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The Nursing Shortage: Contributing Factors, Risk Implications, and Legislative Efforts to Combat the Shortage

Kristin M. Mannino*

I. Introduction

Registered nurses represent the largest single health care profession in the United States and are an integral part of the health care workforce. Yet communities across the country are currently facing nursing shortages, and there is growing evidence that these shortages will only worsen over time.

Many argue that the current nursing shortages are major contributors to emergency department overcrowding, cancellation of elective surgeries, discontinuation of clinical services, and the limited ability of the health care system to respond to mass casualty incidents. Although doctors and nurses nationwide have voiced their concern that shortages necessarily lower the quality of care received

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1 Robert Steinbrook, Nursing in the Crossfire, 346 NEW ENG. J. MED. 1757 (2002).


3 Peter I. Buerhaus et al., Implications of an Aging Registered Nurse Workforce, 283 JAMA 2948, 2953 (2000).

by patients, studies have only recently addressed the issue.\(^5\) Determining the extent to which shortages exist and the means to combat them have proven to be onerous tasks, ones that many states have tried and failed to remedy.

This article first discusses how nursing shortages are measured, factors contributing to shortages, risk implications associated with shortages, and recent state and federal efforts to combat them. Next, this article analyzes the liabilities health care providers face under claims of inadequate staffing of registered nurses, the advantages and disadvantages of California’s mandatory nurse-to-patient ratio, and other recommendations to increase the number of nurses entering the workforce. Finally, this article concludes that sufficient information is now available to adequately address the nursing shortages.

II. Background

Nursing shortages have existed since the inception of the profession\(^6\) and have generally been related to economic factors: when the overall economy declines, nurses who are married or are working mothers are more likely to work longer hours, while in better economic times, nurses are less likely to work or may only work part-time.\(^7\) The current nursing shortages began in 1998 in intensive care units and operating rooms and have since spread to labor-and-delivery units and general medical and surgical wards.\(^8\) Studies have projected that the size of the registered nurse workforce will be nearly 29% below projected requirements in 2020 if the current trends continue.\(^9\) These predictions suggest that short-term solutions

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\(^7\) Steinbrook, supra note 1, at 1760.

\(^8\) Id. at 1761.

will not suffice in remediying the impending shortages.\textsuperscript{10}

A. How Are Nursing Shortages Measured?

Currently, there are no widely accepted standards for determining the adequate level of registered nurse staffing.\textsuperscript{11} Some argue that this lack of clarity causes problems in effective policymaking.\textsuperscript{12} There are, however, some common indicators of nursing shortages.

One common indicator is self-reported shortage status.\textsuperscript{13} In a 2001 survey, 84\% of hospital chief executive officers reported that they had a shortage of registered nurses.\textsuperscript{14} In both 2001 and 2002 surveys, 95\% of nurses reported that there was a shortage.\textsuperscript{15} Hospitals also report that it takes longer to recruit nurses than it did a few years ago. In 2001, it took 13.3 weeks to hire a medical or surgical nurse, compared to 10.5 weeks in 2000.\textsuperscript{16} It also took 16.6 weeks to hire a specialty nurse, compared to 14 weeks in 2000.\textsuperscript{17}

Another indicator is the vacancy rate of nursing positions.\textsuperscript{18} Today, 25\% of all hospital personnel vacancies are for nurses.\textsuperscript{19} The American Hospital Association reported that there were as many as


\textsuperscript{11} Kevin Grumbach et al., Measuring Shortages of Hospital Nurses: How Do You Know a Hospital with a Nursing Shortage When You See One?, 58 Med. Care Res. & Rev. 387, 387 (2001).

\textsuperscript{12} Id.

\textsuperscript{13} Steinbrook, supra note 1, at 1760.

\textsuperscript{14} Id. at 1762.

\textsuperscript{15} Id.


\textsuperscript{17} Id.

\textsuperscript{18} Steinbrook, supra note 1, at 1760.

\textsuperscript{19} Id.
126,000 nursing vacancies in American hospitals as of June 2001.\textsuperscript{20} In 2001, the mean vacancy rate of registered nurse positions at a given hospital was 13\%, and 15\% of hospitals reported vacancy rates of at least 20\%.\textsuperscript{21} Yet in 2000, approximately 494,000 registered nurses did not use their licenses.\textsuperscript{22} This discrepancy suggests that a large number of nurses are choosing to work in other areas.

A recent study found that the above two indicators – self-reported shortage status and nursing vacancy rates – have the strongest association with shortages of registered nurses.\textsuperscript{23} Other indicators include the turnover rate for nursing positions, the number of registered nurses per 100,000 of the population, and the “case mix,” or number of nurses at a hospital after adjustment for the number of inpatients and the differences in the types of patients seen.\textsuperscript{24}

\textbf{B. Factors Contributing to Nursing Shortages}

Although there has actually been a growth in the reported number of nurses since the mid-1980s, nursing shortages still currently exist.\textsuperscript{25} Multiple factors have contributed to this disparity. An examination of some of these factors helps explain why the current nursing shortages are projected to worsen in the foreseeable future.

One of the most significant factors is the reduction in reimbursement paid by managed care companies to hospitals and other acute care facilities.\textsuperscript{26} The decline in reimbursement has led to operating budget cuts and restructuring plans. Because nurses’

\begin{itemize}
\item \textsuperscript{21} Steinbrook, \textit{supra} note 1, at 1761.
\item \textsuperscript{23} Grumbach et al., \textit{supra} note 11, at 399.
\item \textsuperscript{24} Steinbrook, \textit{supra} note 1, at 1760-61.
\item \textsuperscript{25} See \textit{id.} at 1757; Barbara A. Mark, \textit{What Explains Nurses’ Perceptions of Staffing Adequacy?}, 32 J. NURSING ADMIN. 234, 234-35 (May 2002).
\item \textsuperscript{26} Stapleton, \textit{supra} note 22.
\end{itemize}
salaries represent about 20% of operating costs, registered nurses are either laid off or replaced with less trained, lower paid, unlicensed assistant personnel. This, in turn, has caused understaffing or inadequate staffing at many hospitals.

Nurses are also overworked. The burden of care for nurses has escalated due to the substantial decline in inpatient length of stay and the rise in "patient acuity," or the severity of patient illnesses. Many hospitals, in an effort to deal with inadequate staffing, require registered nurses to work overtime. Forty percent of hospital nurses have burnout levels that exceed the norm for health care workers. In a 2001 survey of 7300 nurses, the American Nurses Association reported that 78% of those nurses skipped meals and breaks to care for patients, 73% felt an increased pressure to work, and 58% no longer had time to attend continuing education programs. Furthermore, a recent study found that burnout accurately predicts nurses' intentions to leave their current jobs within a year. Overwork and subsequent burnout seem to be driving many nurses out of the profession.

In addition, women, who comprise over 90% of the registered nurse workforce, are increasingly moving to professions with higher pay and better working conditions. Enrollment at nursing

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27 Id.
28 White, supra note 6, at 286.
29 Steinbrook, supra note 1, at 1757.
30 Mark, supra note 25, at 234.
34 Aiken et al., supra note 32, at 1992.
36 Steinbrook, supra note 1, at 2953.
colleges and universities has declined for six consecutive years. According to a survey by the American Association of Colleges of Nursing, although enrollment in generic baccalaureate programs in nursing increased by 3.7% nationwide last year, enrollment in nursing programs overall is still down 17%, or 21,126 students, from 1995. In addition, since 1991, the salaries for registered nurses have remained relatively flat when compared with the rate of inflation.

Enrollment is also down because nursing schools do not have enough teachers. According to a survey conducted by the American Association of Colleges of Nursing, almost 40% of respondent schools indicated that they did not accept all qualified applicants into entry-level baccalaureate nursing programs because of faculty shortages. There are various reasons for this shortage, including the aging and subsequent retirement of educators, higher compensation in clinical and private sector settings, and fewer graduates from master’s and doctoral programs in nursing.

The aging of the nursing profession is another factor contributing to the nursing shortage. As baby boomers retire, demand for nurses is expected to rapidly increase. Today, the average working registered nurse is approximately 43 years old. Only 12% of registered nurses in the workforce are under thirty years of age. By 2010, it is projected that the average working registered nurse will be 50 years old. Older registered nurses are more susceptible to neck, back, and foot injuries and are less able to perform physical tasks than younger nurses. Furthermore, they may have higher

37 Am. Ass’n of Colleges of Nursing, supra note 2.
38 Id.
39 U.S. DEP’T OF HEALTH & HUMAN SERVS., supra note 9, at 8.
40 Am. Ass’n of Colleges of Nursing, supra note 2.
41 Id.
42 Id.
43 Steinbrook, supra note 1, at 1762.
45 Id.
46 Buerhaus et al., supra note 3, at 2952.
47 Id. at 2953.
expectations of working conditions and require greater autonomy and respect than has typically been afforded to nurses.\textsuperscript{48} The combination of higher expectations and a reduced capacity to perform physical tasks could lead to an exodus of older nurses from the profession in the near future, thereby exacerbating the problem.

To make matters worse, many nurses do not seem satisfied with their profession. The American Nurses Association reported that over half of the nurses surveyed would not recommend the nursing profession as a career for their children or friends.\textsuperscript{49} As one nurse observed, "[t]he work is extremely difficult, very physical, and very abusive. As these young people are coming out of high school, there are many more jobs they can apply for, including ones that pay more money for less physical labor and abuse. Why would you want to work as a nurse?"\textsuperscript{50} The dissatisfaction within the nursing profession may have spread to the general public, thereby decreasing the number of individuals who aspire to be nurses.

C. Quality of Care and Risk Implications Associated with Shortages

Although common sense suggests a connection, research is only beginning to demonstrate that staffing levels are associated with actual patient outcomes.\textsuperscript{51} Therefore, in addition to relevant studies, it is important to examine the opinions of doctors and nurses regarding the quality of care and risk implications associated with nursing shortages.

1. Doctors' and Nurses' Views

Doctors and nurses are concerned that inadequate staffing lowers the quality of care given to patients. Many have argued that the substitution of registered nurses with less trained, lower paid, unlicensed assistant personnel to reduce operating costs compromises patient safety.\textsuperscript{52} As one doctor stated, "[t]here is cutting the fat and then there is cutting the bone and muscle. Nurses are the bone and

\textsuperscript{48} Id.

\textsuperscript{49} AM. NURSES ASS'N, supra note 33, at 12.

\textsuperscript{50} WebMDHealth, America Needs Nurses, at http://my.webmd.com/content/article/3734.6347 (last visited May 1, 2003).

\textsuperscript{51} Grumbach et al., supra note 11, at 389.

\textsuperscript{52} See, e.g., White, supra note 6, at 286.
Doctors and nurses alike voice their concern about the significant difference in the level of education received by nurses relative to aides. Registered nurses must complete an associate’s degree program at a community college, a diploma program at a hospital, or a baccalaureate degree program at a college or university, and subsequently obtain a state license.\(^5\) Licensed practical nurses typically have a high school diploma and are trained in a one-year program at a technical or vocational school, community college, or junior college.\(^6\) In contrast, the training of aides is not regulated by state licensing boards.\(^5\) Training periods can range from six weeks to as little as a few hours.\(^5\) Considering the difference in training that these health care workers receive, patient safety may be reasonably questioned in light of the substitution of registered nurses with aides.

Nurses nationwide consistently report that hospital nurse staffing levels are inadequate.\(^5\) A 2002 study showed that perceptions of staffing among nurses were significantly influenced by the hospital’s case mix index, the growth in hospital admissions, the number of beds in the unit, and patient acuity.\(^5\) In a survey conducted in 2001 by the American Nurses Association, 75% of nurses surveyed felt that the quality of nursing care had declined in their work setting in the previous two years.\(^6\) Over 90% of these nurses indicated that inadequate staffing was the cause of the decline in quality of care.\(^6\) An alarming 41% of all of the nurses surveyed indicated that they would not feel confident having someone close to them receive care in their facility.\(^6\)

\(^{53}\) Stapleton, supra note 22 (quoting Todd Taylor, MD, Arizona College of Emergency Physicians).

\(^{54}\) Steinbrook, supra note 1, at 1757.

\(^{55}\) Id.


\(^{57}\) Id.

\(^{58}\) Aiken et al., supra note 32, at 1987.

\(^{59}\) Mark, supra note 25, at 239-40.

\(^{60}\) AM. NURSES ASS’N, supra note 33, at 6.

\(^{61}\) Id. at 7.

\(^{62}\) Id. at 11.
2. Relevant Studies

Studies have only recently begun to show an association between nurse staffing levels and adverse patient outcomes. In fact, until last year, research on the issue was inconclusive.63

In April 2001, however, the Department of Health and Human Services released a study revealing that the number and mix of nurses in a hospital affects the quality of care received by patients.64 The study, based on data from more than five million patient discharges in 799 hospitals across 11 states,65 found a strong and consistent relationship between nurse staffing and five adverse outcomes in patients: urinary tract infections, pneumonia, shock, upper gastrointestinal bleeding, and length of stay.66 A higher number of registered nurses was associated with a 3% to 12% reduction in the rates of adverse outcomes.67

A study released in May 2002 in the New England Journal of Medicine reexamined and affirmed the results of the Department of Health and Human Services study.68 It also found that a higher proportion of hours of nursing care provided by registered nurses and a greater number of hours of care by registered nurses per day were associated with better care for hospitalized patients.69 Patients with a higher proportion of care provided by registered nurses had shorter lengths of stay, fewer failure-to-rescue deaths, and lower rates of urinary tract infections, upper gastrointestinal bleeding, hospital-acquired pneumonia, and shock or cardiac arrest.70 Although

63 See Needleman et al., supra note 5, at 1715; Seago, supra note 5, at 49. For a summary of studies showing an association between nurse staffing and adverse patient outcomes, see Marguerite Jackson et al., Nurse Staffing and Healthcare-Associated Infections, 32 J. NURSING ADMIN. 314, 317 (June 2002).


65 Id. at xxiii.

66 Id. at 131.

67 Id.

68 See Needleman, supra note 5, at 1715.

69 Id. at 1719.

70 Id. The evidence is not as strong for failure to rescue as for the other five measures. Id.
evidence of an association exists between higher levels of staffing by registered nurses and lower rates of adverse outcomes, there was no similar evidence related to staffing by licensed practical nurses or aides.\footnote{Needleman, supra note 5, at 1720.}

A subsequent study showed an association between fewer nurses at night and an increased risk for specific postoperative pulmonary complications in patients undergoing hepatectomy surgery, in which all or part of their livers are removed.\footnote{Justin B. Dimick et al., Effect of Nurse-to-Patient Ratio in the Intensive Care Unit on Pulmonary Complications and Resource Use After Hepatectomy, 10 AM. J. CRIT. CARE 376, 380 (Nov. 2001).} There was a significant increase in complications and use of resources, such as intubation, with patients receiving post-operative care in intensive care units (“ICU”) with a nurse-to-patient ratio of 1:3 or higher.\footnote{Id.} These results suggest that ICU nurse-to-patient ratios can directly affect patient outcomes.

Even more recently, a study released in October 2002 by the Journal of the American Medical Association revealed that surgical patients have a higher risk of death and injury from infections and other preventable complications when fewer nurses care for them.\footnote{Aiken et al., supra note 32, at 1990-91.} This year-long study of 168 hospitals is the nation’s most comprehensive examination of patient safety and nursing care to date.\footnote{See Michael J. Berens, Report Ties Nurse Shortage to Deaths; Risk Starts to Rise After 4 Surgical Patients to Shift, CHI. TRIB., Oct. 23, 2002, at 1.} The results did not indicate how many nurses are needed to care for patients, nor did it recommend a minimum nurse-to-patient ratio,\footnote{Aiken et al., supra note 32, at 1992.} but it did find that 50% of the hospitals had a nurse-to-patient ratio of 1:5 or higher.\footnote{Id. at 1990.} Additionally, the study found that nurses in hospitals with the fewest nurses caring for patients are more than twice as likely to experience job-related burnout and almost twice as likely to be dissatisfied with their jobs when compared to nurses in hospitals with the highest nurse-to-patient ratios.\footnote{Id. at 1992.}
D. Recent State and Federal Efforts to Combat the Nursing Shortage

In light of the growing evidence that nursing shortages adversely affect patient safety and quality of care, many states have taken actions to remedy the situation. Some states have enacted legislation, including, but not limited to, the prohibition of mandatory overtime, nursing education incentives, and whistleblower protection. California has become the forerunner in establishing mandatory statewide nurse-to-patient ratios. In addition to state efforts, Congress has established grants, funding, and loan forgiveness for those entering the nursing profession.

Several states have introduced legislation prohibiting mandatory overtime. In 2002, five states enacted these prohibitions. In Maryland, an employer cannot require a nurse to work more than the regularly scheduled hours according to a predetermined work schedule, unless specific exigent circumstances exist. Minnesota prohibits action against a nurse who refuses overtime if, in the nurse’s judgment, it would jeopardize patient safety. New Jersey law prevents a health care facility from requiring an employee to work in excess of an agreed-to, predetermined, and regularly-scheduled daily work shift, not to exceed forty hours per week, unless unforeseeable emergent

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81 Md. Code Ann., Lab. & Empl. §§ 3-421(c)-(d). A nurse may be required to work overtime if (1) there is a nonrecurring emergency situation that could not reasonably have been anticipated, the “employer has exhausted all good faith, reasonable attempts to obtain voluntary workers,” the nurse has “critical skills and expertise that are required” for the shift, and continuity of care is needed, or (2) if a condition of employment includes on-call rotation or the nurse works in community-based care. Id.

82 Minn. Stat. § 181.275.
circumstances emerge: overtime is a last resort and cannot be used to fill vacancies resulting from chronic short staffing. Regulations in Texas require hospitals to develop policies and procedures for mandatory overtime. Finally, Washington law provides that overtime is strictly voluntary and that refusal to work overtime is not grounds for action against a nurse.

Also, in 2002, many states either introduced or enacted legislation designed to bolster nursing school enrollment. In fact, state legislatures introduced over 100 bills in 2002 aimed at increasing the number of students who graduate from nursing programs. Seven states enacted such legislation, some of which deserve mention. Florida’s Nursing Shortage Solution Act authorizes loan repayments of up to $4000 per year for up to four years to select graduates of accredited or approved nursing programs who show proof of continued employment in designated facilities within the state. The Florida Act also creates a grant program for school districts to fund exploratory nursing education programs in middle schools or career and technical nursing education programs in high schools that provide programs in nursing. Kentucky created the Nursing Workforce Foundation to provide funding and award grants to nursing education programs and nursing employers for student recruitment and for training registered nurses or licensed professionals.

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83 N.J. STAT. ANN. § 34:11-56a34 (West 2002).
84 27 TEX. ADMIN. CODE § 3162 (West 2002).
85 WASH. REV. CODE § 49.28.140 (2002).
87 Id.
89 FLA. STAT. ANN. ch. 240.4075 (West 2002).
90 Id. ch. 1006.051.
practical nurses.\textsuperscript{91} The Foundation will award nursing scholarships and loan repayment programs for registered nurses enrolled in a state program designed to lead to a master’s degree or higher in nursing.\textsuperscript{92} Virginia even allows part-time nursing students to qualify for scholarship and loan repayment programs.\textsuperscript{93} Finally, West Virginia has created a scholarship program for individuals pursuing master’s degrees in nursing who agree to teach two years in a nursing school.\textsuperscript{94}

In addition, some states have introduced whistleblower laws to prevent employers from taking retaliatory action against nurses for reporting improper quality of care.\textsuperscript{95} In 2002, Maryland and New York enacted such laws.\textsuperscript{96} Maryland prohibits retaliatory action against any licensed or certified employee who discloses, or threatens to disclose, an activity, policy, or practice that is in violation of a law, rule, or regulation to a supervisor or board.\textsuperscript{97} New York law bars an employer from taking retaliatory action against an employee who discloses to a supervisor or public body an activity that he or she reasonably believes constitutes improper quality of care or who refuses to participate in that activity.\textsuperscript{98} In both Maryland and New York, the employee must first bring the activity, policy, or practice to the attention of a supervisor or employer and afford them a reasonable opportunity to correct the problem before the statutory protection against retaliatory action applies.\textsuperscript{99}

On the other hand, California is the only state that has set mandatory nurse-to-patient ratios for all hospitals in the state. In October 1999, California passed Assembly Bill 394, the first comprehensive legislation in the United States establishing minimum staffing levels for registered nurses and licensed vocational nurses

\textsuperscript{91} KY. REV. STAT. ANN. §§ 314.451, 314.454, 314.458 (Banks-Baldwin 2002).

\textsuperscript{92} Id. § 314.462.

\textsuperscript{93} VA. CODE ANN. § 23-35.9 (Michie 2002).

\textsuperscript{94} W. VA. CODE § 18C-3-3 (2002).


\textsuperscript{97} MD. CODE ANN., HEALTH OCC. § 1-502 (2002).

\textsuperscript{98} N.Y. LAB. LAW § 741.

\textsuperscript{99} Id.; MD. CODE ANN., HEALTH OCC. § 1-503.
working in hospitals. In January 2002, Governor Gray Davis announced the proposed nurse-to-patient ratios. The proposed ratios range from 1:1 in trauma units to 1:6 in medical and surgical units, which will be reduced to 1:5 within twelve to eighteen months after the effective date. The regulations are likely to be finalized later this year, after public comments and hearings, and will eventually take effect in July 2003. Other states are currently considering legislation with nurse-to-patient ratio provisions.

The federal government has also made efforts to combat the nursing shortage. Congress passed the Nurse Reinvestment Act in July 2002, which will provide federal money to help pay for nursing training and forgive education loans for trainees who agree to work in areas with acute shortages. President Bush signed the law on August 1, 2002, but Congress has yet to appropriate money to fund the program. The Nurses of Tomorrow Act of 2001 is also designed to reduce the worsening shortage of registered nurses in hospitals, but has yet to be passed into law. Among other things, it would authorize nurse retention and recruitment grants to meet the

102 Id.
103 Steinbrook, supra note 1, at 1762.
cost of continuing nurse education.\textsuperscript{108} It would also establish a $2000 federal tax credit for nurses working in hospitals and authorize basic nurse education expansion grants for nursing schools to expand the number of students.\textsuperscript{109} The Nurse Retention and Quality of Care Act of 2002, which also has yet to be passed into law, would provide programs to improve nurse retention, the nursing workplace, and the quality of care.\textsuperscript{110} It would provide grants to health care organizations for them to develop and implement model practices designed to make the workplace attractive for nurses.\textsuperscript{111}

These state and federal efforts show that our elected officials are taking the issue very seriously. The question remains whether they will entice nurses back into the workforce or whether additional measures will be necessary.

III. Analysis

Recent studies finally confirm what doctors and nurses have claimed for years: the fewer the nurses, the greater the likelihood of adverse patient outcomes.\textsuperscript{112} Now that concrete evidence is available to the trial bar, the courts will probably be faced with patient malpractice claims based on hospital's inadequate staffing of registered nurses. Although there are no cases to date specifically on point, it is only a matter of time before patients are successful in this type of claim. Courts will not shut their eyes to the obvious, especially when patient safety is at issue. Hospitals will then have to grapple with how to best shield themselves from liability.

Hospitals can better protect themselves from allegations of inadequate staffing if there is legislation in place that addresses the nursing shortage and proposes clear, concise solutions. Courts will look favorably upon hospitals that abide by the legislative solutions and unfavorably upon those that do not. If the state does not have legislation in place, or if the legislation proves to be ineffective, hospitals must set their own standards. Hospitals should take into account the current studies and statistics, as well as the unique aspects of the individual hospital when devising standards to ensure

\textsuperscript{108} Id.

\textsuperscript{109} Id.

\textsuperscript{110} Nurse Retention and Quality of Care Act of 2002, H.R. 4654, 107th Cong. (2002).

\textsuperscript{111} Id.

\textsuperscript{112} Needleman, \textit{supra} note 5, at 1715; Aiken et al., \textit{supra} note 32, at 1990-91.
patient safety.

California implemented its mandatory nurse-to-patient ratio because other legislative efforts failed to improve the current nursing shortage.\footnote{Rose Ann DeMoro, \textit{What California Has Started . . . Staffing Ratios, Union Activism Are National Solutions to the Nursing Shortage}, \textit{Mod. Healthcare}, at 26 (Apr. 1, 2002).} Although some argue that the ratios are “the only effective approach to bringing nurses back to the hospital bedside and repairing the patient safety net,”\footnote{Id.} they may have serious unintended consequences. If hospitals are unable to find qualified registered nurses, they may have to eliminate beds, thereby reducing patients’ access to care.\footnote{See Steinbrook, supra note 1, at 1763.} Additionally, the costs of complying with the regulations will be too burdensome for hospitals that are already financially strapped.\footnote{Id.} Finally, no generally accepted standard exists for nurse-to-patient ratios, and, arguably, ratios should be determined for individual hospitals, and even for specific units within those hospitals.\footnote{See FAGIN, supra note 56.} A staffing formula that takes into account the importance of staff experience, patient acuity, availability of support staff, and the physical configuration of hospitals might be a reasonable alternative to staffing ratios.\footnote{See Seago, supra note 5, at 53.} The American Nurses Association, while applauding California’s legislation in general, warned that consideration must also be given to patient needs and unit support functions.\footnote{Press Release, American Nurses Association, Nurse-to-Patient Ratios Proposal Will Strengthen Patient-Care Safety Net, But Broader Solutions Still Needed (Jan. 23, 2002), \textit{available at} http://www.nursingworld.org/pressrel/2002/pr0123.htm.}

Also, more must be done to attract individuals to the nursing profession. One possible solution is the awarding of magnet status to recognize those health care organizations that provide the best nursing care and support professional nursing practice.\footnote{Joint Comm’n on Accreditation of Healthcare Orgs., \textit{Facts About American Nurses Credentialing Center Magnet Recognition Program}, at \textit{http://www.jcaho.org/news+room/press+kits/facts+about+magnet+hospitals.htm} (last visited May 1, 2003).} Magnet status is a major factor in nursing recruitment and retention because it
The Nursing Shortage gives the hospital a competitive edge and recognizes nurses’ contributions to the hospital environment. In order to obtain magnet status, health care organizations must submit documentation demonstrating their compliance with American Nursing Administration standards and undergo an onsite evaluation to verify the information in the documentation submitted. Magnet status is awarded by the American Nurses Credentialing Center for a four-year period, after which the organization must reapply.

There are various other factors that may help to attract more individuals into the nursing profession. The most obvious are higher wages and better working conditions. In addition, increasing diversity in nursing programs may facilitate this goal. Over 90% of students in today’s baccalaureate programs are women and only 12.3% of registered nurses are from racial or ethnic minority groups. The American Association of Colleges of Nursing contends that by using a combination of traditional marketing methods, targeted outreach campaigns, and strategic planning, schools will be able to expand student diversity. Furthermore, fast-track careers in nursing for non-nursing graduates may attract more individuals into the profession. For those with a prior degree, accelerated baccalaureate programs generally run twelve to eighteen months. Generic master’s degrees generally take three years.

Policy-makers, employers, nursing educators, and labor unions need to do more to address the nursing shortage. No single magical solution to the problem exists; it will require a combination of efforts. One commentator promotes developing incentives to encourage nurses who work part-time to work more hours and

121 Id.
122 Id.
123 Id.
124 See Buerhaus et al., supra note 3, at 2953.
126 Id.
128 Id.
129 Id.
contends that recruiting nurses from overseas might help. Another researcher proposes the establishment of management or bedside nursing staff committees that discuss staffing issues and implement adequate nursing staff-patient ratios. Perhaps most notably, in August 2002, the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") released proposed strategies for addressing the nursing shortage. They include creating organizational cultures of retention, bolstering the nursing educational infrastructure, and establishing financial incentives for investing in nursing. In order to create organizational cultures of retention, JCAHO suggests the use of magnet hospitals, emphasizes the need for safer hospital environments, including safe staffing levels, and advocates nurse leadership. In order to bolster the nursing educational infrastructure, JCAHO suggests funding nurse faculty positions and student scholarships for all levels of nursing education, increasing federal funding for nursing education, providing fast-track opportunities for nurses to receive higher levels of education, and establishing standardized post-graduate nurse residency programs. Finally, JCAHO recommends establishing financial incentives for hospitals to invest in nurses, such as making federal funds available to hospitals for investment in nursing services, and making that support contingent on the achievement of quantifiable and standardized criteria and goals.


131 Lynn Unruh, Nursing Staff Reductions in Pennsylvania Hospitals: Exploring the Discrepancy Between Perceptions and Data, 59 MED. CARE RES. & REV. 197, 212 (2002).

132 See Joint COMM'N OF ACCREDITATION OF HEALTHCARE ORGS., supra note 44.

133 Id. at 8.

134 Id. at 28.

135 Id. at 34.

136 Id. at 8-27.

137 Id. at 33.

138 Id. at 36.
IV. Conclusion

If current trends persist, we will be facing a major nursing shortage by the year 2020.139 Studies now show that lower nurse to patient ratios are associated with adverse patient outcomes. Thus, hospitals are on notice that they could potentially be found liable for malpractice under claims of inadequate staffing. State legislators and Congress have attempted to provide solutions to the shortage, but it is apparent that no one solution will remedy this dilemma. California’s mandatory nurse-to-patient ratio, although beneficial on certain levels, has its weaknesses, such as its failure to take into account the individual and aggregate patient needs and unit support functions of each hospital, the imposition of burdensome costs on hospitals, and the possibility that beds may have to be eliminated if there is a lack of qualified registered nurses. A more individualistic approach is needed to meet the demands of each hospital, taking into consideration the hospital’s case mix and patient acuity. We must use the information we have to find a way to permanently retain registered nurses in our hospitals to ensure quality of care and patient safety.

139 Buerhaus et al., supra note 3, at 2953.