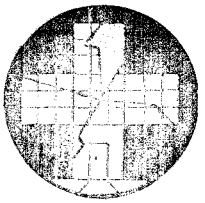
at the present time should be associate degree education in nursing.

In addition to the services of nurse practitioners, people in need of health services require the services of health occupation workers who can function as assistants to nurses. These workers—nurses' aides, orderlies, nursing assistants, and others with on-the-job training—have long been employed by nursing services to perform delegated tasks in the care of the sick in the hospital. Such workers free the nurse practitioner to concentrate on those functions which she alone is prepared to assume. Because health services today are provided in homes as well as in a variety of organized health facilities, and because all health professions are utilizing the services of these auxiliary workers, hospital training courses conducted by nurses no longer are adequate or appropriate for training this group of workers. The functions of workers assisting in the health fields are sufficiently general in nature to be appropriate to many of the health and helping professions. Therefore, *education for assistants in the health service occupations should be short, intensive preservice programs in vocational education institutions rather than on-the-job training programs.*

WHAT'S WRONG WITH AMERICAN HOSPITALS?

A Doctor's Opinion



By THOMAS HALE, M.D.

ONE of the chief mechanisms in producing the nursing shortage has been the accreditation program of the National League for Nursing. In 1953, the National League established certain "standards" that hospitals with nursing schools believed they must meet to gain accreditation. The great mistake that the League made in its accreditation "standards" was to encourage the withdrawal of the student nurse from the bedside of the patient by radically cutting down the number of hours of practice that would be approved for the school. In most hospital schools that have achieved, or are seeking, National League for Nursing accreditation, the hours of bedside practice have been so reduced that the student nurse has, in my opinion, in most cases become merely an observer on the wards. Evening and night assignments have been cut back almost to zero, and the program has been enriched with certain subjects that are admittedly interesting but are not directly pertinent to turning out a good nurse. In general, an academic atmosphere and attitude similar to that found on a college campus has been introduced. The service ideal of nursing has been downgraded and even ridiculed. Students are not given responsibility for patient care, and consequently cannot be taught to feel such a responsibility. At the time they graduate, too many of them are not capable of assuming the normal responsibilities of a general staff nurse in a hospital.

Two very serious problems have resulted from the withdrawal of the student nurse from the patient's bedside. The first is that the student at the time of graduation does not know how to nurse patients, and the second is that the cost of the school has been radically increased.

The first question is one of competency. Three surveys of the competency of the graduates of two-year associate-degree programs in New York State, made by the State Hospital Association in 1965 and 1966, showed in general that most graduates of these community college nursing programs were not capable at the time of graduating of giving safe bedside care, giving treatments and medications, team leading, or taking charge of floors evenings and nights. These are all things that were formerly expected of the graduate of a preaccreditation three-year hospital school. Surveys in New York showed that it would take three to twelve months of close supervision for the graduates of these two-year programs to gain these competencies.

The graduates of most four-year baccalaureate programs are little better qualified, if any. These programs, too, have practically eliminated bedside experience from the nursing curriculum.

An even more disturbing phenomenon is now occurring in hospital schools. Under pressure of accreditation, they also are abandoning bedside practice, and cutting down their curriculum from three years to thirty-three, thirty, twenty-seven or even twenty-four months. Graduates of this kind of shortened hospital-school program are little better prepared to nurse than graduates of two- and four-year baccalaureate programs.

Nurse educationists admit the deficiencies in the graduates of collegiate

A Veteran Nurse Dissents

I AM A nurse anesthetist and deeply interested in the current soul searching within the medical and nursing professions. Since I graduated from nursing school in 1948, I have witnessed the gradual but steady confusion in the definition of a nurse and of nursing.

Instead of clarifying and standardizing the qualifications of a nurse, it seems that the ANA is striving to elevate her professional status by creating a somewhat vague super-nurse.

I would suggest that the title R.N. be dropped and that nurses be classed as either professional nurse or vocational nurse. The professional nurse should be a graduate of a four-year college of nursing. All three-year R.N.'s with five years experience would become P.N.'s. With less than five years experience, the three-year R.N. would have to make up her educational deficiency. The vocational nurse should be a high school graduate with no less than one year of approved hospital training. All two-year R.N.'s would be required to make up two years of training or automatically become V.N.'s. The professional nurse would receive a B.S. degree in nursing, and the vocational nurse would receive a license. Both classes of nurses would be required to pass appropriate state board examinations.

Within five years, the ANA could achieve this unification of nursing standards. An information bulletin of these changes would warn all nursing schools and high school counselors of the new classification and requirements of each type of nurse, each essential to the health of everyone. I'm certain that such a decision would be met with overwhelming approval by the rank-and-file nurse.

The professional nurse would also qualify for specialty training in the following fields: public health, midwifery, anesthesia (50 per cent of all anesthetics in the United States are administered by nurse anesthetists), intensive care, including care of the cardiac surgery patient, extensive care, and perhaps a newly created specialty of medical assistant. The M.A. or medical assistant would be trained to do routine histories and physicals, start I.V.'s, draw blood, do urine and hemoglobin analyses, assist in surgery, and carry out the more complex doctors' orders. The M.A. program should be a joint medical-nursing endeavor.

GERALDINE STEBLAY, C.R.N.A.

San Francisco, Calif.

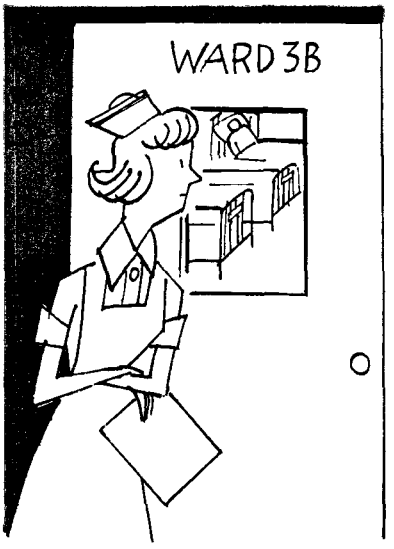
programs. This, I believe, has not happened by chance but by design. They have adopted the concept that nursing education should not train students to be practitioners of nursing, but should concentrate on the theories of nursing. Therefore, they say, it is not necessary for a student to waste time actually doing nursing during the collegiate part of her program. She can learn all she needs to learn about bedside nursing by being an observer for short periods on the wards of some hospital.

They seem convinced that once a girl has graduated from a collegiate program, the hospital should employ her as a general staff nurse at the same or a higher salary than diploma graduates, and then provide her with whatever is necessary in the way of closely supervised experience doing bedside nursing. What was formerly a part of the curriculum of the school of nursing, taught by the faculty of the school, and with the school accepting responsibility for the results, is now, according to the nurse educationists, the responsibility of any hospital that employs one of the graduates of the associate degree or baccalaureate programs.

So one of three things happens. If the new graduate does accept a position on a hospital staff, the hospital is forced to assign someone to watch her for a considerable period in most cases, and to teach her all the nursing skills and arts that were formerly a basic part of the curriculum of nursing schools. Many hospitals, of course, do not have the personnel to provide this kind of supervision. Even when they do have personnel, they are put to considerable expense to give this experience. In addition, they have a serious morale problem when incompetent and unqualified graduates are paid the same salary as nurses who on graduation are capable of handling routine responsibilities on the floor without any close supervision.

The second thing that happens (and happens frequently, I believe) is that the graduate of a degree program, because she herself realizes her inadequacies in nursing patients, does not seek a hospital position, but goes into some other area of nursing. This is particularly true of the baccalaureate graduates, who seldom enter hospital nursing, but more and more frequently obtain positions on the faculties of other nursing schools, either associate degree or baccalaureate programs. Not knowing themselves how to nurse, they easily accept the philosophy that the acquisition of skills in bedside nursing should not be taught in these schools. Some of them also go into public-health nursing.

Third, if the graduate marries, as many of them soon do, she is lost to nursing during her child-bearing period,



just as the diploma-school graduate is lost. But whereas many hospital-school graduates return to nursing after their children are at a suitable age, the degree graduate is much less likely to do so, because she fundamentally lacks confidence in her basic nursing skills and abilities.

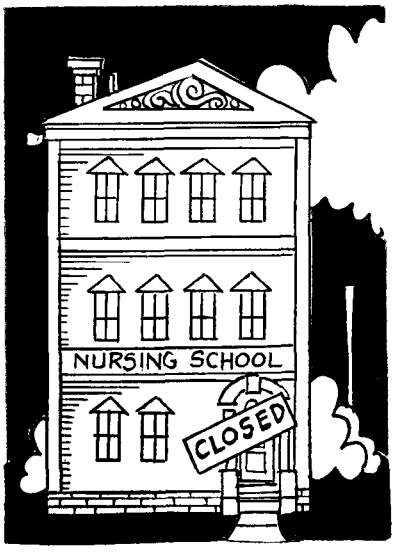
Now this lack of competency is one of the two serious problems that I mentioned as being caused by the withdrawal of the student from the bedside of the patient. The other problem, now approaching a major disaster, is the tremendously increased costs of operating a nursing school. In the past, such costs were balanced by the services rendered to patients by the matriculating students. In the old days no one did any exact calculations, but for years hospitals operating nursing schools on an apprenticeship basis, where the students paid little or nothing for their education, broke even because of the services rendered to patients by the students. Two things happened at the same time, however, to change this picture: As the "standards" of nursing schools were raised by the accreditation program, the costs skyrocketed, as would be expected; and, concurrently, the services rendered by the students to patients began to diminish, and, finally, as explained above, they have been almost entirely eliminated as a result of the accreditation program.

As tuition charges in hospital schools have mounted to meet rising expenses, recruitment has been adversely affected. The low tuition was formerly one of the advantages that the average girl found in a hospital school, as compared with a collegiate program. Hospitals have been forced, however, either to raise their tuition until it hurt them competitively or, as an alternative, to keep their tuition low and subsidize their schools. At first, many hospitals did hold tuition down, but as costs continued to rise, they were no longer able to continue a subsidization which began to amount to $1,500 to $2,500 per student per year.

This would not have happened without the accreditation program. For example, the Albany Medical Center Hospital, of which I am director, has a nursing school of 325 students. It is fully approved by the New York State Department of Education. It still maintains a forty-four-hour week, combining theory and practice, and students on graduation are competent bedside nurses. Many of them subsequently go on to earn a degree. The total net tuition cost to a student for the three-year program is $245. The school has operated on a break-even basis since it was established eleven years ago. National League for Nursing accreditation has not been sought because of our belief that accreditation would result in graduation of incompetent nurses, and would also ruin the school financially. I cite this as a practical illustration of some of the generalities stated above.

Although our school is large enough and strong enough to recruit a competent faculty and full classes of top students, even though it is not accredited by the National League for Nursing, this might well not hold true for smaller schools, particularly in areas where competition for students is keen. But if all schools in an area, or in a state, joined together in eschewing such accreditation, the competitive factor would be eliminated, and all schools would benefit.

As a result of rising costs and other factors, hospital schools are closing in ever increasing numbers, as I have pointed out in a previous article [*New England Journal of Medicine* 270: 1092-1097, 1964]. The totals include



both accredited and unaccredited schools. Between 1959 and January, 1966, ninety-one diploma schools of nursing closed. On January 1, 1966, fifty-nine additional diploma schools had indicated that they were in the process of closing. Out of the present eighty-four hospital schools in New York State, eight have indicated their intention of closing when their last class has graduated. This will leave seventy-six schools out of the ninety-four that were in existence three years ago, a loss of eighteen schools in this period.

BETWEEN 1958 and 1964, sixty-seven new associate degree schools and twenty-five new baccalaureate schools have been established. During this period the admissions to all professional schools of nursing have increased by 6,404, or an average of 1,067 a year, and the number graduating has increased by 4,947, or an average of 824 a year.

However, the Surgeon General's report three years ago stated that to meet the minimum number of nurses necessary for the country as a whole would require an increment of 3,000 additional graduates a year for the next seven years (this was even before Medicare). It seems quite unlikely that this goal can be met.

No evidence has been adduced by the nurse educationists that the two-year and four-year collegiate nursing programs that they are now promoting can produce enough nurses to meet all needs. To the best of my knowledge, no studies have been conducted by anyone that would show this to be so. Nor have I heard of any studies indicating that universities and colleges that do not now have nursing schools will be willing to establish them. It seems irresponsible for nurse educationists to pursue a policy leading to the closing of hospital schools of nursing without first ensuring that there will be enough degree schools in the same general area to make up the deficit. It is not sufficient to establish a good many new schools in two-year and four-year colleges in a few states like New York, Texas, and California, for example, and hope that their graduates will fill vacant positions in hospitals in the rest of the country. These schools cannot even supply enough nurses for their own states. Even if they could, it would be of little help to the states where diploma schools are closing but few, if any, degree programs are opening.

I do not believe that the trend toward closing hospital schools of nursing and the shifting of nursing education from hospitals to the college campus is going to be reversed. One is faced, therefore, with a *fait accompli* produced in the past twenty years by the nurse educationists. If this trend continues, and I believe it will, it behooves the medical profession and the hospital profession to devote their energies to salvaging what they can from the impending wreckage of the hospital schools.

The following program of action is suggested for physicians who are concerned about the nursing shortage and the lack of competency shown by two-year and four-year collegiate graduates:

Every hospital that now operates a nursing school should be urged to continue its school. Many are currently on the verge of closing because they are discouraged about financing and about trying to meet unrealistic accreditation "standards" established by the National League for Nursing. State and federal financial support may well be necessary.

Hospitals with nursing schools should be urged not to cut down the amount of bedside nursing in their curriculums to shorten their courses. To do so automatically increases the costs of the school, and at the same time produces inadequately trained nurses.

Every hospital with sufficient clinical material should start a new school of nursing if it does not already have one.

Colleges, junior colleges, and universities should establish nursing programs where there is available clinical material. This is a broad public responsibility that should be shared equally by public and private institutions.

A state requirement that each graduate of a two-year or four-year collegiate program, or a radically shortened diploma program, must have twelve months' internship before she is licensed to practice nursing should be established. This in turn would accomplish two vitally important purposes: It would ensure that the public was protected by the availability of nurses who were adequately trained to care for people when they are ill; and it would put a large dent in the nursing shortage practically overnight.

Practical-nurse schools should be discouraged from seeking accreditation from the National League for Nursing. Otherwise, they will rapidly go the same way as the diploma schools have gone. The American Nurses' Association and many nurse education leaders have called for the abolition of practical nurses.

The National League for Nursing should be urged to relax its policy of weaning the student nurse away from the bedside.

Hospitals with schools of nursing should stop seeking accreditation from the National League for Nursing unless it changes its present policies. Group action would be most effective.

The American Hospital Association should establish an accreditation program for hospital schools of nursing, with the cooperation of the National League for Nursing if possible, but without it if the League refuses.

The National League for Nursing, and other student nurse recruiting agencies should be influenced to concentrate more on the service ideal of nursing, rather than emphasizing so strongly the career elements. This would attract into nursing more girls who are idealistically motivated, rather than those who merely look on nursing as a stepping stone to more money and prestige.

State and federal governmental agencies should provide financial aid directly to hospital schools of nursing for both construction and operation. Scholarships for individual students are fine, but the schools themselves need basic support.

The discrimination in governmental grants and support that now favor schools accredited by the National League for Nursing should be abolished.

Appointment and advancement of nurses in the Veterans Administration should be made on the basis of merit, and not limited to graduates of schools accredited by the National League for Nursing, as is now the tendency.

Colleges and universities with nursing schools should give more realistic credits to qualified diploma-school graduates for work done during the training period. This credit has generally been dropped to one year or less, although not long ago many of the same colleges and universities did not hesitate to grant even as much as two full years of credit for the work done in the diploma school. *Many are now granting no credit at all!* The ability to obtain a degree after a reasonable period of postgraduate study is a strong incentive to recruitment in diploma schools, particularly where financial hardship exists, as it so often does.

The United States Department of Labor should amend its rules and regu-

lations to permit qualified, or potentially qualified, foreign nurses to enter this country.

The American Medical Association should appoint a nursing committee that is strongly motivated toward preserving hospital schools of nursing and that is willing to stand up and be counted in its dealings with the nurse educationists.

Great changes can be brought about in this picture if those in positions of responsibility in the American Medical Association and the American Hospital Association will only recognize clearly what has happened, and why it has happened. Too many individuals in both organizations have written off the hospital schools of nursing. Although a few years ago 98 per cent of all nurses were graduates of hospital schools, now less than 75 per cent are hospital-school graduates, and the number is diminishing every month. There are now indications that a snowball effect will develop and precipitate the rapid closing of countless more hospital schools.

There is still time to turn the tide, and the day can still be saved. But it will not happen by chance, or by letting things drift. The situation calls for keen analysis and courageous, cooperative action.

EDITOR'S NOTE: *Dr. Thomas Hale is executive vice president of the Albany Medical Center Hospital, Albany, New York. The text above was taken from an address he delivered in North Carolina. It was originally reproduced in full in the New England Journal of Medicine.*

WHAT'S WRONG WITH AMERICAN HOSPITALS?

Would a Stewardess Help?

By LUTHER CHRISTMAN, R.N.

WHEN LOOKED AT dispassionately, hospitals appear to be staffed by a strange and motley array. Patients frequently feel adrift in a miasmic sea of occupations. And when their plight is objectively examined they do, in fact, seem as jetsam caught in an almost aimless ebb and flow. Many different kinds of workers and various examples of each kind move in and out of patients' rooms at erratic intervals during the course of a day. Not only do these intrusions into patients' privacy occur at a time when the patients are least psychologically capable of coping with the invasions, but the fleeting involvement of so many strangers in his life tends to create in the sick individual an apprehension that no one person has a vital concern in the proceedings.

This state of affairs exists because of the pattern of thinking habitual to management of hospitals for many years. Each time a series of tasks either can be routinized or can be given a new dimension, another work group is invented. Nearly all the workers in each group perfunctorily perform highly selected tasks in an impersonal manner. Frequently little or no coordination seems evident. Tasks not specifically assigned to one group or another often are not done at all. Despite what physicians may wish to believe, the brief visits they make are not sufficient to stabilize the situation for the patient, who frequently is not even sure who to ask for help he needs. The result is a fragmented pattern of depersonalized care that adds tremendously to the frustration and anxiety generally associated with illness.

What can be done to assist the hospital team in responding more effectively to the stress of patients? Creation of new work groups, such as suggested in this magazine by Dr. Joseph Stokes III ["A New Profession Within Medicine," *SR*, Dec. 3, 1966] is a plausible solution. Theoretically, all the loopholes in patient care could be plugged in such fashion.

However, much of the research that has been done in hospitals casts doubt on the ultimate contribution of Dr. Stokes's proposed "medical practitioner," or assistant physician. Studies completed at Ohio State University have demonstrated that the more the stratification of personnel around the patient, the poorer the quality of care, and *vice versa*. Other studies show that when a new work group is added, the internal strain and difficulty of coordination increases measurably. Each additional group probably tends to increase the strain geometrically rather than arithmetically. Furthermore, the problems generated by the need of the several groups to accommodate to one another often absorb energy that should go into patient care. Indeed the patient may actually be put in some therapeutic jeopardy by the system intended to safeguard his life.

Instead of adding more layers of personnel to those already surrounding the patient in the hospital, perhaps there are better ways of arranging the care pattern. The essential requirement is for simple, direct, and continuing contact with the patient by those persons most important to his care.

Taking the patient as the starting point—what type of organizational arrangement would be most beneficial to him?

Basically, patients need two kinds of care: The primary one clinical and therapeutic, the second one concerned with his comfort in the sense of hotel-like accommodations. Most of the resources to accomplish these ends are in place. We need a means of optimizing their effect on the patient.

Since physicians and nurses are the main providers of continued clinical care, an examination of their problems rates priority. The members of these two professions have the greatest potential for assisting patients to make the most progress. If the clinical skills of both can be articulated and sharply focused on the patient, a major gain in patient care can be achieved. Unfortunately, this fine articulation usually is not found in most hospital settings, for at least three reasons.

The first reason is that during the time all other professions moved their education into universities, the nursing profession remained attached to hospital schools of nursing. Since hospitals are not educational centers, provisions for continuing and advanced education for nurses were not available through these institutions. At the same time, the education and training of physicians became extremely intensified. Consequently, the knowledge gap between physicians and nurses steadily widened.

THE second major influence was the enactment of the Hill-Burton Bill by the United States Congress in 1946. This legislation gave impetus to construction of new hospital facilities and a rapid beds. Much of this expansion was unexpansion in the number of available planned, with each community and each hospital attempting to furnish every possible service.

Little or no thought was given to the nursing manpower needed to staff these new hospital units. Confronted with the necessity of opening the beds, hospital administrators exerted strong pressure on the nursing staffs to find a way to serve the rising patient population. Unable to do the work themselves, the nurses attempted to provide the care through others -- by supervising large numbers of partially trained and untrained nursing aides. Professional nurses failed to foresee fully what this service-by-proxy would do to high-level nursing practice. Hindsight now shows that this managerial type of nursing made mediocrity in nursing a certainty.

Once nurses became managers of care, the quality of their ministrations was lowered progressively by circumstance. Being present in the hospital around the clock, nurses accumulated responsibilities previously beyond the