TOWARD AN UNAMBIGUOUS PROFESSION?

A REVIEW OF NURSING

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FOREWORD

THE EDUCATION and assignment of functions in nursing has been under intense study and debate for years. There is no concensus as to solutions for the questions of quantity and quality of nurses needed in this country. This indecision is not due to the recalcitrance of those who could effect change. Rather the debate reflects the changing climate in which medical care is delivered and the surge of new knowledge which continues to affect the nursing profession and the health field generally.

Too often nurses have stood alone as they struggled to find a solution compatible with public need and professional interests. Their expressed objectives cannot be obtained without sympathetic and broad support. Often those confronted with the current shortage of nursing personnel have criticized and resisted plans of the nursing profession without evidence of a broad understanding of the issues. However, understanding cooperation is most necessary to any plan which would permit accommodation to the changes which have taken place in society, in the health field, and in nursing.

This monograph by an experienced behavioral scientist who has devoted his career to study of the medical care field evaluates the forces which are affecting nursing and suggests likely directions for change. No observer, however well qualified, will find easy answers to settling the "nursing controversy". Nevertheless the issues need to be understood if the public, nurses, and their co-workers in the health field are to give constructive attention.

This monograph is, then, a review of change and its effects on the role of the nurses with suggestions for proper directions for the future. It endeavors to bring understanding of this most pressing problem which must be solved if we are to maintain and improve patient care at a time when demand from a growing population increases.

GEORGE BUGBEE

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ACKNOWLEDGEMENTS

EARLY IN 1967 the Illinois Study Commission on Nursing approached me to assist it in evaluating and organizing the great abundance of data on nurses and nursing in the State of Illinois that had been collected under the Commission's auspices since its establishment eighteen months earlier. With the able staff work of Joanna Kravits, my assistant, on whose judgment I placed great reliance, the data were incorporated into the Commission Report released in February, 1968, entitled *Nursing in Illinois: An Assessment, 1968, and a Plan, 1980.*

In the course of pondering the problems and issues regarding nursing in general and the Illinois situation in particular, I was stimulated into writing a review of nurses and nursing as a nationwide phenomenon. It seemed to me that the problems and issues regarding nurses and nursing in Illinois were essentially the same as those for the nation generally. Again with the assistance of Mrs. Kravits, national data on nurses and nursing more or less paralleling the data collected for Illinois were assembled. Mrs. Barbara Nausieda, my secretary, deserves special mention for the arduous job of typing reams of tables and text accurately and neatly.

It goes without saying, of course, that the observations and generalizations I make in this report are strictly my own. I do thank, however, the Chairman of the Commission, Professor Mary K. Mullane, Dean, College of Nursing, University of Illinois, and the members of the Commission for the informative and stimulating exchange of views while I served as the research consultant in the preparation of the final report already mentioned. I hope that my report is a contribution to the clarification of problems and issues regarding nurses and nursing in this country.

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I. THE NURSING PROFESSION AND SOCIETY

FOR INTELLIGENT formulation of public policy regarding the recruitment, education and retention of nurses, it is necessary to realize that the supply of people, their training and allocation of skills, and their rewards are all linked to a market in a society where one is supposed to have choice of occupation and be free to work anywhere where circumstances permit. This is the core value in looking at any labor supply in this country, nursing included.

All sources of labor to get the country's work done are now tied to a labor market exclusive of homemaking and sisterhoods. But even homemaking is having competition in the labor market in that approximately 40 per cent of the married women work outside the home; it also seems to be difficult to recruit sisters because of the range of alternative occupations and activities women have today, an expression of the continuing expansion of equal rights for women in this country. The consequences to the health services system are that it is no longer in a favored position to attract women into the nursing services as one of only two or three alternatives that women have had within living memory. Since all labor supply is tied to the labor market, this means that our society increasingly and now wholly has to pay standard and competitive wages for all the skills and services it wants.

In the past a large part of the servers—professional and nonprofessional—in the health services system were paid less than prevailing wages because of the nonprofit and eleemosynary nature of health care and the dedication presumed to be expressed by the workers in being willing to care for the sick and disabled. Physicians made their living in private practice and provided free services to

the indigent in hospitals and dispensaries. The health services system was pervaded by an atmosphere of altruism, however carried out to meet peoples' needs, and money was a dirty word. The health services system is now an extremely large and very expensive enterprise, a very technical one, and, further, an effective one; hence it is now forced to compete in the labor market on equal terms with industry and government. The old family farm concept of contributed and unaccounted-for labor is gone. In substance, the health field is now a place to work among a variety of work opportunities for men and women, and especially women, for nurses and supporting personnel. This would then seem to be the *first fundamental* fact that employers in the health field now face, which influences their labor force recruitment and retention policies.

The *second fundamental* fact facing employers attempting to recruit and retain the nursing type of health professional—registered nurses, licensed practical nurses and aides—is that of a rather major shift in proportion of patients who are suffering from long-term, intractable, and non-lethal illnesses. The health services system that developed from 1875 to 1920 to embody the medical technology that emerged during that time was geared to acute and dramatic disease episodes. It is still geared to such episodes, not by force of habit and unwillingness to change as is often alleged but because this is the most interesting and rewarding aspect of the patient care process; it is the aspect which draws on the dazzling medical technology and sets an exciting and feverish pace in general hospitals. This aspect of the patient care process is technique oriented, possibly the finest expression of an extremely technically oriented society. It implies attack and intervention and frequently total victory and other times total defeat. The result of the patient care process is definitive. Long-term management of patients with intractable and relatively stabilized illnesses is allocated to long-term facilities of various kinds including, if possible, home care, where there is an atomosphere less steeped in crisis and pervaded by the long and tedious haul.

If there is a general recruitment and staffing problem regarding various types of nursing personnel, there is a particular problem regarding the staffing of long-term facilities, not to mention mental hospitals. Our living patterns and standards and the health services have created, as mentioned earlier, a large number of patients who

are old, sick, and relatively helpless. An estimate made several years ago on the basis of a household survey of people 65 years of age and over in this country revealed that 14 per cent were unable to care for their daily bodily functioning and needed constant surveillance [1]. Fourteen per cent of all those 65 years of age and over amounts to 2.8 million people in this country, not to mention similarly situated individuals below the age of 65.

The assumption is that acute and crisis disease episodes require a highly technically qualified nursing staff. The stress is on "technique" rather than "tenderness" as expressed by Genevieve Meyer in a book on nursing called *Tenderness and Technique* [2]. In long-term disease conditions the stress is less on highly technical qualifications and more on a "tenderness" quality of a management and custodial nature. It is quite possible to staff adequately for acute and crisis disease episodes but not not for long-term and largely terminal disease conditions. In short, technique is purchasable, but, fundamentally, tenderness is not. Many long-term patients who are helpless, incontinent, uninteresting, and unrewarding need the kind of care and attention which can normally be expected only of family members and relatives, and I raise the question whether or not it is possible to pay enough to obtain the help needed. I also raise the question whether or not those who are motivated primarily by high pay are the ones who are appropriate for these tasks.

The *third fundamental* fact facing the recruitment, education and retention of various types of nursing personnel is the attitude in our society toward tasks that are of a servant nature—as distinguished from the usual professional helping service. Tasks that are mainly directed at serving a person and his situation—waiters and waitresses, maids, being on demand at the served person's convenience, cleaning, laundering, pushing wheel chairs—are low status and demeaning to the server. Our equalitarian society has attempted to automate many of these functions, but an important residue must remain. To the degree that nursing functions perforce include many of these serving tasks, to that degree there will be recruitment and retention difficulties. Hence, attempts at professionalization aim to give an occupation a certain autonomy and independence from the blandishments of sick people who need a whole range of assistance,

from professional helping service to that normally provided by servants and relatives. The proper balance of servant and service tasks is difficult to determine and results in role conflicts. Like all social changes, equilitarianism has side effects in that no one is supposed to be content with low status even in essential positions. This makes for difficulty in getting onerous but exceedingly necessary tasks done. The labor market today is characterized by a contractual relationship—*quid pro quo*—the obligation and duty element of an employer-employee relationship has become minimal.

The very concept of shortage needs to be examined. When one reviews the hospital literature, even as far back as the turn of the century hospital administrators were complaining about recruitment and retention difficulties. Indeed the concept of personnel shortage has been chronic for a very long time, but the impression would be that the sense of shortage has intensified since World War II. This feeling is not limited to the health field but seems to be endemic, so to speak, among all fields which require technical skills needed by a rapidly expanding technological society; the educational system is not turning out trained people fast enough although it seems that the basic manpower pool may be there. This phenomenon appears to pervade all highly developed economies so it is not peculiar to the United States but an aspect of the so-called new type of industrial revolution economies are undergoing. This is particularly apparent in economies like Sweden and Switzerland where the manpower resources in relation to their increasingly refined production, distribution and service structure are driving these countries into exceedingly intensive and rational use of their labor supply—part-time employment, adjustment to housewives' housekeeping hours, odd hours, and so on.

This country has barely scratched the surface of adjusting its labor resources to the characteristics of some types of labor. It would seem that in nursing particularly, because of its high proportion of inactive nurses, a problem it shares with other women-dominated professions (Table 1), more adjustments could be made by hospitals to accommodate to the family responsibilities of nurses in order to induce more inactive nurses to return to nursing. Even under the present relatively unaccommodating system, 12 per cent of the inactive nurses in Illinois in 1966 had returned to work, mostly

TABLE 1

PER CENT OF U.S. WOMEN COLLEGE GRADUATES EMPLOYED AT LEAST PART TIME SEVEN YEARS AFTER COLLEGE GRADUATION, BY UNDERGRADUATE MAJOR, 1964

UNDERGRADUATE MAJOR	PER CENT EMPLOYED
Religion	33
Home economics	39
History	41
Speech, dramatic arts	41
Art	45
Chemistry, physical sciences	50
Language	50
Nursing	*50*
Education	53
Health fields other than nursing	61
Music	65

Source: Table F-10, *College Women Seven Years After Graduation*, Bulletin 292, U.S. Department of Labor, 1966.

part-time, in 1967, according to a study of inactive nurses by the Illinois Study Commission on Nursing [3]. According to national trends, at any rate, it would seem that it is to a large extent the increase in the part-time nurses in proportion to all active nurses which is enabling hospitals to staff even as well as they do (Table 2).

TABLE 2

PER CENT OF R.N.'S IN PRACTICE WHO WORK PART TIME ONLY, U.S., 1960–1964

YEAR	FULL TIME	PART TIME	PER CENT WHO ARE PART TIME	ACTIVE RN'S PER 100,000 POPULATION
1960	414,000	90,000	17.8	282
1962	433,000	117,000	21.2	298
1964	450,000	132,000	22.7	306

Source: Derived from Table 3, p. 12, *Facts About Nursing*, American Nurses' Association, 1967.

The usual view of economists is that if a shortage of labor among certain occupations persists, there is then by definition no shortage because if the demand for such labor were as intense as is implied, somehow wages would rise to increase the supply. In the long run

the proportion of people in a range of occupations represents a balance of differential demands. Hence, the nursing shortage is an illusion from the economists' point of view, a concept in the heads of hospital administrators who dream of an ideal hospital staffing pattern and even budget for positions they know cannot be filled at current salary rates for nurses. These rates are shown in Table 3.

TABLE 3

AVERAGE SALARY OF REGISTERED NURSES IN NON-GOVERNMENTAL HOSPITALS, U.S., JULY, 1966

POSITION HELD	AVERAGE SALARY	
	Weekly	Annual
Director of nursing.....	$154	$8,008
Supervisor of nurses....	129	6,708
Nursing instructor.....	124	6,448
Head nurse.....	114	5,928
General duty nurse.....	101	5,252

Source: Derived from Table 1, p. 139, *Facts About Nursing*, American Nurses' Association, 1967.

The concept of budgeted but unfilled positions is an interesting one. It presumably means that there is money actually available to staff hospitals according to going standards if the existing supply of nurses would only work at current salary rates and working arrangements. The concept of budgeted and unfilled positions has now appeared in both industry and government, indicating, perhaps, that wages and salaries, as such, do not now have the dominant influence on the allocation of labor that they once had. Many other factors are achieving relatively greater importance—working conditions, convenient hours, and fringe benefits such as vacations. The wages and salaries in general appear to be high enough so that labor now considers marginal returns after incomes reach a certain level.

It would then seem that the shortage is real enough in terms of the standards and objectives of an economy which wishes to produce more and more goods and services at higher quality—needs are quite open-ended, i.e., there are no logical limits given the tremendous productive capacity of the economy if the labor supply were there in sufficient quantity.

The health services are particularly characteristic of a need in the population which has no logical limits set by objective criteria because the aims of the health field are essentially utopian—relatively equal access to cure, prevention, rehabilitation, and extended care regardless of ability to pay. It is thus exceedingly difficult to establish standards for staffing ratios in hospitals or for the proper number of physicians and auxiliary personnel.

Possibly the chief reason for the difficulty in establishing standards is that the health field is changing so fast because of improvements in medical technology and an increasingly productive economy. The number of nurses per bed and other personnel have been increasing since the turn of the century, and the demand is apparently continuing.

This is why there is a great deal of concern today, for example, with the way hopsitals are used. There are many allegations of so-called "overuse" and "abuse." Short of very gross examples—such as examples of a children's hospital being used as a baby sitter while the parents went off on a weekend holiday—there are no objective criteria of proper hospital admission rates or even length of stay. What can be presented are customary patterns in various places which may considerably vary between them although the environing economy and society are quite similar to standards of living, level of industrialization and so on.

For example, in a free hospital system as in Great Britain, i.e., no payment at time of service by the patient, the admission rate per 1,000 population in a year is 85 and the average length of stay is 15 days. In the United States, with invariably at least partial payment by the patient at time of service, the admission rate is 130 and the length of stay is eight days. In the province of Saskatchewan, where there is a free hospital service, the admission rate is 200! Obviously, these use patterns affect staffing patterns and they also vary considerably for no readily discernible reasons. In Sweden, for example, where the admission rate is 130 and the length of stay 15 days (almost twice ours) there is one personnel member (exclusive of physicians) per bed. In the United States there are 2.5 personnel per bed. These data are presented to show how extremely variable use and staffing patterns are between countries and areas which have more social and economic similarities than dissimilarities. And they all

complain of shortages, particularly a shortage of nurses! And, as in this country, the number of personnel per bed has been increasing since the turn of the century.

II. THE STRUCTURE AND NATURE OF THE NURSING PROFESSION

IT WOULD SEEM that much of what will be presented in this section is quite self-evident and already known by people who make decisions and policy in the health field. I make no pretense of originality, having drawn information and insights from many sources—a raft of studies on the nursing profession, particularly the summary report entitled *Twenty Thousand Nurses Tell Their Story,* by Everett Hughes and collaborators [4]; and the recent and thoughtful book edited by Fred Davis, entitled *The Nursing Profession* [5], with contributions also from Anselm Strauss, William Glaser, Hans Mauksch, Virginia Olesen, Elvi Whitaker, and Esther Lucille Brown; and the perceptive study by Genevieve Meyer, *Tenderness and Technique: Nursing Values in Transition,* mentioned earlier. Hence, it is hoped that this discussion will at least serve the purpose of synthesizing what is already known but in terms of sharpening our perceptions of the problems of nursing personnel.

In modern society, career advancement is through the educational system, particularly undergraduate college and postgraduate university training. This is the giant sieve selecting aptitudes, skills, intelligence, ambition, earning power and status in American society. Women have increasingly entered this sifting process in that about three-quarters of them now graduate from high school. About a quarter of these graduates earn a bachelor's degree (a sixth of all women now in high school), and about 15 per cent of the latter (3 per cent of all women) earn various graduate degrees [6]. The nursing profession, which was shaped by the apprentice system as an arm of administration rather than a clinical department during an era when relatively few women attended college, is now trying to overcome its past. It is attempting to by-pass the hospital as the primary training center and take the path of all young people who

aspire to some high level technical and professional status (Table 4).

TABLE 4

TRENDS IN ENROLLMENT IN COLLEGE PROGRAMS LEADING TO THE R.N. COMPARED WITH HOSPITAL BASED PROGRAMS, U.S., 1955–1965

YEAR	PER CENT OF TOTAL ENROLLMENT			
	DIPLOMA	Associate Degree	Baccalaureate	TOTAL
1955....	83.6	1.2	15.2	100.0
1956....	83.0	1.3	15.7	100.0
1957....	82.3	2.2	15.5	100.0
1958....	81.6	2.7	15.7	100.0
1959....	81.4	3.2	15.4	100.0
1960....	78.2	4.2	17.6	100.0
1961....	76.8	5.0	18.2	100.0
1962....	73.6	7.0	19.4	100.0
1963....	72.0	8.5	19.5	100.0
1964....	68.8	10.7	20.5	100.0
1965....	64.1	14.2	21.7	100.0

Source: Derived from Table 1, p. 92, *Facts About Nursing,* American Nurses' Association, 1967.

This aspiration toward unambiguous professional status through the formal educational system recommended in the controversial and thoughtful position paper of the American Nurses' Association in 1965 will have many consequences, both intended and unintended [7]. It is the unintended consequences that are probably the most worrisome because they may worsen the nursing shortage as nursing duties are now defined, given emphasis on higher standards. The intended consequences are commendable, i.e., higher quality of training and increased professionalization. At the same time it would seem that unless the college and university becomes the main entree to nursing, the continued recruitment of young women will be jeopardized.

The nursing profession is attempting to enhance its professional status in the name of higher quality nursing service and an unambiguous professionalism—the former should result in *better* patient care, while the latter should result in both higher self and public regard. Together, these attributes should further result in increasing the attraction of nursing to intelligent and highly motivated women

and—always as an afterthought it seems—men. Nursing has, however, always been overwhelmingly a women's profession (over 99 per cent of all R.N.'s are women [8]) and will undoubtedly continue to be although there are occupational niches which can be made attractive to men. This assumption of a predominantly women's occupation will, naturally, influence all subsequent observations and predictions.

In reading the voluminous literature on and by nurses and in talking with the principals, I am struck by the feeling of lack of appreciation which pervades the thinking. This is particularly evident in a vignette of a quote loaded with meaning—probably more than intended—in the A.N.A. position paper: ". . . The bulk of nursing today is being done by men and women who . . . expect a competitive salary, appreciation, a feeling of worthwhileness, and an operating democratic philosophy; *in return they expect to give as much of themselves as can be safely let go* [9]." (Emphasis mine.) The last clause is of great significance because one of the characteristics of a profession dealing with people intimately is the need to withhold one's deep self. Overinvolvement leads to professional ineffectiveness and personal exhaustion. Apparently the nurses feel that current nursing situations make tremendous demands on the self—the mother type in our society being a prime example—and hence professional status and therapeutic effectiveness are impaired.

What are other characteristics for a profession? Usual characteristics are: (1) a high level of commitment, i.e., once a person selects a certain profession the likelihood of remaining active through life in this line of work is very high; something on the order of possibly 90 per cent; (2) a profession implies a relatively long and disciplined educational process resulting in some kind of formal recognition; (3) related to the foregoing there is implied a body of knowledge and skill which is more or less unique to that profession and transmissible; (4) there is implied an active and cohesive professional association which is self-governing and which watches all standards and ethics. American society gives a great deal of autonomy to professional associations in this regard; (5) lastly, there is implied a great deal of discretionary authority and judgment for the profession to practice its knowledge and skills with little direct supervision. The relationship with other professions is a collegial rather than a hierarchial subordinate-superordinate relationship.

How does nursing measure up to these characteristics now, and how might it do so in the future if present trends continue?

Taking these points in the same order: (1) the current level of commitment among those who aspire to nursing would appear to be relatively low as measured by both women and men in college teaching, medicine, law, engineering, and the ministry. It seems that even among women the commitment among those who select these professions remains high; the turn-over is low; the length of continuous practice is high. For example, 88 per cent of women M.D.'s are practicing medicine, the majority of them full time [10]. A third of the women who enter nurses' training quit before completing their training; another third or so become inactive for very long periods after a few years of service. Only a small group make a career of nursing, and those who do so attain status through administrative and teaching posts rather than through direct patient care. Hence, there is a great deal of turn-over among the masses of trained nurses, producing a small, highly committed top group and an exceedingly small "middle-management" group. This is an unfavorable base on which to build a strong professional group because it would seem that any profession would need a high proportion of professionals from which to recruit for leadership, training, and high level practice positions. The current education and practice structure of the registered nurse is anything but encouraging to this type of professionalism.

In points (2) and (3) professional education implies a rigorous and long process in a university or college setting and course content based on theoretical and proven knowledge of relevance to application. The great bulk of the nurses are still being trained in diploma schools associated with hospitals and largely on an apprenticeship basis with unsystematic exposures to theoretical and tested knowledge. This is, of course, the reason that the American Nurses' Association is recommending the eventual elimination of the diploma schools to be replaced by the junior college associate degree and university related baccalaureate degree nursing schools. All nurses will then become college graduates, the minimum symbol

of professionalism in American society. The question is, will this shift in emphasis supply enough registered nurses?

As regards point (4) relating to the need of a professional association to be cohesive, self-governing, and a source of professional self-discipline, standards, and ethics, it would seem that in general the American Nurses' Association meets these criteria. Currently the A.N.A. is handicapped, however, by the fact that only one-fourth of the active nurses belong to their professional association. The Association is also limited by the structure and characteristics of the nursing profession already described. Thus, unless the commitment to nursing and the educational level are raised, the professional association is operating under serious handicaps, given its long-range objectives.

Finally, on point (5) regarding the characteristics of discretionary authority and judgment, this power is delegated by society to a few selected occupations on the presumption that it is in the public interest. The work that needs to be done can most effectively be carried out by such delegation. Those who are accorded this discretionary power and judgment are supposed to be rigorously trained and indoctrinated in the sciences, art and ethics of the respective profession. Is the nursing profession accorded this power and respect? The answer is obviously "no" in principle, but not necessarily so in practice. This ambiguity is part of the reason for the restiveness among the nurses. In one of the studies (Hughes, ed., *Twenty Thousand Nurses Tell Their Story*, p. 72) it was observed that within a hospital the physician did not exercise fully the power of discretionary authority and judgment that he had in relation to the nurse and other aspects of the hospital service structure, and the nurses in effect exercised more discretionary authority and judgment than they were formally accorded. In other words, the exigencies of the working situations resulted in the muting of the physicians' authority and the stretching of the nurses' authority. Whether this degree of ambiguity and tension is functional—it is certainly inherent in the current nurse-patient-physician relationship —is an open question. It may be too intense; a partial resolution is an upgrading of the position of the nurse in institutional settings. The position of the nurse outside of the hospital would seem to be different enough to warrant separate observations.

As a natural trend of the times and very likely an increasing portent for the future is the fact that the American Nurses' Association and its state constitutents have committed themselves since 1946 to collective bargaining to improve the status and salaries of nurses. The hospital is caught between the squeeze of rising costs and the pressures of third party payors and the general public; an important component of these costs is, of course, nursing. The nurses have also been caught in their need to have a competitive salary and working conditions worthy of professionals in order to maintain and possibly even increase the supply of nurses. It is a truism in our society that for any type of personnel who are employed by others, rather than as independent contractors with individual customers, clients or patients, as the case may be, the now generally accepted means to improve economic status is through group activity and collective bargaining. Modern society is characterized by groups at interest bargaining with each other in one way or another as relatively autonomous units.

Nurses occupy a strategic place in hospitals and other places where they are employed. They provide expert care to patients; they supervise other employees; they are the link between the administrator, the physician, and the patient. All these parties surely know this. The nurses are trying to improve their status—a common American propensity. Individuals by themselves are quite powerless to do this; groups can.

The nursing profession, however, runs the risk of giving the impression that their chief grievance is money. In this country it is very easy to use wages and salaries as the sole basis for grievances; they are tangible. It is much more difficult to use status and an increase in professional prerogatives as a basis for group action. The nursing profession then needs to use a judicious mix of improved status through upgrading education and standards and through group activity and collective bargaining.

It is easy for opponents of group action and collective bargaining by nurses to wax moralistic on this issue, but the right of employees of all types to organize is now so implicit in our society that it is really a dead issue in the long run. The last few years, for example, have brought strikes by teachers and social workers—two other groups who are similarly situated. Hospitals, as usual, are slow

to follow the personnel policy trends of the larger society of which they are a part, but sooner or later events catch up with them. It is a commonly accepted observation in the labor market generally that in the absence of a counterforce brought to bear at the point where salaries are set, employers are not likely to be induced to increase salaries commensurate in pace and amount with the larger society. Hence, collective bargaining in some form becomes a method for all groups.

There are many observations about inappropriate use of nursing skills. It would seem likely that raising salaries promotes improvements in utilization through all types of rationalization and management techniques. This is usually regarded as the impetus to higher productivity and greater efficiency. It is assumed that registered nurses will be relieved of low-level-of-skill duties when higher salaries push management into increasing the efficiency of the work force. In the hospital this is easier said than done because of the very nature of a personal and professional service; nevertheless, group action and collective bargaining have become almost ends in themselves for employee groups to receive recognition in the market place.

As usual, the nursing profession occupies an ambiguous and difficult position in this situation as well as the others mentioned. The nursing profession also has to assure that sick people will be nursed. Hence the ultimate weapon of organized employee action—the strike—has to be used sparingly, selectively, and partially. Skeleton staffs have to be maintained at the hospitals for emergency care. Eventually, it would be expected that clearer ground rules governing the collective bargaining activities of professionals and their employers will evolve than we now have. In nursing as in other occupations, tactics and strategy have to be devised to suit the needs and interests of the groups being represented as well as the public being served.

It may be pertinent to point to the basic problem in nursing today, underpinning everything that has been presented. Famous lawyers are famous because they are practicing law; famous professors are famous because they conduct research and teach; famous clergymen are famous because they are great preachers and pastoral workers. Today famous nurses are famous not because they

practice nursing, but because they are administrators or college faculty members or skillful collective bargainers and negotiators—but removed from the practice of nursing, i.e., direct patient care. The crowning irony is that the farther a nurse is from direct ministration to the patient, the higher is her status in today's distorted value system. On the other hand, the closer a physician is to the patient—and particularly inside the patient both actually and metaphorically—the higher is his status. So it is with the other professions mentioned—their fame is related to the generic task for which each profession was educated. This is now happening to administration, since management of institutions and programs is increasingly assigned to especially trained people who are evolving a managerial profession in their own right.

A. INSTITUTIONAL NURSING: THE GENERAL HOSPITAL AND RELATED FACILITIES

ALMOST TWO-THIRDS of the active registered nurses in the country work in hospitals of various types (Table 5), and over 90 per cent

TABLE 5

DISTRIBUTION OF ACTIVE NURSES BY FIELD OF EMPLOYMENT, U.S., 1966

FIELD OF EMPLOYMENT	NUMBER	PER CENT
Hospitals and related institutions	408,700	65.1%
Nursing homes	17,400	2.8
Public health (including schools)	40,200	6.5
Nursing education	22,700	3.6
Occupational health	18,000	2.8
Private duty, office nurses, and others	119,000	19.2
Total	621,000	100.00

Source: U.S. Department of Health, Education, and Welfare, Bureau of Health Manpower, Division of Nursing, 1967.

of these work in general and allied special hospitals, the remainder in mental hospitals. Hence, the policy problems regarding the recruitment and staffing of nurses are directed very largely to the

hospital setting although other working sites are also of great importance to the health field, perhaps even disproportionately so because of the greater difficulty of substituting nurse's aide type o personnel.

In the United States there are over 6,000 short-term genera and special hospitals and almost 900,000 beds. Over 28 millior patients are admitted to these hospitals in a year, and at eight days per admission they therefore utilize over 247 million bed-days (Table 6). Against a total population of 200 million people this

TABLE 6

NUMBER OF HOSPITAL BEDS, ADMISSIONS, AND TOTAL PATIENT DAYS BY TYPE OF HOSPITAL, ALL U.S. HOSPITALS, 1966

TYPE OF HOSPITAL	NUMBER OF HOSPITALS	NUMBER OF BEDS	TOTAL ADMISSIONS	TOTAL PATIENT DAYS
General and short term special	6,184	873,580	28 million	247 million
Psychiatric	513	694,261	512 thousand	231 million
Tuberculosis	159	31,317	46 thousand	17 million
All other long term	304	79,500	179 thousand	25 million
Grand Total	7,160	1,678,658	29 million	520 million

Source: Derived from Table 2, p. 454, *Hospitals, J.A.H.A., Guide Issue*, American Hospital Association, August 1, 1967.

NOTE: There are also 17,098 nursing homes and homes for the aged in the country with a total bed capacity of 666,822. (Source: National Center for Health Statistics, Series 12, Number 1, *Institutions for the Aged and Chronically Ill*, July, 1965.)

means that there are about 140 admissions per 1000 population in a year. Use of hospitals has been increasing for many years. In 1945, for example, the admission rate was around 100 and the length of stay probably around 12. Thus the long-term trend has been an increasingly greater turnover of patients, which has the general result of intensifying the work load for the hospital staff. It has also been estimated that in recent years there have been at least 100 million visits annually to out-patient departments (including emergency departments) nationwide [11], and the general impression is that this type of demand has been rising dramatically in the larger cities and increasing the pressures on the hospital staff.

Altogether there are over 7,000 hospitals of various types with almost 1,700,000 beds. About one-half of these are in mental hospitals. All in all, then, there are about eight beds of various types per

thousand population. The number of general hospital beds per 1000 population is around 4.5. Various types of extended care facilities are increasing rapidly. The last count of nursing homes revealed over 17,000 with nearly 670,000 beds. (See note, Table 6.) In all these types of extended care facilities there is need, naturally, for various grades of nursing personnel, presumably largely of the licensed practical nurse and nurse's aid types. Staffing patterns for these facilities have been anything but stable, being mainly an exacerbation of the staffing problems already existing in other types of institutions.

The most intense seekers and users of nursing personnel are the general hospitals and the mental hospitals. All in all, however, the most intense recruiters are, of course, the general hospitals. It is thus seen that the hospitals and other types of institutions constitute a tremendous market for nursing personnel by all standards. It is also a very complex type of market in that there is no systematic and central employment registry for nurses to facilitate the connection of hospital personnel offices and the nursing supply. The A.N.A. has made some attempts in this direction through its state affiliates, particularly at the supervisory level, and most nursing magazines run extensive advertising sections. Also, state and private employment agencies are used. Presumably hospitals with diploma schools, still the great bulk of sources of registered nurses, create their own supply.

There are several characteristics of the recruitment and retention of registered and other levels of nurses that have a direct bearing on the problems being faced today. As has been mentioned previously, a third of the students who enter nursing schools for registered nurses drop out before graduation. After graduation it has been estimated that there is an attrition of nearly 50 per cent in the first year, mitigated later on by the return to nursing of many those who had left nursing. Presumably the attrition continues until a small hard core of career registered nurses remain, to form the cadre through which there is tremendous in-flow and out-flow nurses. Further, it is generally assumed that there is an unusually high turnover in general hospitals and even higher in the mental health system. From all reports it would seem that the nursing field has always been volatile, and it may be a tribute to the capacity of

as complex an institution as the hospital to function as well as it has. Presumably the situation is getting even more volatile; hence the mounting concern.

Another significant characteristic of the registered nurse employment pattern is the increase in the proportion of married nurses in the nursing work force. It is now 61 per cent, paralleling the development in the general labor force, where 63 per cent of employed women are married. However, less than 40 per cent of all women of working age are in the labor force, compared with almost 70 per cent of all women trained as nurses [12]. There has also been an increase in the proportion of nurses working part time, now around 30 per cent for all active nurses but around 40 per cent for all nurses in general hospitals. Further, the active nurses are on the average a little older than in previous years. In the United States as a whole the average age was 34 in 1940 and 40 in 1962. Apparently, however, the relative proportions of active and inactive registered nurses have remained quite constant over the years, i.e., about one-third of the registered nurses at any given time are not working as nurses [13]. These are important indications that the registered nurse labor market has been anything but stable. Adjustments are taking place within the opportunities and constraints of everyday life. If these seemingly spontaneous changes had not taken place, the hospital system would have been in shambles. This is certainly not the case, although there are difficulties.

An important phenomenon in addition to the changes in the labor market of registered nurses mentioned in the foregoing is the rapid increase—although never rapidly enough—of various types of auxiliary nursing personnel—licensed practical nurses and nurse's aides. The data on them are difficult to obtain—particularly as to active and inactive—but estimates have been made that in 1949 there were more than 300,000 auxiliary nursing personnel working in hospitals of whom an unknown, but small, number were licensed practical nurses. By 1964 there were 650,000 auxiliary nursing personnel of whom 150,000 were licensed practical nurses [14]. The ratio of licensed practical nurses to other auxiliaries is increasing markedly as more and more states pass licensure laws and encourage the development of schools. The current proportion of all types of bedside nursing staff in U.S. general hospitals is 31 per cent registered

nurses, 21 per cent licensed practical nurses, and 48 per cent nurse's aides [15]. The number of various types of nursing personnel employed in hospitals has increased faster than the number of beds, another phenomenon in staffing patterns of hospitals. There has been no stabilization of staffing patterns apparently since the turn of the century, and no set and codified staffing formula is in sight. In this regard a consultant group of the Office of the Surgeon General recommended a staffing ratio in general hospitals of 50 per cent registered nurses, 30 per cent licensed practical nurses, and 20 per cent nurse's aides [16]. Undoubtedly, this is a rule-of-thumb standard based more or less on an "ideal" existing pattern with possibly a suggestion for a higher proportion of licensed practical nurses than may now be true.

In a recent national self-appraisal by short-term general hospitals, it was reported that about 18 per cent of the budgeted or required positions for registered nurses were vacant [17]. Other studies have shown that, in general, registered nurses have higher vacancy rates than less skilled help. This makes sense in that the hospitals strive for the highest level of staffing that the market permits before there are substitutions of personnel with less training. If hospitals must maintain a given staff complement on given budgets, obviously adjustments have to be made. It is apparent that these adjustments have been made and will continue.

The concept of shortage as measured by budgeted but unfilled positions needs further study. It is difficult to accept this measure on face value. Is it the relationship of the hospitals' ideal staffing pattern for which it apparently has the money at going salary rates to its actual staffing at going rates? Would an increase in budgets for salaries close this gap? Undoubtedly this would help, but it is not reasonable to assume that there would be a one-to-one relationship. The labor market is much more complicated than that. Nurses' salaries in the general hospitals are increasing appreciably. It is too soon yet to determine whether or not this increase has had an effect on recruitment sufficient to satisfy the hospitals. The hospital usually lags behind the rise in the general wage scale. In today's economy it can hardly expect to be a pace-setter. The hospital responds to the larger economy rather than leading it.

B. INSTITUTIONAL NURSING: THE MENTAL HOSPITAL AND RELATED FACILITIES

SOCIAL AND MEDICAL tradition have kept the treatment and custody of the mentally ill and the so-called physically ill apart in separate institutions with separate staffs, and indeed separate concepts of ill- and well-being. Consequently, the staffing of mental hospitals has to be considered as a separate problem more or less peculiar to their situation. Since World War II, however, a social and medical philosophy has been growing to merge the treatment of the mentally ill and the physically ill both geographically and conceptually. In substance, however, the separation remains although progress is slowly being made to merge these two traditions.

Separate budgeting and staffing of mental and general hospitals is largely due to the fact that care of the mentally ill is almost wholly a state responsibility while the care of the physically ill is largely in the voluntary hospitals and a small portion in the publicly supported general hospitals. Private psychiatric hospitals and psychiatric units in general hospitals account for a very small per cent of the total beds. Hence, the state legislature must be appealed to directly for funds to operate the mental hospitals in direct competition with many other activities the state must finance in the public interest. In this regard, it is generally recognized that, country-wide, mental health has always had a relatively low priority. Slowly, however, better financing and the increasing acceptance of progressive concepts of patient care are coming forward.

Although generally known, it is nevertheless a startling fact that mental hospitals comprise less than ten per cent of hospital type institutions and admit less than two per cent of all patients entering all hospitals annually, yet comprise almost half of all the beds. There are over 500 institutions for the mentally ill and deficient of various types with a total of almost 700,000 beds [18]. In a year there are over half a million admissions to mental hospitals from a population of 200 million, or two and one-half per 1,000 population. This does not include admissions to the psychiatric units of general hospitals, which increases the admission rate to four per 1,000 population. The daily census of institutionalized psychiatric patients is

over 650,000, counting those in psychiatric units [19]. The trend during the recent past has been an increase in the admission rate but a decrease in the number of patients in institutions at any given time because of the shorter length of stay due to chemotherapy and the development of out-patient clinics and psychiatric units in general hospitals.

About 600 general hospitals now operate in-patient psychiatric units [20]. It is estimated that these units and the private psychiatric hospitals together discharge almost as many mental patients annually as the state mental hospital system, which discharges about 300,000 patients each year. A certain but unknown proportion of psychiatric patients with severe conditions are undoubtedly discharged from general hospitals and referred to psychiatric hospitals. The creation of psychiatric in-patient units in general hospitals is a prime example of the attempt to merge the health systems for the mentally ill and the physically ill.

Another attempt to diffuse the treatment of the mentally ill and to de-emphasize care in mental hospitals is the creation in recent years of psychiatric out-patient clinics in some states to serve patients who live at home but register at and seek services at these clinics.

In recent years the number of registered and licensed practical nurses has been increasing as have also so-called psychiatric aides. There are now about 16,000 R.N.'s employed by the *public* mental hospital system, according to a recent Public Health Service report [21]. Nevertheless, the proportion of unfilled budgeted positions to all positions is by any standard staggering, and it is a wonder that the system can function at all.

The contrast with the general hospital, as will be recalled, is startling. Even the substitutes for the registered nurses' positions have a high vacancy rate indicating a serious shortage of qualified personnel according to current professional judgment. It can be seen that the number of personnel of various types regarded as needed runs in the thousands. Worsening an already serious situation is the high annual turnover rate.

In the early part of this paper there was allusion to the generally open-ended nature of the health field, making it difficult to set up objective criteria of need, demand, and personnel. Although this

is true of so-called physical illnesses, the difficulty is worse for mental disease. Hence, it would seem that professional judgment deems that there are greater shortages of personnel in mental health than in the somatic diseases. Consequently, it is also more difficult to convince the custodians of public funds that mental health problems are as critical and that the shortages of personnel are as great as they are. Mental health continues to be the step-child in the spectrum of health needs and services among public policy makers. For one thing, it is not an important, purely political issue. A great many of the needs and possible impairments must be taken on faith, and this faith must flow from a greater humanitarianism in the body politic for the mentally ill than is now the case. Although society has come a long way from the demon theory of mental illness which held sway as recently as the latter nineteenth century, the mentally ill are now more likely to suffer from indifference rather than deliberate harassment and neglect. Society can be judged by how it regards and handles the mentally ill. Our society has no particular reason for pride in this regard.

C. COMMUNITY NURSING

THE PREVAILING image of the nurse is the nurse in a hospital setting, and, as measured by the proportion of nurses so situated, this is understandable. Today two-thirds of the registered nurses work in hospitals, and the overwhelming majority of these in general hospitals. Although the hospital based nurse is the one that appears to be getting most of the attention, a very neglected area of nursing and one which will become increasingly important is the type generally referred to as the community nurse, the nurse practicing outside of hospital settings and associated with public health agencies of various types and sponsorships. This type of nurse will become increasingly important because this is the natural group for expansion to cope with the growing problem of long-term illnesses, preventive services, health education, and family health counseling.

Currently about 40,000 nurses are associated with agencies such as public health departments, schools, visiting nurse associations,

and voluntary agencies dealing with maternal and child health. Nurses associated with industry number around 18,000 and probably should logically be included under the classification of community nurse. If all nurses engaged in community nursing are combined (including industrial health nurses), almost 10 per cent of the active nurses in the United States are so engaged. If the industrial health nurses are excluded, then 7 per cent of the active nurses are engaged in community nursing.

Community nurses are engaged in the following activities: controlling the spread of communicable disease; maternal and infant health protection; pre-school and school age protection; mass screening programs for tuberculosis, diabetes, arthritis, heart disease and cancer; mass immunization programs against smallpox, diphtheria, polio, and influenza; venereal disease control; health education, and family health counseling. Further, there is involvement in mental health and mental retardation, home care of chronic illnesses, and related problems.

The very listing of the functions and diseases gives little clue to what the community nurses actually do, where they practice, and the agencies with which they are associated. There is now less concern with communicable disease control as such, but more concern in the direction of the long-term chronic illnesses. In any case, community nursing today is very difficult to describe clearly because it is in a very fragmented state. The nurses are caught up in this fragmentation and are struggling to achieve some overall view and working order.

While the early emphasis was on communicable disease control, the general improvement in the standard of living surely has played a significant part in conquering these diseases. Hence, nursing is entering an era of general community health. So far, public health programs have not been comprehensive enough and have not had the resources, quality or coverage required to reach the entire population. New goals are now being established to reduce and where possible eradicate the incidence of diseases which are both major threats to life and make life miserable. The contemporary thinking looks toward broadening health protection by widening the application of programs that are family and patient centered and that attempt to consider total health needs rather than disease

entities. These naturally would include the extension of the community health center principle to the recently enacted programs of community centers for mental health, heart disease, cancer, and stroke.

There is, of course, no end to health problems that must be attacked from a community approach. Those that readily come to mind are alcoholism, cigarette smoking, air and water pollution, pesticides, automobile accidents, and the population explosion. Then there is also the imminent possibility of programs utilizing the computer for large scale diagnostic screening of the population leading to early diagnosis.

The much touted "community" approach to health problems is exceedingly underdeveloped in this country. The main development has taken place in the acute disease and curative sector of the health services system, and all other endeavors have been more or less secondary to or even a residual of this sector. Heroic efforts will need to be made to achieve a community approach in terms of coordinating the existing fragmented structure of curative and preventive services.

There are almost 9,000 separate public health agencies vying for the 40,000 or so nurses employed in public health work [22]. The vast majority of these agencies, employing almost 95 per cent of all nurses in the area, are local in control. Boards of education and local governmental agencies (such as well-baby clinics) split the lion's share of these nurses about equally—they each employed about 15,000 nurses at last count [23]. There are also 651 separate visiting nurse associations, many of them under private auspices, employing almost 5,000 nurses [24]. In general, the vacancy rates for nurses in public health service positions appear to be slightly lower than in hospitals and mental institutions. In 1966, about 6 per cent of the budgeted staff nurse positions and 11 per cent of the supervisory nurse positions were unfilled [25]. These relatively low vacancy rates do not mean that the area is well saturated with nurses, of course. Probably more than any other field, except perhaps public mental hospitals, public health nursing is chronically underfinanced and understaffed.

Despite the great fragmentation evident from the above, there are signs that public health nursing is moving in the direction of

consolidation. The total number of agencies active in the field dropped by 241 (from 9,094 to 8,853) between 1964 and 1966. The drop was not due to the loss of any agency services but rather to the consolidation of several small agencies into a large district or system [26].

D. OCCUPATIONAL HEALTH

THE LAST GROUP to be considered in the community health nursing category is the occupational health nurse in industry, constituting three per cent of the active nurses, or around 18,000 nurses. About four-fifths of these nurses work for firms with at least 500 employees. A third of all occupational health nurses are employed by very large firms—over 2,500 employees [27]. The registered nurses employed by industry are working largely without medical or nursing supervision; the vast majority are graduates of diploma schools. As with the other fields of community health nursing, information is quite fragmentary.

It is generally felt that without adequate supervision and/or consultation service, no in-plant health maintenance program can have much value. Health experts have recognized the value of such programs for a long time to the employee, the employer, and the general public. It may be a reasonable assumption that in-plant health maintenance programs would lighten the pressure on hospitals, clinics, and mental institutions.

Obviously, then, another area of nursing needing special attention is in-plant occupational health programs. The present shortage of nurses, however, makes expansion difficult. In addition, there is a natural attrition, and occupational health nurses seem to be somewhat older than nurses in general. (The Bauer and Brown report, U.S. Public Health Service, 1966, revealed that 44 per cent of the occupational health nurses were 50 years of age and over compared with 26 per cent of all professional registered nurses.)

It is clear that the number of nurses required to meet the professional standards of occupational health needs is at least twice the present number, an unrealistic goal. Hence, there should be

efforts toward a gradual and steady increase in the long run. Also, management needs to realize the value of in-plant occupational nursing.

This section on community health nursing is confusing because of the fragmentary nature of this field of nursing practice. The long-range efforts would appear to be self-evident, namely, to evaluate the entire community nursing service field in order to work toward some central coordination on state and local levels. It would seem necessary to establish some kind of central agency to pool the community health nursing resources to meet as efficiently as possible the mounting new health problems now facing us.

E. OTHER NURSING PRACTICE SITES

As REVEALED, nurses have a great range of sites and combinations of sites in which to work according to predilections and opportunities. Other sites which absorb a large minority—almost 20 per cent—of the active nurses are private duty in the hospital and home, and employment in physicians' and dentists' offices.

It is estimated that there are currently 64,000 nurses available for private duty; another 44,000 or so work in the offices of physicians and dentists. There are approximately 183,000 physicians in private practice [28] and 97,500 dentists [29].

1. *Private Duty*

The number of nurses active in private duty has been decreasing, and those in physicians' and dentists' offices have been increasing. It is within living memory, of course, that most of the active nurses were engaged in private duty, contracting directly with patients in hospitals and homes, somewhat analogous to private medical practice. Even as recently as 1949, 20 per cent of the nurses engaged in private duty; now it is less than 10 per cent. The great shift to salaried nurses on hospital staffs took place in the thirties so that now nursing is characteristically a salaried service with the exception of the private duty nurses, who provide an interesting example of

the tenacity in this country of demand for personal service engaged on an individual basis. As might be expected, private duty nurses are generally older than other active nurses (a quarter of them are over sixty) and are more likely to be generalists and diploma school graduates. Although the private duty nursing contingent has been decreasing for a long time, it would seem to be premature to predict its extinction in the near future, if ever, unless hospitals very actively discourage patients from engaging private duty nurses. It would seem that there will continue to be a demand for them in an affluent society if they are not deliberately restricted. A concern which pervades the consideration of the private duty nursing group is their degree of willingness and ability to keep up with medical technology which is changing rapidly, even for the general nurse. Private duty nursing in intensive care units is presumably out of the question. There is also the question of proper supervision.

2. *Physicians' and Dentists' Offices*

The number of registered nurses working in the private offices of physicians and dentists has been increasing although the proportion to all active nurses has remained quite constant. It would seem reasonable to predict that the demand will continue to increase if physicians and dentists, and particularly physicians, continue to practice in groups of various types, even small ones of three physicians or more, where it is expedient to share personnel. Common sense has it that nurses regard positions in private offices as desirable because of the informal staff structure. Their association with the physician and the patients approximates the type of informal team relationship of a bygone age recalled by many still alive. The physician's office is contrasted with the formal personnel structure of the large hospitals. There is general concern, however, as with private duty and community health nursing regarding supervision, standards, and keeping up with medical technology.

III. NURSING EDUCATION

A DECREASING proportion of the nurses are being trained in diploma schools attached to hospitals although these schools still account for 75 per cent of all graduates, a drop from 89 since 1955 [30]. An increasing proportion are being graduated from associate and baccalaureate degree schools. The proportion of female high school graduates who are entering the nursing profession is decreasing (from 6.1 per cent in 1955 to 4.7 per cent in 1965) although the absolute number is increasing because of the increasing number of young women who finish high school. Nationwide, there were 739 thousand female high school graduates in 1955 compared with 1.3 million in 1965 and an estimated 1.7 million in 1975 [31].

Despite the continued closing of diploma school programs as the nursing education system shifts to collegiate education, there has been a slight rise in total number of nursing schools nationwide. Since 1960, the number of diploma programs has declined from 908 to 797, but the total number of programs has increased from 1,137 to 1,225, the largest growth coming from the junior college programs which virtually quadrupled in number [32].

The resolution of the American Nurses' Association regarding diploma schools notwithstanding, the diploma schools are being eliminated for reasons predating that resolution in increasing numbers; this trend may well accelerate. Common knowledge in the field has it that the number of qualified applicants is falling off and the hospitals are finding it onerous and increasingly expensive to operate the schools. It does not seem reasonable to assume that diploma schools will totally disappear, at least not rapidly, but will stabilize somewhat at a relatively low number. The demand of hospitals for registered nurses of whatever educational level appears to be too great to forecast the disappearance of the diploma school if the hospitals are willing to continue them; somewhere there will be a balance between the number of available and qualified applicants and the number of diploma schools and places for students. In any case, the associate degree and baccalaureate degree programs cannot take up the slack fast enough. A direct result will continue to be the substitution of lesser trained personnel such as licensed practical nurses and nurse's aides.

Not only is there a high attrition rate of nurses leaving nursing employment, there is also a high rate of students dropping out of school before graduation. In 1964, 26 per cent of the girls who entered diploma schools of nursing failed to graduate, 44 per cent of those entering associate degree programs, and 42 per cent of those entering baccalaureate programs.

From 1955 to 1965 the number of graduates from all schools of nursing throughout the country inched slowly upward from 30,000 to 35,000 [33]. This increase is by no means marked, certainly not enough for substantial optimism. As might be expected, the net gain has come from associate degree programs, increasing from 252 graduates in 1955 to 3,349 graduates in 1965. The baccalaureate programs also have increased their supply (from 3,156 to 5,498) while the number of diploma school graduates has barely held its own [34].

There have been many studies of reasons for withdrawing from nursing schools before graduation. A third of the students give "failure in courses" as a reason, and a fifth mention "marriage and family," both combined accounting for 50 per cent of the total. The remainder offers a variety of reasons. In any case, the high withdrawal rate and the reasons given do not reveal the level of commitment usually expected of those choosing a professional career. Many diploma schools still frown on married students. Motherhood seems to constitute an even greater barrier in view of the live-in arrangements and hours of ward duty required. Associate degree programs undoubtedly are more flexible in this respect.

Programs of practical nursing have been increasing rapidly. From 1955 to 1965 the number of schools of practical nursing increased from 439 to 1,081 nationwide with graduates increasing from 10,000 to 25,000 a year, truly a rapid growth [35]. As with those entering registered nurse programs, the withdrawal rate among students of practical nursing is also high, close to 25 per cent for a one year program. Reasons for withdrawal follow the same pattern as for registered nurses.

Considering the long-range policy of the American Nurses' Association in having the associate degree and baccalaureate degree programs replace the diploma schools, it would seem that the in-

crease in these types of nurse graduates is not encouraging enough to fulfill this objective for some time to come. Further, the objective of increasing the number of registered nurses aspiring toward the master's degree, not to mention the doctorate, seems to be difficult to fulfill in that only 1,379 completed the course for a master's degree in 1965 and 1,279 in 1966 [36]. Although this represents a substantial increase over the 376 nurses earning master's degrees in 1951, still, literally the only way to improve quality of nursing services and to provide the leadership in teaching, research, and supervision is through graduate education which should attract intelligent and highly motivated women.

It is self-evident, of course, that as the number of diploma schools decreases, the support of nursing schools will shift from the voluntary hospital to the university or senior college and the junior or community college. Further, within these academic institutions, it appears that there will be a sharing of support and control between public and private agencies in the baccalaureate degree programs. Junior or community colleges are, of course, almost always publicly supported. What is portended, naturally, is the need for an increasing portion of nurse education being supported by public funds. Nursing education may emerge with the characteristic American interrelationship between the public and private sectors in the health field.

IV. OBSERVATIONS AND CONCLUSIONS

THIS COUNTRY subscribes in principle to the public policy objective that everyone should have relatively equal access to health services regardless of level of income. All of us subscribe to the objective in principle that health services should include the full range of services necessary for cure, prevention, rehabilitation, and management of long-term and intractable illnesses. This is a tall order, but given the resources and managerial skills in an affluent society such as the United States, attainment of these objectives should be approximated without quibbling over what constitutes attainment.

The chief debate in this country is over the means as to sources

of funds—private and/or public—and methods of delivery. The essentially utopian objective of equal accessibility, perforce, will influence heavily the means. In order to attain this objective even approximately, it would seem that a primary public policy objective should be to increase the health facilities and personnel to keep up with the increase in population and, desirably, to increase the ratio to population of various types of facilities and personnel needed for problem areas such as chronic illness, mental health, community preventive services and the like. It would seem desirable to work with various methods of delivery of services in a context of relative abundance rather than in one of relative scarcity. Hence, it is imperative to increase supply and raise the quality of various types of nursing personnel.

At the same time there is already great and justified concern with methods of organizing and delivering services. The problem of increasing and improving the quality of the supply is in essence one of social engineering, as it were, providing there is a will to recruit and finance nursing personnel. Modifications and expansion of the existing structure of education will accomplish this objective. As to methods of organizing and delivering services, this is a far more difficult and long-range endeavor because it concerns the heart of the elements of a professional service, career patterns, incentives, standards, job descriptions.

It would seem, however, the need for maintaining and increasing the supply of various types of nursing personnel is as self-evident as anything can be, given the trends in population, disease, and disability that are as clear as day. The question of increasing productivity of these personnel and facilities is a more difficult problem, and means for its attainment are far from self-evident. They will require study and application.

Recommendations regarding public policy must clearly be a balance between utopian goals and the constraining and liberating factors of the objective circumstances. Let us examine the objective circumstances, with trends irreversable in the foreseeable future, which, therefore, will be ignored at our peril. They are arranged in a rough order of priorities as to influence on policy.

A. The population will continue to increase in the foreseeable future. The United States now has a total population of 200 million;

by 1980 it is expected to increase to 242 million [37]. There will then be an absolute and possibly a relative increase in age groups under five (although there has been a drop in number of births over the last ten years, this trend is due to be reversed as the "post war" babies move into the child bearing ages), and over 65, both comparatively high users of health services.

B. According to most economists the economy will continue to expand for the foreseeable future, resulting in an increasing gross national product and increasing discretionary income in both the public and the private sectors. Hence money, as such, need be of diminishing concern. The chief problem will increasingly be priorities.

C. Medical technology will increase in size, complexity, and effectiveness in saving and prolonging life. Many of the people whose lives will be saved and prolonged will require never-ending, closely supervised medical care.

D. Perforce, there will be an increase in the number and proportion of people with long-term and frequently incurable illness who will need basic, custodial care. This prediction is made despite possibilities for better prevention and rehabilitation which, in the long run, will only retard the development of disease and prolong life, not abolish disease.

E. The unit cost of personnel will increase in order to compete with the labor market, and this will intensify the desire for substitutions for registered nurses and give the registered nurse an increasingly higher status within the hierarchy of nurse types.

F. Associated with the last trend will be increasing differentiation among registered nurses in clinical specialties because of the intensification of specialization and specialized procedures in medicine itself.

G. Women of high school age aspiring for professional status will do so through the avenue of the college and university rather than through institutions associated with vocational training. The aspiring R.N. will increasingly seek education via the college and university route.

H. The qualifications for professional attainment will continue to emphasize technical proficiency based on physical and natural sciences rather than nurturance based on behavioral science, feeling,

and compassion. This will be one of the problems the nursing profession must watch diligently as it aspires toward higher professional status. The nursing profession is in a strategic position to bridge the behavioral and medical sciences in behalf of total patient care. Indeed, it is very conscious of the need for a behavioral science component in professional nursing education.

I. The quality and skill of the managers of the health services system will continue to improve, with incalculable effects on the administration of health services. The result should be greater effectiveness, but not necessarily less cost.

What do the foregoing objective conditions portend for the health services in general and the nursing services in particular? First, it would seem that it is necessary to keep up the facilities and types of personnel in relation to population growth or scale down the utopian objectives of cure, prevention, rehabilitation, and custodial care. Further, since there is general dissatisfaction on the part of both professionals and significant segments of the public with current supply, it would seem that a policy of expansion should pervade the health services. Hence, there should not be undue concern with the specious precision of current ratios and projections. This will give the false impression that there is a "proper" ratio of facilities and personnel to population. The possible needs and expectations for health services are so open-ended that they defy objective criteria. If this were not so, professional judgment of need and the facilities and personnel in existence would not be so far apart, nor would there be such wide differences between areas and countries with quite similar social and economic levels. The prime example is the area of mental health, which has been starved for sufficient personnel and funds for generations.

Unless personnel, facilities, and financing keep pace with, and in fact outdistance, population growth, the result will be a health care system which will deal well with acute emergencies and dazzling surgery and dramatic chemotherapy but will handle quite badly the less "popular" areas of prevention, rehabilitation, and humane custodial care.

Despite the achievements regarding the control of infections and communicable diseases—prevention has barely begun to scratch the surface of potential need and application, not to mention rehabili-

tation. It would seem that the problem of personnel as deduced from obvious social priorities set by the profession and the public will be in the area of prevention, rehabilitation and custodial care —technically known as community health, occupational health, and long-term institutional care. In our highly technically oriented society it would seem that it will be possible to recruit and train enough nurses for the clinical specialties dealing with acute and dramatic conditions because of their appeal to health personnel, the interesting education required, and the priorities set by society. Within the institution of the general hospital the struggle for status is taking place. This is the area most visible to the policy makers and the public. Community health will take more selling and should be an expanding sector for reasons described earlier.

The irreversable trends affecting the health services system have been described, and, in gross terms, what they mean for the future. Can they be met? Will they be met? It would seem that they can be met because this country has the resources and the finances. There would seem to be enough discretionary income to enable, say, a 50 per cent increase in expenditures for various services, and a net increase in appropriate personnel and facilities. These trends are nothing new; the health field has been expanding for 100 years. The cumulative effect of science, medical effectiveness, affluence, and longevity is now being experienced. Gross retrenchment would be disastrous—gross expansion would be salutary and permit the working out of delivery methods in a context of abundance.

The nursing leadership aspires toward an upgrading of the registered nurse and a professional status symbolized by education, responsibilities, prerogatives, and commitment to a career. In terms of the characteristics of a profession described earlier, the nursing profession has great odds to overcome to attain the status they desire. Studies of nursing students in nursing schools have indicated weak commitment to career goals in that the future life styles of the student are determined more by personal interests in the prevailing feminine role in society than by letting the life style of a professional career determine the basis of it. If nursing is to become a cohesive and strong profession, it must attract women who desire a professional life style, with all other interests complementary or subsidiary to such interests. Women in law, medicine, research and teaching in

higher education seem to combine a profession and homemaking without withdrawing from the profession. This also seems to be true to some extent in primary and secondary education, social work, and librarianship, all predominantly staffed by women. Nursing, however, like no other occupation, is primarily a women's occupation, and, perforce, the nursing profession has great difficulty in developing a cohesive professional image which can fight for its place as a profession and win. It would then seem that if nursing education is upgraded, particularly at the baccalaureate and post-baccalaurete levels, and as nursing specialties related to clinical nursing are further developed, and their market value puts them in the well-paid income brackets (certainly over $10,000 a year), the personal investment of women who choose professional nursing careers will be so great that they cannot afford to withdraw even temporarily. Perhaps under these career nurses there can be a high turnover of lesser trained and lesser professionally committed nursing personnel.

It would seem that these developments may come about anyway, and it is indeed these irreversable trends that the nursing leadership is acutely aware of and is seizing hold of. All signs seem to point to increased specialization, increased education and in-service training along the trends of increasing medical technology, so that the registered professional nurse will be associated with acutely ill patients of relatively short duration. The licensed practical nurses and nurse's aides will be allocated to patients who do not need constant surveillance in the general hospital and in the extended care type of facilities, nursing homes, and homes for the aged. Other types of nurses —such as public health, school, private duty, and occupational health nurses—will need training appropriate to their responsibilities and duties. Underpinning the entire problem of nursing personnel should be an emphasis on expansion and quantity with quality considerations appropriate to the duties and responsibilities.

From the standpoint of comprehensive patient care the trend toward technical specialization as an integral aspect of professionalization is distressing because it would seem that it is more than a cliché to observe that specialization tends toward so-called fragmentation of the patient. At the same time it would seem that the nursing profession both historically and structurally, as pointed out

by Fred Davis and others in "Problems and Issues in Collegiate Nursing Education," *The Nursing Profession,* (1966), that ". . . the nursing profession is admirably suited to combine the complex technical expertise which will be needed with a decent, humanistic regard for patients as persons." Indeed, the nursing profession has shown much more interest than the medical profession generally, with the exception of psychiatry and pediatrics, in the psychological and sociological aspects of patient care.

The challenge to collegiate nursing education is then immense. If the medical specialist becomes the model, the behavioral aspects of patient care will languish and be preempted by lesser trained nurse types, de facto. If the patient-as-a-person orientation can be the model, then, it would seem, professional nursing has a viable role model to develop in its educational program. Undoubtedly, the tension between the patient orientation and the assistant to the physician orientation will persist as an inherent part of the nursing role. The issue seems to be drawn, and perhaps it will be resolved by a formal stratification in various levels of nursing, as now seems to be the case. Whatever the outcome, "tenderness" and "technique" need to be properly mixed, but, frankly, this writer is not optimistic about a viable emphasis on "tenderness." Our dazzling technological culture continues to show impressive results with technique. As long as this continues, "tenderness" will wait, since its results on patient care cannot be measured clinically.

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