

Putting Patients First: The Role of Nursing Caring

DORIS GRINSPUN

Congratulations to *Hospital Quarterly* for launching a nursing column. I am honoured to be invited to share my thoughts. Several of the articles in this issue provide a perfect springboard to address what I believe is a key challenge for hospitals: a thirst for caring while the resources required for caring continue to dwindle.

Three of the articles highlight the need for quality nursing services while new data from the Canadian Institute for Health Information (CIHI) confirms a shrinking supply. Tranmer speaks about the different perceptions that patients and nurses have regarding what is important to patients as they receive nursing care. Ferguson-Paré and colleagues explore best practices in the care of elderly persons in hospital settings. Fitch stresses that treatment for individuals with cancer must be interwoven with supportive care so that “the cancer tumour is attacked and the human spirit upheld.” While these three articles point to the need for excellence in nursing services, the CIHI data reveals that Canada’s registered nurse workforce is aging, full-time employment is shrinking, and the number of registered nurses per capita is declining.

These articles not only point to the increasing gap between need for, and supply of nurses, but also shed light on key elements that help explain this worrisome gap. In my view, this gap is a reflection of the struggle between a caring paradigm that requires providing appropriate nursing resources to enact care, and a healthcare system conceptualized as an industry where cutbacks dominate. Not surprisingly, nurses leave the profession in frustration and fewer people are attracted to join.

“Nurses care” is an expression often used to describe the essence of nursing practice. There are distressing signs however, that the economic forces guiding the management of healthcare services make it difficult, and at times impossible, for nurses to maintain a caring practice. We know that nurses, patients and their families are not willing to dispense with caring. Public poll after public poll attest to the fact that nursing has the full support and the highest trust of the public. In fact, the public says that RNs are the key to ensuring quality healthcare.

CIHI Reports Continued Drop in Registered Nurses and an Aging Work Force

The latest statistics on Canada’s nursing workforce, released in July by the Canadian Institute for Health Information (CIHI), show a continued drop in the number of registered nurses per capita and a continued trend in the aging of the workforce. In 1999, there were 228,450 registered nurses employed in nursing compared to 234,393 in 1994, a drop of 2.5%. The number of registered nurses per capita declined 7%, from 80.3 registered nurses per 10,000 population in 1994 to 74.6 in 1999.

Nursing Workforce Aging

According to CIHI’s analysis on the age distribution of registered nurses, the number of registered nurses under the age of 35 decreased by 21% between 1994 and 1999, while those aged 50 and over rose by 19%. The average age of a Canadian registered nurse has also risen, from 41 in 1994 to 43 in 1999. Newfoundland had the youngest registered nurses in Canada in 1999 (average age of 39), while in British Columbia the average age was highest at 44 years.

More Registered Nurses Pursuing University-Level Education

CIHI’s report also notes that more registered nurses are entering the workforce with a bachelor degree in nursing. In 1999, 11.1% of registered nurses employed in nursing obtained a bachelor degree in nursing before entering practice, compared to 8.4% in 1994.

Provincial/Territorial Variations

Between 1994 and 1999, the provinces/territories showing the greatest declines in the number of registered nurses per capita employed in nursing were: the Northwest Territories (84.1 registered nurses per 10,000 to 70.6); Nova Scotia (98.8 to 91.5); and, Ontario (74.7 to 67.6). The Yukon (67 to 80.1) and Newfoundland (90.7 to 97.2) experienced the greatest increases in the number of registered nurses employed in nursing per 10,000 population from 1994 to 1999.

Shift towards Community Care Settings

While hospitals still represent the largest employer of registered nurses, employment has been gradually moving out of general hospitals to community-based settings. In 1994, 66.4% of registered nurses employed in nursing worked in hospitals compared to 62.5% in 1999. During the same period, an increasing proportion of registered nurses were working in community health agencies (from 6.0% in 1994 to 8.1% in 1999), nursing homes (from 10.8% to 11.7%), and home care (from 3.5% to 4.0%).

Part-Time Employment Rising

CIHI's report also showed a continued upward trend in the number of registered nurses working part-time. In 1994, of the 234,393 registered nurses employed in nursing, 54.9% worked full-time while 39.5% worked part-time. However, by 1999, the number of registered nurses working part-time rose to 45.3% compared to 51.1% working full-time.

Today's Canadian Nurse

The following comparative profile of a typical registered nurse in Canada highlights the differences between nurses under the age of 35 and those aged 50 and over.

	UNDER 35 YEARS	50 AND OVER
Supply* (228,450)	50,335 (22%)	61,203 (27%)
Initial Nursing Education	79% diploma 21% bachelor	95% diploma 5% bachelor
Employer	69% hospitals 11% nursing homes	51% hospitals 12% nursing homes
	9.5% community/ home care	12% community/ home care
Multiple Employers	23% yes 71% no	10% yes 83% no
Full-time or part-time status	38% full-time 56% part-time	60% full-time 38% part-time

* Registered nurses employed in nursing.

Data Source

Data are derived from the provincial/territorial nursing registration data. There may be minor variations between CIHI annual data and year-end provincial/territorial figures due to differences in the CIHI and the provincial/territorial reporting periods.

Several aspects within the re-engineered healthcare system have impacted on the ability of nurses to care. The diminished managerial role of nurses is one principal element. Eliminating formal nursing structures, and in some agencies taking nurses out of their administrative roles altogether, has made it too easy to implement strategies which have proven to be problematic.

One of these strategies was the move away from full-time positions to part-time and casual ones. Today in Canada, 45.3% of registered nurses work part-time or casual. For four years the re-engineering machinery conveyed to nurses a message that they were expendable. The psychological implications of this message on the nursing workforce have been deep and the consequences far-reaching. Many nurses chose to leave the profession, and fewer men and women are choosing to join. What began as a misconstrued cost-saving exercise is now turning into a full-blown crisis, as more and more nurses are opting to remain in part-time or casual employment status. If you cannot get a full-time position with the conditions necessary to enact excellence in caring and advance a satisfying professional career, why bother? At least, a part-time or casual position allows for more flexibility in your life.

Another mistaken initiative has been the unbundling of nursing care into a series of tasks and their distribution to various care providers. Although administrators implementing this approach are careful to ensure that the appropriate caregiver is providing the appropriate level of care the overall impact of this strategy has been underestimated. Despite the best intentions and the most conscientious application of this strategy, there is a basic flaw in this method that good intentions cannot overcome. The approach shifts the attention away from the patient as a person, as a whole, and places that attention onto a series of tasks to be successfully completed in the most efficient way. It is the antithesis of patient-centred care.

The fragmentation of patient care is deeply troubling since it leads to a separation of the thinking, being and doing of nursing care. It is also a predecessor for clinical errors. This fragmentation of nursing care greatly limits registered nurses by denying them opportunities to enact caring practices with patients. It prevents meaningful relationships from flourishing. Registered nurses have experienced a dramatic decrease in the time they have available to be with patients.


Putting patients first and attending to patients in a way that is meaningful to them requires work environments that respect and adequately support caring practices. Being asked to work one day and not the next, having only some component of the total care of a patient, being understaffed and overworked – all these limit the ability of nurses and other healthcare providers to engage in caring practices. No nurse is exempt – whether in the hospital, the home, or the community at large.

The key strategy for putting patients first and for solving a potentially dangerous nursing shortage, is resolving the paradox

in which patients and nurses seem to be caught: a thirst for caring relationships in a system that refuses to support and resource caring practices. What needs to be done?

Hospitals should greatly increase the ratio of full-time to part-time nursing positions to about 70:30. They should all but eliminate casual positions. They should strengthen the role of nurses in administration and leadership positions. They should implement models of care delivery that emphasize continuity of care and continuity of caregiver. They should provide staffing ratios that allow nurses to spend time with

their patients and families who expect nurses to engage in caring relationships.

What is at stake is the fundamental role of caring in our institutions. Neither administrators nor healthcare professionals can morally allow this caring to slip away. I am certain that consumers will not allow it. The time is right and the stakes are high: action is needed now! 

Doris Grinspun, RN, MSN, PhD (cand.), is the Executive Director of the Registered Nurses Association of Ontario.

Canada's Physician Workforce Also Aging

According to CIHI, the age distribution of physicians indicates a steady increase in the number of physicians between the ages of 50 and 59 years. In 1999, these physicians represented 22.8% of the total physician supply compared to 19.6% in 1995.

In contrast, there has been a small and ongoing decline in the number of younger practitioners. In 1999, 28.1% of Canadian physicians were under the age of 40 compared to 33% in 1995.

The average age of a physician increased to 47.2 years in 1999 from 46.3 years in 1995. The average age of a family medicine physician increased from 44.3 years in 1995 to 45.8 years in 1999, while the average age for a specialist physician increased slightly from 48.3 years to 48.8 years over the same period. Close to 16% of the country's physicians were over the age of 60 in 1999.

In 1999, the youngest family medicine physicians were found in the Northwest Territories with an average age of 41.4 years, while Prince Edward Island family physicians were the oldest in Canada with an average of 48.7 years.

In 1999, specialists in the Yukon had the oldest average age of 51.5 years, while the Northwest Territories and Alberta had the youngest specialists with average ages 44.7 years and 46.9 years, respectively.

NUMBER OF PHYSICIANS

In 1999, there were 56,990 physicians in Canada up from 55,006 in 1995, an increase of 3.6% compared to a 3.7% growth in Canada's total population over the same time period. Over the five-year period, provincial/territorial data indicate that Newfoundland and the Yukon experienced decreases of 1.4% and 4.5%, respectively. All other provinces/territories experienced increases.

Most of the growth in the number of physicians has been due to an increase in the number of specialist physicians which has risen by 6.7% over the past five years. During the same period, the number of family medicine physicians remained stable, increasing less than one percent.

PHYSICIANS PER 100,000 POPULATION: DIFFERENCES BY TYPE OF PRACTICE

Between 1995 and 1999, there was no change in the number of physicians (186) per 100,000 population. Three provinces/territories exceeded this ratio (Quebec with 212 physicians per 100,000 population, Nova Scotia with 199 and British Columbia with 194). The Northwest Territories had the fewest physicians per 100,000 population (92) in 1999.

However, when looking at the physician supply by type of practice, there were differences in the number of physicians per 100,000 population over the five-year period. The number of family medicine physicians per 100,000 population decreased 3.1% while the number of specialist physicians per 100,000 population increased 3.4%.

Family Physicians

Six provinces/territories experienced a decrease in the number of family physicians per 100,000 population between 1995 and 1999. The Northwest Territories (9.7%) and Ontario (8.6%) had the greatest declines. The Yukon (4.0%), Newfoundland (3.7%), Alberta (1.1%) and British Columbia (0.9%) also registered decreases.

Specialist Physicians

The number of specialist physicians per 100,000 population increased for all provinces/territories except Prince Edward Island, which had a decrease of 1.8%. Among the provinces the largest increases were recorded in Newfoundland (15.3%), Nova Scotia (12.8%) and Alberta (6.8%). Significant percentage increases occurred in Yukon (25%) and Northwest Territories (22.7%), the underlying numbers are small and both the Yukon (20) and Northwest Territories (27) remain well below the national average of 92 specialist physicians per 100,000 population.

Between 1995 and 1999, the number of physicians returning to practice in Canada increased by 34% from 256 to 343 physicians. The 343 physicians returning to Canada represented 0.6% of the physician supply in 1999.

The figures are from CIHI's publication, *Supply, Distribution and Migration of Canadian Physicians, 1999*. The data reflect figures as of December 31, 1999 and include physicians in clinical and non-clinical practice.