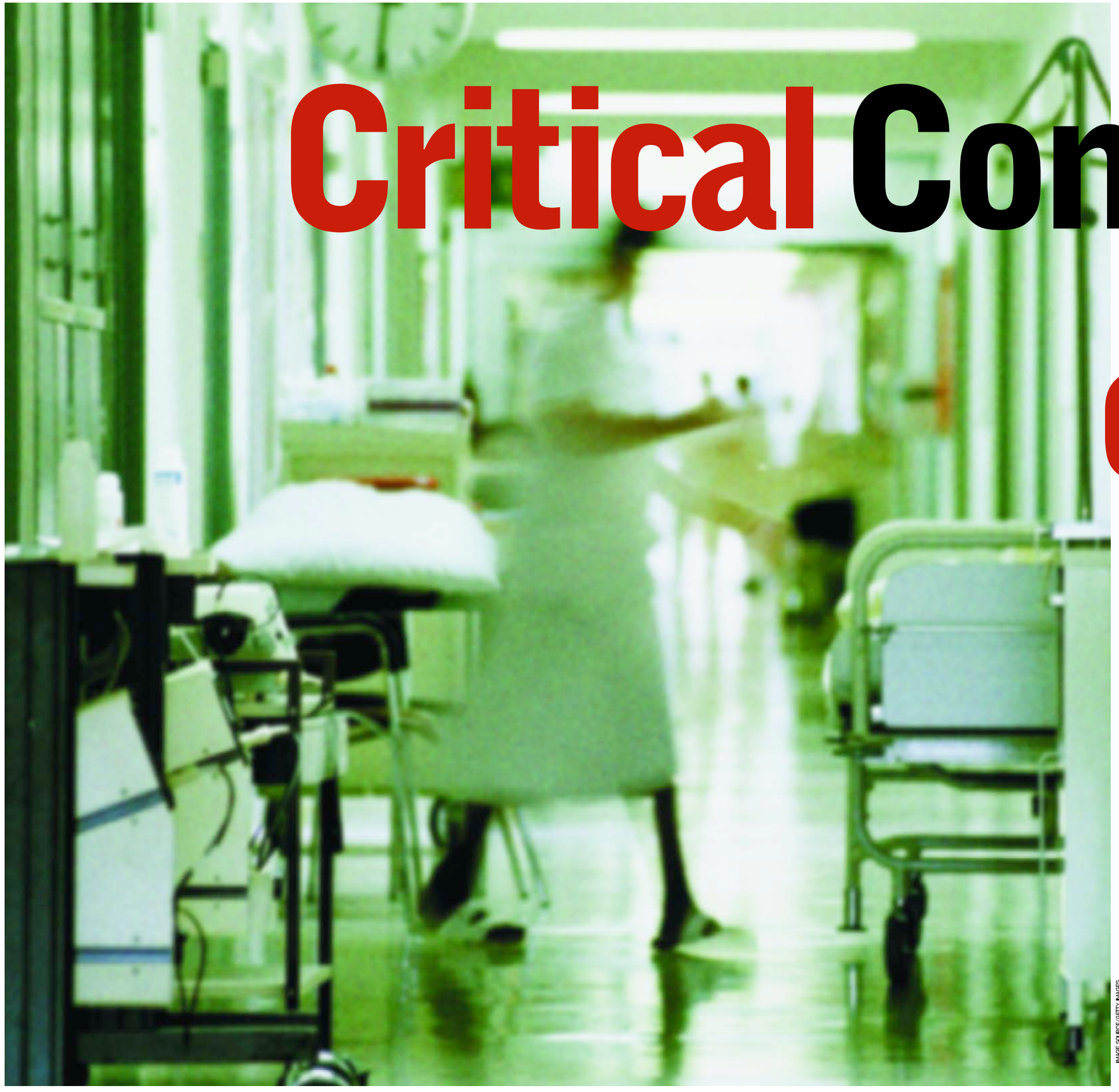


IMAGE SOURCE/GETTY IMAGES

Critical Condition

By Lisa A. DuBois

Hospitals are pulling out all the stops—but can anything fix a nine-year nursing shortage?

On any given Sunday morning, the local Nashville newspaper runs pages of classified advertisements appealing for nurses across Tennessee, Kentucky, Georgia, Alabama and Mississippi. The range of openings is so vast, and the promise of benefits so attractive, that it's safe to infer the published demand is merely the tip of the iceberg.

"More and more people are realizing that nursing is the best-kept secret in the job market," says Colleen Conway-Welch, dean of the Vanderbilt University School of Nursing. "Nowhere else can you do a hundred different things on one license. You can be a staff nurse, you can teach, you can be in administration, you can be a traveling nurse, you can be a helicopter nurse, you can work in a hospital, you can work for the insurance industry, you can start your own business. The word is getting out."

Word may be getting out—but not quickly enough to satisfy need. While nursing remains one of the most revered professions in the eye of the public, while the work environment is undergoing radical improvements, and while nursing salaries are experiencing a dramatic upswing, both developed and developing countries are caught in a rapidly spreading nursing shortage.

Nursing shortages have coursed through the United States through various intervals of history, each usually lasting two or three years before being rectified. The current shortage is entering its ninth year, with no end in sight.

How did a nursing shortage evolve into a global fiasco? The answer lies in a complicated, unwieldy fusion of events, says Peter Buerhaus, senior associate dean for research at Vanderbilt School of Nursing, who has spent the past 15 years studying the nursing labor market.

A Quick-Fix Solution That Failed

In the early 1990s, in an attempt to get a handle on the spiraling costs of health care, medical administrators examined their operating expenditures and realized that a large chunk of their revenues went to pay nurse salaries. Hospital and clinic administrators across the United States turned to a quick-fix solution. Following the advice of managed-care consultants, they replaced higher-paid registered nurses (RNs) with lower-salaried licensed practical nurses (LPNs). They shifted master's degree-prepared nurses, such as clinical nurse specialists, into roles as case managers where they were responsible not for patient care, but rather for increasing the number of patients seen, and for moving them more quickly in and out of their facilities. Some hospitals went so far as to fire entire staffs of, for example, nurse anesthetists, and have medical residents take on those duties.

It took only a few years for physicians and patients to realize this quick-fix solution was a bad idea. Experts had underestimated the crucial roles nurses played in health-care delivery. They either misinterpreted or didn't foresee the boom in technology and pharmacology that would routinely begin saving the lives of patients who would have had no chance of survival five or 10 years earlier. Nor did they predict a 21st-century emphasis on wellness and disease prevention. All these factors would fuel the urgency for more—not fewer—nurses in the workforce.

Oops.

Throngs of laid-off nurses had entered the profession as a humanitarian calling, driven by a desire to help others. When they were treated as extraneous burdens on a struggling medical system, many walked away from nursing, never to return. The sounds of closing doors echoed down the line as college and junior-college students opted for more stable job opportunities. Enrollments at nursing schools declined, and universities began cutting back on nursing faculty.

At the same time, women interested in health care began entering medical schools in record numbers. Nurses who toughed it out felt underpaid and underappreciated, forced into seeing more patients while spending less time with each. In the wake of this failed experiment, hospital managers discovered they had been grossly mistaken to assume that a medical resident could take the place of a highly trained, experienced nurse anesthetist or other nurse with specialized expertise.

But the damage had already been done—and the implications for the health and well being of our society are frightening. In 2001 there were 126,000 vacant positions nationwide. On the bright side, between 2002 and 2005, the country began to experience its first significant turnaround in two decades, as the number of RNs employed by hospitals rose by 185,000. Even so, these new employees did not ameliorate the shortage.

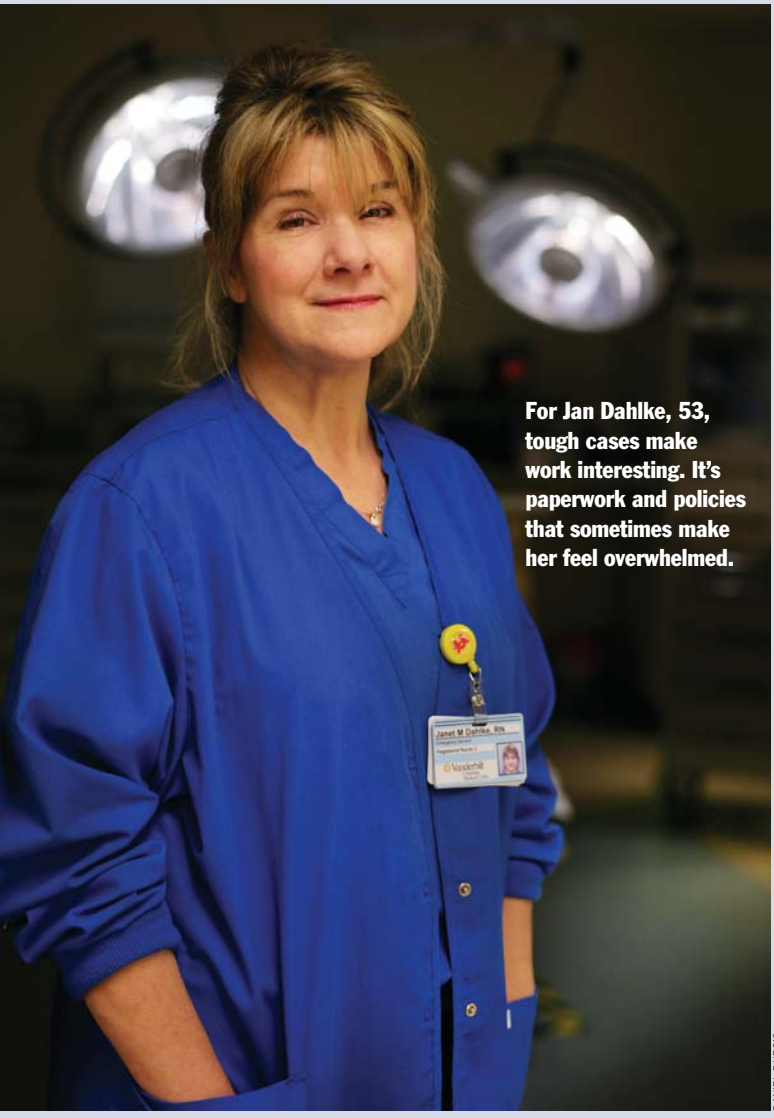
Buerhaus explains that the influx came largely from older nurses re-entering the workforce. When hospitals began raising wages to attract more applicants (adjusting for inflation, average nursing wages had not risen since 1993), nurses began to return to the profession. Many were compelled by the economic downturn—their spouses had lost jobs or had their hours reduced, and families needed a second income. At the same time, the United States began recruiting foreign nurses in unprecedented numbers: 75,000 between 2001 and 2004. Previously, in shortage years only 3,000 to 4,000 foreign nurses had entered the workforce. By historical standards, the recent infiltration was explosive.

"Both of those factors—older women returning to nursing and the hiring of for-

ANTONY NAGELMANN/GETTY IMAGES

The gaps in generations of nurses are like open wounds. Only 24 percent of the nursing workforce is under the age of 35, compared to 50 percent 20 years ago.

More Paperwork, More Patients, and the Promise of Technology



For Jan Dahlke, 53, tough cases make work interesting. It's paperwork and policies that sometimes make her feel overwhelmed.

DANIEL DUBOIS

Senior staff nurse Jan Dahlke arrived at Vanderbilt University Hospital in 1987 to help Dr. John Morris set up the state's first designated Level I trauma unit, which meant delivering around-the-clock care to every emergency patient who came through the door. Level I Trauma requires that every position in the department be staffed 24 hours a day, seven days a week. Previously, Dahlke had served in a variety of nursing roles, from medical-surgical to Third-World health care to rural public health nursing. She says that when she encountered the adrenaline-charged, fast-paced challenges of emergency nursing, she realized she'd found her home.

"I'm not just a nurse from 7 a.m. until 7 p.m.," she says. "I'm a nurse when I'm sleeping, exercising, shopping. It's an extension of who I am. That's why I'm so crazy about it. I believe that what I do is so critical that I would do for free whatever I could."

Peter Buerhaus, senior associate dean for research at Vanderbilt School of Nursing, says it is significant that the current long-term shortage began in the intensive care units, the emergency departments and the operating rooms—all subspecialties that require highly skilled, dynamic nurses. "What we found was that most specialty care units had traditionally staffed with a higher proportion of young RNs," he says. "They were bold, confident, cocky. They wanted to get as much experience as quickly as possible. They were the kind of people you want in those units—the kind who'd say, 'Give me your toughest cases.'" However, as these nurses began to age out, hospitals faced a dwindling supply of top guns to replace them.

To hone her skills and to keep her job interesting, Dahlke prefers to take on the most complicated and critically ill patients who come into the emergency department—victims of stroke, car accidents, heart attacks, drug overdose and gunshots. At age 53 she is at the top of her game professionally and has not experienced burnout. But as the trauma unit's reputation for excellence has matured, and as the increasing number of emergency transport helicopters, fixed-wing aircraft and ambulances contribute to her patient load, she sometimes feels inundated by federal, state and university policies and regulations—in other words, paperwork. These little annoyances, these intrusions into her workday that force her to labor through a 12-hour shift with no lunch break, make her sad.

Unfortunately, the regulatory pieces of a nurse's job are not going away, says Marilyn Dubree, chief nursing officer and director of patient care services for Vanderbilt University Medical Center. To counter those necessary inconveniences, she has tried to create an environment for nursing practice that is rewarding for nurses and nursing leaders, while also enhancing patient care.

"We are in the midst of implementing an automated clinical documentation tool that will allow us to electronically input data about patients, share data across the medical center, and have that data cross-connected with monitors and ventilators," Dubree says. "This will allow us to spend more time with patients and also to better interact with colleagues. We are constantly examining technology that will allow us to work smarter, despite increasing paperwork and limited resources. We never want to sacrifice the softer, relational pieces of nursing."

Capitalizing on technology to benefit the day-to-day life of the nurse is a relatively new phenomenon. For example, as patients are getting older, more obese, and living longer with chronic illnesses, nursing has become more physically demanding. To make their jobs easier (and to stem the number of worker's compensation claims), Vanderbilt's Occupational Health Clinic recently rolled out a program known as "Smooth Moves," which provides specially designed equipment and lifts to assist in patient care. A remote-controlled lift helps patients move from a seated to a standing position, an electronic sling raises up people who may have fallen, and a special mat gently slides patients from, say, a gurney onto a hospital bed. These kinds of engineering innovations hold tremendous promise for healthcare delivery.

eign nurses—are self-limited opportunities," says Conway-Welch. "That's not a solution to the crisis."

To achieve stability every profession requires a fresh generation of new hires to start at the bottom of the employment ladder, work their way up, and then age out of their positions some 40 or 50 years later. The gaps in generations of nurses are like open wounds. The average age of practicing nurses in this country was 42.1 years in 2002 and is projected to increase to 45.4 by 2010. Buerhaus predicts that in only four years, the bulk of baby-boomer RNs will begin retiring, will shift into part-time positions, or will transfer from the bedside into jobs in industry and less physically demanding roles. And the country isn't producing enough young nursing graduates to replace them. Only 24 percent of the nursing workforce is under the age of 35, compared to 50 percent 20 years ago.

"We'll have fewer nurses and older nurses at the same time society needs more nurses," says Buerhaus. "The large number of baby boomers will require more health-care and nursing services."

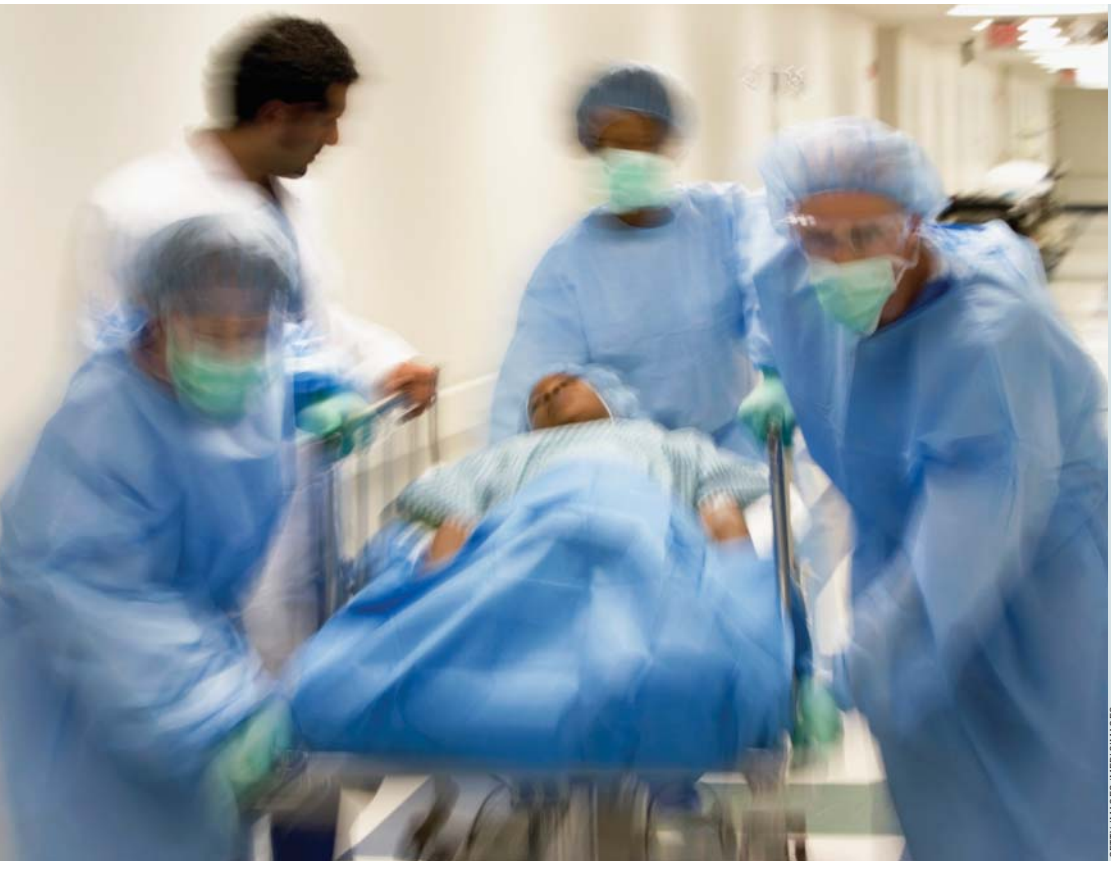
Nine percent of our nation's economy is driven by health care, so the nursing shortage has the potential to create a massive societal problem. "We have the best doctors in the world," Buerhaus says, "but if you take away the nurse, the glue that holds the system together is gone."

Vanderbilt, with its huge complex of hospitals, clinics, public health programs, research faculty, and highly ranked nursing school, provides a microcosm for examining issues that have led to the current nursing shortage, as well as steps that might resolve it. In many ways Vanderbilt is a best-case scenario. The shortage has not hit Vanderbilt Medical Center as drastically as it has in other places. The region has a pool of nursing training programs from which to draw employees, and Vanderbilt Nursing School graduates about 250 master's-level nurses each year. Still, on any given day, the Office of Human Resources lists between 120 and 200 job openings that span the spectrum of nursing positions across the Vanderbilt system. Medical administrators are grateful there are only that many.

One upside of the shortage has been a general newfound reverence for nurses. Physicians have begun to appreciate the value RNs contribute to the medical team. In a 2004 study, 81 percent of physicians reported that their hospitals were experiencing a nursing shortage, which they believed significantly impacted safety, efficiency, equity and effectiveness of care. Problems were cropping up in communications with patients, lack of responsiveness to pages and calls, delays in discharges, and excessive waits for tests and procedures. Consequently, anecdotal reports indicate nurses' relationships with doctors have never been better.

For years, says Buerhaus, nurses justifiably adopted a "victimization mentality." They felt undervalued because of low pay and minimal power within the medical hierarchy. Over time those complaints developed into a self-perpetuating cycle. "Evidence in recent national surveys shows the workplace has gotten better. Nurses' job satisfaction is at a very high level—83 percent, which is higher than physicians, attorneys, teachers, business people. Almost 90 percent of nurses would recommend nursing as a profession to students. Those are phenomenal numbers."

In a 2005 nationwide survey of 114,000 nurses, Vanderbilt nurses indicated they were



GETTY IMAGES/MEDIOIMAGES

"We have the best doctors in the world. But if you take away the nurse, the glue that holds the system together is gone."

significantly happier than their counterparts at other hospitals. Hospital administrators hope to capitalize on this upward trend of satisfaction by applying for designation as a "magnet facility," which would give Vanderbilt national recognition among medical personnel as a hospital offering not only top-quality care, but also a collegial atmosphere.

Dean Conway-Welch says, "You don't go for magnet status unless you believe your work environment is a very positive one and that nurses feel supported throughout the work environment, which is not the case in a lot of other places."

As part of the effort, the hospital paid the dues so that all emergency department nurses could become members of the Emergency Nursing Association—an investment of thousands of dollars.

Shared Solutions

The logical solution to America's nursing shortage would be to recruit, provide incentives, and train enough college and junior college nursing majors to alleviate the shortage. To spur interest, for example, Johnson & Johnson launched a series of campaigns to draw attention to nursing as a respected and rewarding career. Their initiative has helped turn numbers around. In 2005, according to the American Association of Colleges of Nursing, enrollments in entry-level baccalaureate programs in nursing increased by 14 percent over the previous year. But enrollments would need to increase by 40 percent over the next several years to replace all the RNs currently retiring from the workforce.

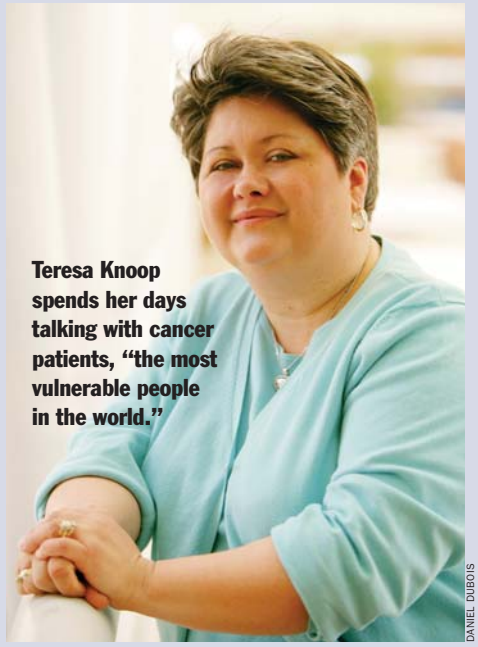
At best, nursing schools are simply bandaging a wound that actually needs stitches.

In the 1980s Vanderbilt decided to eliminate the School of Nursing's baccalaureate program and only confer master's-level degrees. Today's students take either three or four years of an undergraduate curriculum and then enter the nursing "bridge," or six semesters' worth of specialty courses, ultimately earning a graduate degree as a clinical nurse specialist, a nurse practitioner, a nurse midwife or a clinical manager. Each year about 250 students graduate from Vanderbilt with an M.S.N. degree, which makes a dent in the national demand for nursing specialists.

The shortage has hit hardest, however,

All of Us "Old" Nurses Have Pacts That We'll Take Care of Each Other

Teresa Knoop started her nursing career with a B.S.N. in 1978, and worked the night shift in a rural Kentucky hospital. Through the years she moved several times and found employment on a medical/surgical floor, in the pediatric unit, as an instructor of nursing at a junior college, and as a nursing educator on the oncology unit at St. Thomas Hospital in Nashville. Over a four-year period, working full time, she took courses at Vanderbilt School of Nursing towards her master's degree and became a clinical nurse specialist. In the mid-1990s, St. Thomas, like many hospitals, switched a number of clinical nurse specialists into case manager positions, making them responsible for getting patients in and out of the system quickly.



Teresa Knoop spends her days talking with cancer patients, "the most vulnerable people in the world."

DANIEL DUBOIS

"That was not my cup of tea," Knoop says. She began to feel she was burning out. Rather than leave nursing, she applied for a job with the Vanderbilt-Ingram Cancer Center (VICC), which was then seeking designation as a comprehensive cancer center by the National Cancer Institute. At that time no specific person was in place to handle the barrage of calls coming in to the Cancer Center—patients seeking referrals and second opinions, physicians inquiring about clinical trials, families exploring treatment options. Knoop was hired to set up a centralized office and a toll-free number to handle those calls. Her job was to help cancer patients navigate through the health-care maze.

"When I went into this job, they warned me that I'd be talking to the most vulnerable people in the world," Knoop says. "Our goal is to make sure the voice they hear on this end of the line is compassionate and caring. Once people understand they can speak to a real person, not a voice-mail system, and once they realize someone will call them back right away with answers to their questions or will help them set up appointments, it calms even the most distraught patient."

Knoop has a small staff of veteran oncology nurses to assist her. Their jobs require an extensive background in hands-on nursing oncology, a broad knowledge about the realm of cancerous diseases, and patience. On the day she was interviewed for this story, she was assisting an assortment of patients with melanoma and cancer of the prostate, breast, lung and colon.

"This is the best nursing job I've ever had," Knoop says. "I am learning something new every day. The Vanderbilt physicians are doing research with some of the most exciting cancer drugs coming along, and it keeps me on my toes. This is a nursing position where every morning when I come in to work, I am directly helping people."

Still, Knoop knows that flocks of young RNs are not following closely behind her, preparing to advance into these positions. "It's scary for my age group to think of who will be taking care of us when we have to go into the hospital in a few years," she says. "All of us 'old' nurses have made pacts that we'll take care of each other."

among staff nurses. VUSN is addressing that issue on the regional level through a partnership with the local campuses of Fisk and Lipscomb universities. Both colleges believe it fits their education mission—Fisk as a school with a large minority student population, and Lipscomb as a faith-based university—to offer a nursing undergraduate major. Students complete five semesters of prerequisite course work at their home institution and then spend their final three semesters at Vanderbilt taking courses in the bridge program. They ultimately receive a baccalaureate degree in nursing from their home institution.

Because Vanderbilt's tuition is much higher than tuition at the other two schools, Vanderbilt Medical Center offers the program's graduates a tuition forgiveness option if they work at Vanderbilt for at least two years postgraduation. In Lipscomb's initial class of 30, 28 students accepted the offer. While working at Vanderbilt they can take courses and accrue credit hours towards an M.S.N. degree—again, with tuition forgiveness.

Says Linda Norman, senior associate dean for academics at VUSN, "We anticipate that once we reach a steady state, we'll have 50 nursing graduates each year from Lipscomb and 30 from Fisk."

While this small infusion into the workforce helps, it does not address the vortex of the crisis—a drastic faculty shortage. The National League for Nursing estimates that in 2005, nursing schools across the country rejected a staggering 147,465 *qualified* applicants due to capacity problems.

"In some schools there's a shortage of faculty," says Buerhaus. "In some schools there's a shortage of classroom space. And in some schools they have faculty and class space, but they don't have the clinical space in which to educate nurses in the clinical environment."

At the Vanderbilt School of Nursing, the elephant in the room is the shortage of clinical placement opportunities. "It is expensive for an institution to incorporate students into the workflow of their nurses," says Conway-Welch, adding that while medical centers receive general medical education monies to support the training of medical residents, nursing students come attached with no such funding. "The nursing school can't pay for clinical placements, so we essentially rely on the kindness of professional nurses who want to train their replacements."

In terms of faculty, the top 30 nursing schools—Vanderbilt among them—are locked in an aggressive bidding war for high-quality, doctorate-prepared educators. "Recruiting is awful," Conway-Welch says. "All the deans are friends, we're all about the same age—and we all know the reality is that I will take your most treasured faculty member if I can get him or her."

Training: Expensive and Labor Intensive

One approach to training that VUSN has taken is through satellite clinics run by nurse practitioners, established to bring excellent health care to underserved neighborhoods, to promote wellness and disease prevention, and to provide a training ground for students. Vine Hill Community Clinic in Nashville is one such facility. Vine Hill handles between 18,000 and 20,000 patient visits each year, and bustles with interaction between caregivers and patients. All the nurse practitioners at Vine Hill are VUSN faculty members who serve as educators and preceptors, or one-on-one mentors. Preceptorships, where faculty nurses allow trainees to get hands-on experience by shadowing them in clinical practice, are time and labor intensive, allowing for only four or five students to rotate through the clinic each year.

Martha Shamy graduated from Earlham College in 1998, went to work in the nonprofit arena, and decided to come to Vanderbilt to become certified as a nurse practitioner. She is interning at the Vine Hill Clinic. "In this job I get to work with my hands and my head," she says. "It demands a combination of skills."

Salaries and Wage Compression

One offshoot of the nursing shortage has been a substantial increase in nursing wages. According to the U.S. Bureau of Labor Statistics, annual salaries paid to RNs range from $38,000 to $77,000, with the mean annual wage being around $56,000. LPNs are earning from $28,000 to $36,000. Nurses with advanced degrees, such as nurse practitioners, clinical nurse specialists, nurse midwives and acute-care nurses, often command salaries well into the six figures. The rise in wages has inspired more men to enter the field, though not in massive numbers: They comprise about 7 percent of the U.S. nursing workforce.

"Relative to most other comparable occupations and professions with the same degree of education, salaries are attractive," says Peter Buerhaus, senior associate dean for research at Vanderbilt University School of Nursing. "The problem is that we have nurses who've been in the profession for 20 years, and they're not making much more than the new nurse. That's a long-standing issue that doesn't seem to be getting resolved."

The wage compression issue is forcing senior, more experienced nurses to look around, says Colleen Conway-Welch, dean of the School of Nursing. Medical centers are willing to pay top dollar for a new hire who already has years of experience. "As a new employee, you're in a better place to negotiate."

Industry is also pillaging from the ranks of seasoned, highly skilled nurses. Large companies have figured out that they can save costs and reduce days lost from work by employing staff nurses on site to diagnose and treat a variety of on-the-job injuries, and to handle routine medical exams. Experienced nurses offer skill sets that are attractive to corporate managers, particularly those in the biomedical and pharmaceutical fields.

Which means that nurses are now blazing uncharted territory. Traditionally, nursing has been seen as a profession with little upward mobility, but now new horizons for successive advancement are opening—although these opportunities rarely follow a linear path, and the model is constantly changing.

Says Terri Crutcher, clinical director of the Primary Care Faculty Practice, "Our nurse practitioners love taking care of a disadvantaged population. They want to be on the front lines."

Much of their daily responsibility, Crutcher adds, involves helping patients understand which medicines to take and determining whether a health complaint is minor or requires major medical intervention. In the latter cases, which are not uncommon, the nurse practitioners have patients immediately transported to an emergency facility.

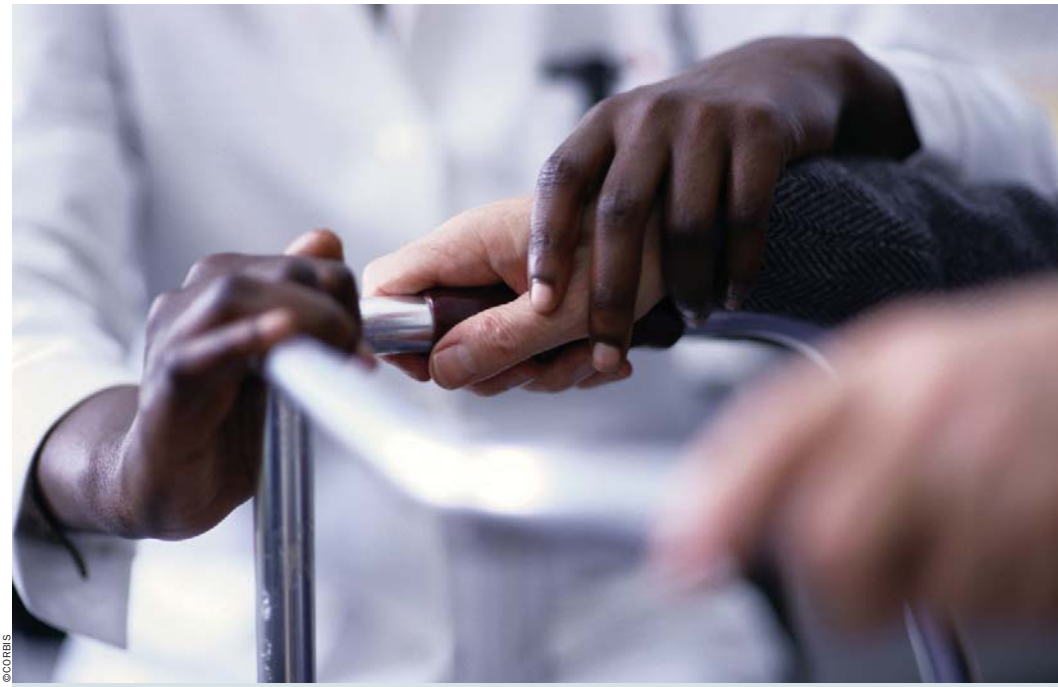
A nurse's training helps him or her to recognize subtle problems and quickly triage patients into the proper service, providing a vital link in the national health-care structure. The results of a recent study published in the journal *Health Affairs* indicate that by increasing the number of hospital RNs, specifically, medical facilities could save 6,700 lives and 4 million days of hospitalization each year. (The results were mixed when LPNs were factored in.)

Because RNs have more exposure to liberal arts and critical thinking, Buerhaus explains, and have greater depth of knowledge of physiology, anatomy, and the science of nursing, they can detect complications early and intervene independently or seek help from physicians as needed. By interpreting understated clues from patients, they are constantly running interference on disease and saving lives. This surveillance function of nurses is central to a healthy community.

At the Vine Hill Clinic, caregivers recently installed a digital retinopathy-screening machine for the screening of diabetic patients for a certain ophthalmologic problem that can lead to blindness. In the course of screening these patients and transmitting images to the Ophthalmology Imaging Center, they discovered another eye problem, a silent precursor for stroke, in several relatively young patients. Those patients were immediately sent to Vanderbilt Hospital.

Chalk up another point for the value of surveillance.

"In today's world, with the potential for natural and manmade disasters, surveillance is a big issue," says Conway-Welch. The person most likely to pick up trends of a flu epidemic or some kind of biological threat will be someone working in the community and/or with children. But local education systems are cutting back on the number of school nurses, leaving secretaries, teachers, and others with no background in health care to judge whether a child complaining of illness, injury or allergic reaction is sick enough to warrant being seen by a doctor.



©CORBIS

"It's irresponsible to recruit nurses from developing countries because they desperately need nurses. . . . They spend a lot of money educating nurses, which further depletes their struggling economies."

"The public-health infrastructure in this country is cracked," Conway-Welch continues. "And the gaps will widen as fewer nurses go into public health because, frankly, it pays very poorly. When you've got a choice of jobs and there's a significant salary difference, chances are you're going to take the higher salary."

The Ethics of Going Global

If the system is cracked, and if the nursing shortage is oozing into every fracture and chink in the nation's infrastructure, why can't foreign nurses serve as a stopgap solution?

The issue, for the most part, is not that foreign nurses aren't as well trained. "They just haven't had the same exposure to technology, and they face language issues," says Buerhaus. "They may speak and write English passably, but they may not get the nuances, colloquialisms and expressions."

Foreign-born nurses are a benefit to hospitals with large foreign-born populations of patients because they tend to be more sensitive to cultural preferences. On the flip side, foreign nurses may come from countries where women are considered subservient to men, and where lower-paid employees cannot question decisions made by more powerful members of the medical team. Which, again, hearkens back to surveillance. Nurses must have the confidence to be willing to call a doctor in the middle of the night to come in and see a patient. They must question a protocol they are certain is wrong, or speak with a supervisor if someone in the treatment group needs to be called down. The American system depends on that kind of shared power.

Then there is the ethical question of hiring foreign nurses. The United States and Europe have been accused by other nations

continued on page 86

Critical Condition *continued from page 53*
of sucking away their intellectual, professional workforce.

"It's irresponsible to go to developing countries because they desperately need nurses," says VUSN's Linda Norman. In South Africa, for example, roughly 50 percent of nurses leave the country within three years of completing training so they can make more money, send that money home to destitute families, and take advantage of opportunities unavailable in developing health-care systems.

"These countries spend a lot of money educating nurses, which further depletes their struggling economies," she says. "On the other hand, the Philippines is a country that has always over-trained nurses. They have more trained nurses than positions. Filipino nurses are considered an export commodity."

Estimates suggest that foreign-employed Filipino nurses funnel billions of dollars back to their home country each year. But *Nurseweek* (April 11, 2005) questions the end result. According to a recent report, "Exportation of 15,000 nurses each year to developed nations … poses a serious long-term threat to the Philippines' health system. … Filipino physicians, realizing they can make more as nurses in America, are enrolling in nursing school with the intention of immigrating to the U.S. to work."

Recognizing that the foreign nurse debate will need to be resolved on an international level, Norman helped set up a communications and training program in collaboration with Medlink International, a health-care recruiting firm that places foreign nurses in jobs in the U.S. and Europe. Although Vanderbilt does not recruit foreign nurses, Norman believes that both foreign nurses and the receiving institutions to which they are recruited must prepare for and accommodate multicultural differences. Easing this complicated transition ultimately works for the good of patients—even while the politics are being hammered out.

In the end, politics will likely determine how the nursing shortage is solved anyway. For years Buerhaus and others have been frustrated by Congress' lack of action. Recently, the Federal Bank of Boston convened Buerhaus and others to examine the state of the nursing workforce, fearing that if the workforce in New England were not adequate, the economic viability of the health-care industry—a large driver of the region's economy—could be at risk.

Dean Conway-Welch proposes that Congress implement something akin to the Cadet Nurse Corps of the 1940s, when the U.S. faced a critical nursing shortage after entering World War II. The federal government provided stipends for people to attend nursing school, funds for tuition and fees, and expanded residential facilities. Thanks to the Cadet Nurse Corps, the nursing workforce grew by 169,443 within two years.

Says Conway-Welch, "I expect something like that will happen when things get serious enough."

They're already getting pretty serious. Buerhaus' data predict an escalation of the nursing shortage—estimated to be as high as 400,000, but which the U.S. government says may reach 800,000, by 2020. This deficit looms at the same time nursing schools are turning away thousands of qualified students.

"Congress needs to step up and quickly fix this capacity problem because, frankly, we're never going to get through a shortage of 400,000 to 800,000 nurses," Buerhaus says. "The lights will be turned off long before then." **V**

Southern Journal *continued from page 88*
room schoolhouses in Tennessee. I began my schooling there, learning to read, write and "cipher" in a class of about 30 students. We were taught by a single teacher who had charge of eight grades. There was no electricity or running water in the schoolhouse. It was lit by kerosene lanterns and heated by a pot-bellied cast-iron stove. My teacher was a superb instructor, however, and I benefited from the setup. When I was not being instructed myself, I would listen to the lessons of the other students. Thus began my formal education.

I learned other things, too, mostly about myself. As I indicated earlier, everybody on the island participated in planting, tending and harvesting the cotton crop. All of that is done mechanically now, but in my boyhood most of it was done manually. That meant chopping cotton in the summer (hoeing weeds) and picking it in the fall. Both labors are incredibly difficult, but they wonderfully concentrated my mind.

I never keep a New Year's resolution today, but I've kept two that I made in the cotton fields on Shoaf's Island as a boy of 10. The first was to get an education. I noted in my infrequent trips to the mainland that most of the people who weren't working in the sun had a college education, so I resolved to get myself one. The second was that I was never again going to wear blue jeans or boots, the garb of the field hand.

I didn't know it then, but I would soon test those resolutions. Change came slowly to the island, but it came nonetheless. The mechanical harvesters became more efficient, and factories moved from the North to the Tennessee mainland. Thus, as the '60s came on, people began to leave, until only a dozen remained by decade's end. In fact, I left myself. My parents divorced, and I moved to the mainland with my mother and became a "town boy" enrolled in Ripley schools. Even that was temporary. I got a scholarship to a boarding prep school and left West Tennessee for good in 1966. I've been on the run ever since, living all over the world and trying my hand at several professions. I also picked up some book-learning (some of it at Vanderbilt), although I've concluded that Mark Twain, another boy who grew up on the River, was right: You shouldn't let your schooling interfere with your education. And part of that education arose from the fact that I was singularly fortunate to have grown up on the island. I came to love the land, appreciate the value of hard work and, mostly, to know in an increasingly rootless world where I'm from.

I still don't own any blue jeans. But every October I renew a ritual I began in 1972. I go home, back across the river, and into the fields where I labored as a boy. My father, now the island's lone inhabitant, is too old to put in a crop. But the people who lease the island from him know good cotton land when they see it. So I snap off one boll of cotton and carry it back to Nashville. For the next year it, like 33 bolls before it, will sit on the corner of my desk to remind me what real work is and where I came from.