Elizabeth Blackwell Women's Health Center

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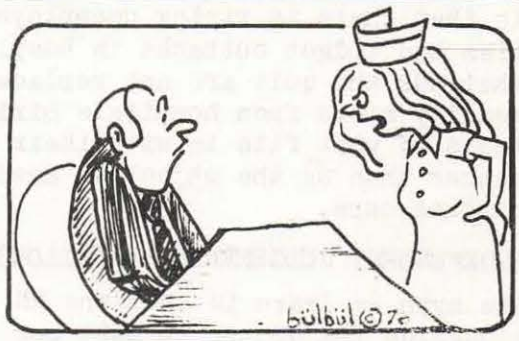
Spring 1979 Newsletter

NURSING: You Can't Pay the Rent with Professionalism



The Myths and Realities of Nursing

As nurses, we have learned that nurses and nursing are special--different from factory or secretarial work, because we perform a vital service to people. The myth is that performing the service should be more rewarding to the nurse than good pay and benefits. Based on this myth, we expect nursing to offer us personal growth, job mobility, educational opportunities, good pay and benefits, well organized and efficient working conditions, finally respect as professionals on the health care team. Instead, the reality is that we find high turnover rates among nurses, low pay in comparison to other skilled jobs and long hours. Faced with this reality many nurses leave nursing when we become frustrated with the working conditions in hospitals that prevent us from giving the high quality of care we are taught to give and which people deserve. In this issue of the newsletter, we want to examine the contradictions between the myths and realities of nursing--why nurses become so frustrated and what's holding us back from moving to change these conditions.

HIGH QUALITY HEALTH CARE vs SPEED-UP:

One myth is that our goals and the goals of the institution are the same--high quality of patient care. Along with the physical care, nurses can offer emotional support to sick people, help with family problems, plan and offer health teaching to the person. To meet this goal, we are taught to efficiently plan and implement our work to avoid staying late and causing any hardship on the patient.

The reality is that when we get to the floor, we find there are shortages of very basic supplies like linen and pillows which are part of the minimum standard of comfort and cleanliness essential to recovery. In hospitals and nursing homes, we find that shortstaffing is the rule and not the exception. Shortstaffing means that individual nurses must work harder to provide minimum physical care. Most nurses aren't paid for much of the overtime that is generated by the practice of shortstaffing. Supervisors may erase overtime on time cards or require each nurse to fill out elaborate forms stating the specific reason for the overtime compensation request.

RESPONSIBILITY: CARROT vs THE STICK:

Nurses are taught that they are responsible to protect the patients dignity and well-being. This is true even in regards to other workers. A dr. who leaves a side

rail down is not responsible for the patient's subsequent fall out of bed--rather the nurse is. This responsibility also extends to areas where nurses not oriented to special procedures and medications are required to float because of shortstaffing. When accidents and errors occur, it is the individual nurse who is blamed.

JOB AVAILABILITY vs STAFFING CUT-BACKS:

Another myth is that nursing is a job that we women can always fall back on. The logic of this myth is based on the reality that there are always plenty of sick people who need nursing care. The reality is that there is rising unemployment of LPNs and budget cutbacks in hospitals mean that RNs who quit are not replaced. This reality stems from hospitals hiring on the basis of what fits in with their budget rather than on the objective need for nursing care.

INDEPENDENT JUDGEMENTS vs FOLLOWING ORDERS:

The myth we learn is that the RN stands alongside the doctor to make her own unique contribution to the patient's recovery. In reality, the doctor is the superior figure--nurses follow orders. We learn that most doctors do not respect the work of nurses as they seldom seek us out or read what we write in the chart. They expect us to drop everything and do what they ask regardless of the effect on other patients or work we are doing.

Nurses and the Health Industry

In our society health care is a profiteering industry. Medical costs to patients are rising 2-3 times faster than other goods in the economy. Health care is big profits for drug monopolies, and well paid administrators. Under capitalism health care is a commodity and is offered for a price. High quality health care is bought and sold in the marketplace to people who can afford it as opposed to health care based on people's needs. The high price paid by the consumer is the profit which goes to sustain doctors, administrators, drug and insurance companies.

The health care system focuses on profits as a goal at the expense of the people's health. The system accomplishes this goal by using cheap labor, shortstaffing, unnecessary procedures, broken equipment, providing little or no preventive care, and the purchasing of many specialized medical machines.

As nurses we are constantly aware of our supervisors and the administration. We seldom come in direct contact with them yet they make the decisions that govern our working conditions every day. We all know who rewards and punishes us, hires and fires us and most of all, who gives us the pay check every month. The majority of the nurses in the administration or staffing office rarely come in contact with the patients. Their priorities are to stay within the budget. Even if a sympathetic supervisor does comprehend our difficulties of being bedside nurses, the other administrators may feel that she can't handle her job or the responsibility of staying within the budget and thus replace her with someone who thinks the same way they do.

SHORTSTAFFING:

Shortstaffing forces us to neglect all but the most urgent needs of patients. The patients quickly learn that the sicker they are, the more care and attention they will receive. They are forced to fight for the care that they pay for emotionally and physically. While at the same time, hospitals charge the same rates regardless of the number of nurses on duty. By having a shortage of nursing staff the hospital gets free labor from the nurses who continuously skip their breaks and lunches to get their work done decently due to the heavy patient loads. As if shortstaffing is our responsibility, we feel guilty for taking a few minutes to go to the bathroom for fear something may go undone or our patient's call light will go unanswered. And if nurses or nursing assistants work overtime we are harrassed by the supervisor as to the need for the overtime--we should have been more organized in the daily routine.

Another aspect of shortstaffing in many hospitals is that LPNs are being phased out. For every one or even two LPNs, one RN is expected to fill the vacancy. The administration supposedly feels her extra education gives her the edge on the double work load. In reality, one RN is cheaper than two.

Often nurses that call in sick are called by their supervisor charge nurse to come in to work because their peers will have to take their patients and work harder because

of the shortage and once again the nurse is made to feel guilty. The hospital or nursing home benefits by having to pay neither a float nurse nor sick day benefits. This continuously keeps the hospital costs down and the profits up. Profits are further increased by the payments the patients pay for care and use of elaborate machines.

We nurses waste our precious and limited time searching for equipment to aid the patient and if we are lucky to find what we need, it is often broken or dirty. Patients are degraded when they must use this equipment and we feel guilty because nothing else is available. We have no control over these conditions. When we deny the real source of the problem--the profiteering health care system--we continue to accept these conditions and strive onward but not upward.

WHAT IS THE SOURCE OF HIGH PROFITS?

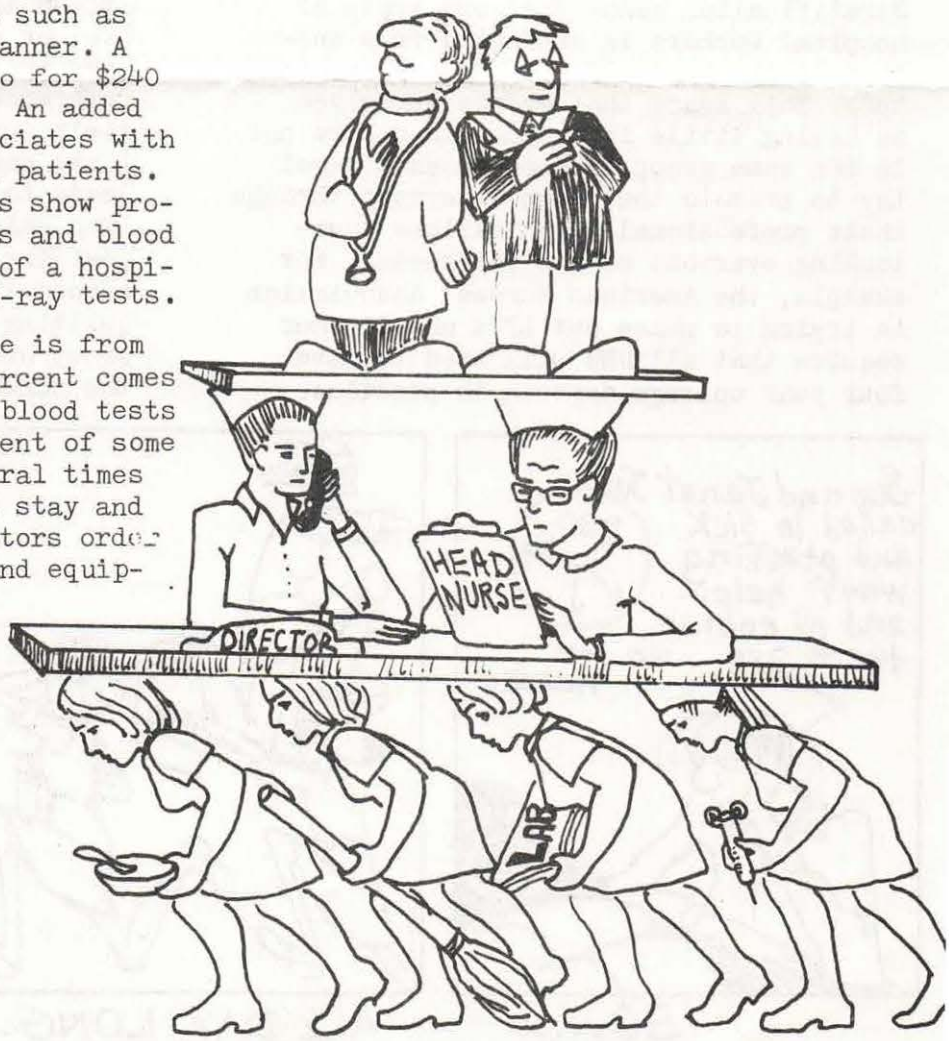
Hospitals make little return from investing in lots of wheelchairs and IV poles, so there is always a shortage of these. They do receive a visible return from highly advanced technological equipment that doctors and other professionals use such as the half a million dollar CAT scanner. A scan takes about 20 minutes to do for $240 each time--several times a day. An added wheelchair or IV pole only depreciates with the use and is shared by several patients. Statistics from certain hospitals show profits gained from excessive x-rays and blood tests done. Thirty-one percent of a hospitals income comes from lab and x-ray tests.

Forty-eight percent of the income is from inpatient care and only four percent comes from outpatient care. Specific blood tests are necessary for further treatment of some patients yet most are drawn several times for the duration of the hospital stay and are expensive--a fee for the doctors order and one for the lab technician and equipment used. We find that this disease oriented care for patients brings profit for the doctors and the hospitals, whereas prevention and outpatient services brings little gains.

WHERE THE MONEY GOES

Those of us who have experienced the conditions in the hospital and nursing homes of the unnecessary operations, overuse of expensive equipment and the drastic understaffing also realize that others are profitting from our oppression. Private hospitals are on a non-profit status. This means that the excess income doesn't belong to shareholders, but is used to expand the facilities and add medical equipment with the aid of Federal assistance and the exclusion of taxes.

We, the nurses, nursing assistants, housekeepers and dietary people, essential to the health care team, continue to remain on the bottom of the workers scale. Our low paid, overworked positions insure the people in the administration high profits and a remaining position at the top.



What's Holding Us Back?

PROFESSIONALISM IN NURSING:

Nurses are highly skilled health workers who are taught and encouraged to identify as "professionals" in school, but who are really wage workers. They assist doctors and follow doctors' orders in the care and treatment of patients. Their professionalism exists to the extent of how they decide to carry out the doctors' orders. Professionalism within nursing leads to stratification between 2,3,4 year RNs and LPNs. This professionalism is highly encouraged by administrators because it is less costly to promote status differences than salary differences.

These "professionals" have associations with their own ethical codes, publications and dues which substitute as symbols of professionalism for control and independence on the job. By promoting professionalism, hospitals are assured of a highly trained cheap labor force.

STRATIFICATION IN HOSPITALS:

Stratification means that one group of hospital workers is separated from another on the basis of differences in status. This means that we see ourselves as having little incommon with others not in the same group. Those in each level try to promote their own interests through their professional organizations overlooking everyone else's interests. For example, the American Nurses' Association is trying to phase out LPNs and further require that all RNs will need to have four year college degrees to practice. These groups compete rather than cooperate to strive for better patient care.

We have an image of ourselves as professionals. We incorporate within ourselves as guiding principles that if we don't finish our work, make significant relationships with patients or learn to control our work day, it is our fault. We are pushed to do better, and are continuously evaluated to find better and more efficient ways of getting the job done. If we don't get our work done, we stay late, so as not to leave work unfinished for the next shift. Often we leave work with a sinking feeling because of the mistakes we may make in our busy and rushed day. We accept the blame for all that happens on the floor while we are on duty.

The hospital and the administration benefit from our oppression. The staffing is not adequate so we work harder to get the work done and this helps to keep hospital pay costs down and increase hospital corporation profits.

We fear losing our jobs, if we are outspoken against working conditions as they are; or we are labeled troublemakers and have the possibility of losing good job references. Nurses are encouraged by their supervisors to rat on each other and blame each other for the problems. This leads to intense suspicion and backstabbing which makes the conditions of shortstaffing more unbearable. Individual nurses try to find personal solutions by quitting their jobs, going back to school, or by having babies in order to get out of the workforce for awhile.

confrontive forms

When we internalize the problems of short-staffing, poor working conditions, low quality equipment, nurses take these problems created by the health care profiteers and make them our own. Because of this we feel guilty when we can't give the best of care and time to our patients due to adminstration shortstaffing. When we go along with these conditions, we are helping to maintain the health care system that is based on profit not on people's needs.

As we have seen rigid stratification and professionalism serve to divide nurses from the other health care workers in the hospital. Hospitals use this "divide and conquer strategy to ensure that no group of hospital workers threatens their high profits. Even among those most closely connected with the actual bedside care of the patient--RNs, LPNs, & Nursing Assistants--there is intense stratification and distrust fostered by the elitism of professionalism. RNs and LPNs have always had the option of joining their respective professional organization. These organizations reinforce the divisions among nurses based on professionalism.

Nurses Go on Strike

On JUNE 7, 1974, 4,400 nurses in the San Francisco Bay Area began a strike that lasted 21 days. This strike was different from typical labor disputes. The central demands were for better input into patient care and staffing. The management saw it as unthinkable to allow any group of hospital workers to have a voice in the control of hospital expenditures.

The strike was led by the California Nurse's Association(CNA) who encouraged the nurses to see themselves as professionals and to fight the battle of shortstaffing and poor working conditions without the support of other hospital workers. Concretely, CNA leadership discouraged other hospital workers like the x-ray tech in one hospital from honoring the RNs' picket lines. Because of this, the other workers felt the strike demands benefitted only the RNs and that the nurses were trying to become an elitist group along with the doctors and administration. In fact, nurses have more in common with the rest of the hospital workers and are exploited as such.

The professional elitism of the CNA ensured that the nurses acted alone and kept them from realizing the central demand of the strike--control over staffing policies. Instead, after three weeks of bargaining, the RNs got an 11% pay increase felt by many nurses to be an attempt to buy them off.

In spite of the fact that nurses did not gain their central demand, the California strike was an important step forward for nurses to take. This was the first time that a significant number of nurses refused to accept the blame for the poor working conditions and the resulting low quality health care. This demonstrated to many other nurses to unify to change our working conditions.

Why not to Join ANA: AMERICAN NURSES' ASSOCIATION

The ANA and its state association affiliates (Minnesota Nurses Association/MNA) is the professional organization open only to RNs. It sets professional standards of nursing practice and negotiates contracts for many RNs on state and local levels. ANA/MNA is not a union. As a professional organization it assumes that all RNs share the same needs regardless of their rank and position in the hospital. This is because many state organizations are run by administrator and supervisor nurses. These nurses carry out budgetary and economic policies determined by hospital administrators and boards of directors. Concretely, these are the same nurses who veto our overtime pay, pressure us to come in when we are sick, work double shifts and blame individuals for the effects of shortstaffing. These are the same people who are negotiating our contract agreements over issues like pay, benefits and staffing with the hospital.

Finally, the same people in ANA/MNA have now taken the position that increased educational requirements for entry into nursing will socially and economically upgrade nursing. Their present plan proposes to eliminate LPNs altogether, requiring all RNs to have a 4-year college degree in order to be called professional nurses. The proposal would relegate all 2- and 3-year graduates to technical bedside nursing--replacing LPNs. The key thing to understand here is that only a few would advance in status to more prestigious positions with some increases in pay. The obvious self-interest of nursing supervisors and administrators is towards protection of their own positions in the hospital.

Clearly, MNA/ANA as an organization, rather than uniting nurses in our common struggle against exploitation on the job, divides 2-, 3-, and 4-year RNs from LPNs and NAs. Based on this fact, ANA/MNA as an organization cannot and will not push for changes in the working conditions for nurses in unity with other health care workers.

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