to otherwise similar hospitals, the

Table 3
Overstressed Hospitals

Percent of RNs Reporting Dangerous Conditions are "Not Infrequent"	
Patients receiving the wrong medication or dose	15.7 percent
Nosocomial infections	34.7 percent
Patients with injuries falling	20.4 percent
Complaints from patients or families	49.1 percent
Verbal abuse directed at nurses	52.7 percent

Source: Aiken et al. 2001, 50

former proved consistently superior (American Hospital Association 2002, 18; Aiken et al. 2000, 26-35):

- Patient mortality rates were 4.6 percent lower.
- AIDS patients were 60 percent more likely to depart the hospital alive.
- Nurses suffered fewer needle-stick injuries.
- Patient satisfaction was significantly higher.

The Impact of Collective Bargaining: Unions Prevent Heart Attacks

Unions clearly have a significant impact on wages, benefits, and staffing levels—the most important determinants of recruitment and retention. In addition, unions also play a critical role in providing nurses a meaningful voice on the job. One recent study compared union and nonunion hospitals in California, controlling for both staffing levels and wages, among other factors. Researchers found that unionized hospitals had 5.7 percent lower mortality rates for patients suffering acute myocardial infarction (Seago and Ash 2002, 143-151). The study's authors conclude that RN unions may promote "stability in staff, autonomy, collaboration with MDs, and practice decisions that have been described as having a positive influence on the work. environment and on the patient outcomes"—exactly those attributes identified as constituting the heart of magnet hospital practices (Seago and Ash 2002, 150). This finding suggests that not only nurses themselves, but the country as a whole, may have an interest in seeing increasing numbers of nurses win the right to represent themselves through collective bargaining.

High Road versus Low Road: Hospitals Can Afford to Do the Right Thing

—Beyond the quality of working life for nurses and quality of care for patients, there is reason to believe that high-road practices may ultimately save

Notes

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2 Molly O'Connor. Interview with the author, August 2002

3 CA Health and Safety §1276.65(b).

4 Kathy Sackman, vice president, American Federation of State, County, and Municipal Employees. Interview with the author, 2001.

5 Christine Baker, Human Resources Director of Cape Cod Hospital. Interview with Helen Moss, University of Oregon, July 2002.

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