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**SAFEGUARDING THE PUBLIC:
WHY WORKERS' RIGHTS EDUCATION SHOULD BE REQUIRED
LEARNING FOR NURSES**

*Esperanza N. Sanchez**

ABSTRACT

Nurses are integral to the delivery of quality health care in this country. They set aside their own needs and fears to provide care and other social services to people across a multitude of settings, taking on the burdens and stresses of others. However, our profit-driven health care system incentivizes employers to maximize productivity at reduced costs by asking nurses to do more with less. Nurses are expected to endure harsh working conditions, proven to be harmful to the nurses' health and well-being, despite evidence showing that poor working conditions can lead to poor patient outcomes.

There are numerous worker protection laws designed to empower nurses, as workers in this country, to advocate for better working conditions. Yet, despite the inextricable link between poor working conditions and compromised patient safety, licensing bodies do not require nurses to understand their rights in the workplace. This has resulted in a nursing workforce that is woefully unprepared to deal with the adverse working conditions that are naturally borne from our profit-driven health care system. Thus, this Article argues that, as a

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public health and safety measure, workers' rights education should be required for nursing licensure.

I. INTRODUCTION

Nurses represent the largest segment of the health-care workforce in the United States.¹ They provide care in a variety of settings, including hospitals, clinics, and long-term care facilities, as well as in schools and homes.² Nurses can also be found caring for people on battlefields and in community and public health centers.³ The nursing profession, as it exists today, has undergone a “jaw-dropping evolution” over the course of just a few generations.⁴ Before the nineteenth century, “most sick care took place in the home and was the responsibility of family, friends, and neighbors with knowledge of healing practices.”⁵ However, the urbanization and industrialization at the turn of the nineteenth century led to the proliferation of hospitals that could deliver care to individuals with illness, who lacked the necessary resources to provide their own care.⁶

Sickness care provided in those early nineteenth-century hospitals differed drastically from the health-care system that exists today.⁷ Those early hospitals hired individuals with family caretaking

¹ Lisa M. Haddad et al., *Nursing Shortage*, STATPEARLS (Feb. 22, 2022, 1:26 PM), <https://www.statpearls.com/ArticleLibrary/viewarticle/26039>.

² See Jean C. Whelan, *American Nursing: An Introduction to the Past*, UNIV. PA.: PENN NURSING, <https://www.nursing.upenn.edu/nhhc/american-nursing-an-introduction-to-the-past> (last visited Dec. 14, 2021).

³ See *Military Nurse*, EVERYNURSE (Sept. 29, 2021), <https://everynurse.org/careers/military-nurse> (“It’s not uncommon for military nurses to work right alongside military personnel in war zones. One of the most dangerous and difficult aspects of a military nursing career is caring for deployed military members during wartime. This often includes treating severe life-threatening injuries, such as gunshot wounds or lost limbs.”); Anjali Stenquist, *What Is Community Health Nursing? Examining this Important Role*, RASMUSSEN UNIV.: NURSING BLOG (Jan. 27, 2020), <https://www.rasmussen.edu/degrees/nursing/blog/community-health-nursing>.

⁴ *History of Nursing Timeline: How Nursing Education Has Evolved*, POST UNIV. BLOG (June 24, 2021), <https://post.edu/blog/history-of-nursing-education-timeline>.

⁵ Whelan, *supra* note 2 (“Sick care delivered by other than family and close acquaintances was generally limited to epidemics and plagues that periodically swept through towns and cities.”).

⁶ *Id.*

⁷ *Id.* (“In hospitals operated by religious nursing orders, patients received high quality care. But, in other institutions, nursing care was more variable, ranging from good in some hospitals, to haphazard and poor in others.”).

experience to provide nursing care, and few nurses in those days pursued additional training, knowledge, or skills.⁸ However, in 1873, a year widely regarded as “a watershed year” in the history of American nursing, three formal educational programs for nurses began operations in the Northeast.⁹ The decades that followed saw a proliferation of these nurse training programs,¹⁰ and by the turn of the twentieth century, hundreds of these schools for nurses were in operation throughout the country.¹¹ Today, nurses “have varying levels of education and competencies—from licensed practical nurses, who greatly contribute to direct patient care in nursing homes, to nurse scientists, who research and evaluate more effective ways of caring for patients and promoting health.”¹²

Public perception holds nurses in high regard, with nurses rated highest in honesty and ethics compared to other professions.¹³ However, the general understanding of the roles nurses play in our health-care system is often limited to hospital work and a bit

⁸ *History of Nursing Timeline: How Nursing Education Has Evolved*, *supra* note 4.

⁹ Whelan, *supra* note 2. The three seminal nursing programs that opened in 1873 were the New York Training School at Bellevue Hospital, the Connecticut Training School at the State Hospital (subsequently known as New Haven Hospital), and the Boston Training School at Massachusetts General Hospital. *Id.*

¹⁰ *Id.* These early nursing programs were essentially apprenticeship programs. The nursing schools were either affiliated with or owned by the hospital where the students received clinical training. Student nurses in these programs, which consisted of two or three years of training, provided most of the “patient care activities offered in the hospital, receiving only a modicum of classroom education in the form of lectures on patient care and related subjects. At the end of the educational program, students received a diploma and were eligible to seek work as a trained nurse.” *Id.*

¹¹ *Id.* Despite the exploitative nature of the early nursing education system, hospital-based nursing education remained the standard until the mid-twentieth century. *Id.*

¹² INST. OF MED., *THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH* 23 (2011) [hereinafter *FUTURE OF NURSING* 2011].

¹³ Lydia Saad, *U.S. Ethics Ratings Rise for Medical Workers and Teachers*, GALLUP: NEWS (Dec. 22, 2020), <https://news.gallup.com/poll/328136/ethics-ratings-rise-medical-workers-teachers.aspx>. Since 1990, Gallup’s annual Honesty and Ethics poll asked Americans to rate the honesty and ethics of several occupational groups as very high, high, average, low or very low. Gallup added nurses to the list of occupational groups in 1999, and since then, nurses have consistently ranked highest in all but a single year, which occurred in the immediate aftermath of September 11th when firefighters took the top spot. *Id.*

ambiguous.¹⁴ This limited view of nursing—despite nursing’s vital and outsized role in the health-care system—is due, in part, to the lack of media coverage regarding the contributions of nurses in health news stories.¹⁵ The romanticized depictions of nurses in popular film and

¹⁴ In the opening article to Kathleen D. Sanford, *Always a Nurse: A Profession for a Lifetime*, 44 NURSING ADMIN. Q. 4 (2020), nurse executive Kathleen D. Sanford describes the public perception of nursing as follows:

For most of the public, the primary visual image of nurses is probably a group of (mostly) women dressed in scrubs, who perform a variety of personal care or technical procedures in a hospital or clinic setting. Some older individuals may still envision women in white uniforms. Others, who have recently interacted with them outside of acute care, might include both men and women in business clothes, military uniforms, or laboratory coats in their description. They may have encountered nurses in homes, schools, office buildings, birthing centers, rehabilitation centers, prisons, drugstores, or freestanding urgent care and emergency facilities.

All of these depictions have one thing in common: all the nurses in these environments are seen in roles that involve direct interactions with those they are serving. In other words, it is recognized that nurses work in a variety of settings, but very few people would associate an image of, say, a virtual clinician or an executive in an office with “nurse.”

Id. at 4. See also Kristen Choi & Anna Dermenchyan, *The Nursing Science Behind Nurses as Coronavirus Hospital Heroes*, STAT (July 30, 2020), <https://www.statnews.com/2020/07/30/science-behind-nurses-as-coronavirus-hospital-heroes> (“Despite being the largest health care profession in the U.S., with almost 4 million nurses, we are hard-pressed to find almost anyone who can articulate exactly what ‘nursing’ is . . .”). Additionally, “the title ‘nurse’ is frequently extended to include non-licensed support personnel who often wear scrub uniforms in clinical settings.” Annette Bourgault, *Does Nursing Need a Brand?*, 41 CRITICAL CARE NURSE 8, 8 (2021).

¹⁵ See SIGMA THETA TAU INT’L, *THE WOODHULL STUDY ON NURSING AND THE MEDIA: HEALTH CARE’S INVISIBLE PARTNER* 8 (1997) (“Nurses and the nursing profession are essentially invisible to the media and, consequently, to the American public.”). In 1997, the Sigma Theta Tau International Nursing Honorary Society conducted a study examining “the portrayal of health care and nursing in U.S. newspapers, news magazines, and health care industry trade publications.” *Id.* at 15. Researchers based the study on the premise that “popular knowledge” primarily derives from news media and, therefore, “people learn and form opinions about nurses and nursing based, in large part, on what [is published in those sources].” *Id.* Thus, when the contributions of nurses are not included in the health news stories being reported, readers can assume that nurses “have little influence, standing, and authority in society.” *Id.*

In 2017, researchers replicated the study to examine the extent to which the representation of nurses in health news media had improved in the twenty years since the landmark study. Diana J. Mason et al., *The Woodhull Study Revisited: Nurses’ Representation in Health News Media 20 Years Later*, 50 J. NURSING SCHOLARSHIP

television may also contribute to this narrow conception of the nursing profession.¹⁶

However, following the emergence of the Coronavirus disease 2019 (“COVID-19”) global pandemic in early 2020,¹⁷ nurses around the world received a public outpouring of praise and admiration.¹⁸ Given their position on the front line providing direct care to patients in hospitals and their “active[] involve[ment] with the evaluation and monitoring [of] the community,” nurses were tasked with “ensur[ing] that all patients acquire[d] personalized, high-quality services irrespective of their infectious condition.”¹⁹ Nurses rose to the occasion, playing a vital role in the pandemic response despite significant risks to their own health and safety, and despite the uncertainty surrounding the availability of critical resources like personal protective equipment (“PPE”).²⁰ Images of nurses on the front line in the battle against COVID-19 led to the labelling of nurses

695, 696 (2018). The study ultimately found that nurses were “not quoted as sources any more frequently than in 1997” and, therefore, remained “invisible in news media” despite the twenty-year lapse since the original study. *Id.* at 701. Notably, less than two years after the publishing of this study, the COVID-19 pandemic gave nursing “a rare moment in the media spotlight.” Choi & Dermenchyan, *supra* note 14.

¹⁶ See, e.g., Abby Monteil, *20 Iconic Nurses from Film History*, NURSINGEDUCATION (July 28, 2021), <https://nursingeducation.org/20-iconic-nurses-from-film-history>; Christine Persaud, *The 10 Best TV Nurses of All Time*, SCREENRANT (Aug. 27, 2020), <https://screenrant.com/best-tv-nurses-of-all-time>.

¹⁷ Tedros Adhanom Ghebreyesus, Director-General, World Health Org., Remarks at the Media Briefing on COVID-19 (Mar. 11, 2020).

¹⁸ See, e.g., Gary Hardcastle, *Every Night, New York City Salutes Its Health Care Workers*, NPR: ALL THINGS CONSIDERED (Apr. 10, 2020, 4:08 PM), <https://www.npr.org/2020/04/10/832131816/every-night-new-york-city-salutes-its-health-care-workers>; Kirk McKoy, *Nurses Are the Coronavirus Heroes. These Photos Show Their Life Now*, L.A. TIMES (Apr. 17, 2020, 10:15 AM), <https://www.latimes.com/world-nation/story/2020-04-17/nurses-are-the-coronavirus-heroes>; William Booth et al., *In Fight Against Coronavirus, the World Gives Medical Heroes a Standing Ovation*, WASH. POST (Mar. 26, 2020), https://www.washingtonpost.com/world/europe/clap-for-carers/2020/03/26/3d05eb9c-6f66-11ea-a156-0048b62cdb51_story.html.

¹⁹ Mirna Fawaz et al., *Nurses at the Front Line of COVID-19: Roles, Responsibilities, Risks, and Rights*, 103 AM. J. TROPICAL MED. & HYGIENE 1341, 1341 (2020).

²⁰ See Abdullelah Al Thobaity & Farhan Alshammari, *Nurses on the Frontline Against the COVID-19 Pandemic: An Integrative Review*, 3 DUBAI MED. J. 87, 91 (2020).

(and other health-care workers) as “heroes” by politicians, news media outlets, and the public.²¹

The reality is, however, that the hero narrative and the romanticized view of the nursing profession ignore the longstanding challenges faced by nurses in this country.²² For decades, public health authorities and scholars have warned of a public health emergency posed by an existing nursing shortage, caused by an aging population with increasingly complex health-care needs, coupled with a shortage of nursing education programs, and exacerbated by deeply ingrained retention issues.²³ In 2018, researchers projected that, without genuine reform, the nursing shortage in the United States would worsen to half a million nurse vacancies by 2030.²⁴ Those studies did not, however, take into account the profound and catastrophic impact the COVID-19 pandemic would have on the nursing workforce.²⁵

²¹ A study published in the *International Journal of Nursing Studies* examined the implications of the hero discourse to the professional, social, and political identities of nurses. Shan Mohammed et al., *The “Nurse as Hero” Discourse in the COVID-19 Pandemic: A Poststructural Discourse Analysis*, INT’L J. NURSING STUD., May 2021, at 1. The study found that the hero discourse had a destructive effect on nurses and served as “a tool for politicians, leaders, and decision makers to publicly demonstrate their support for nurses while concealing the preservation and extension of existing power relations that limit nurses such as racism, gender discrimination, austerity measures, and managerialism.” *Id.* at 2. Anecdotally, the findings of this study are consistent with my own experience as a critical care nurse practicing in the District of Columbia during this time. The constant “hero” messaging during the initial surge of the pandemic exacerbated my anxieties about caring for COVID-19 patients. It seemed—at the time—that people called us “heroes” because they were expecting us to die.

²² Although many of the issues discussed in this Article may apply to the nursing workforce of other countries, this Article will focus solely on the American nursing workforce.

²³ See generally KARL D. YORDY, *THE NURSING FACULTY SHORTAGE: A CRISIS FOR HEALTH CARE* (2006); BOBBI KIMBALL & EDWARD O’NEIL, *HEALTHCARE’S HUMAN CRISIS: THE AMERICAN NURSING SHORTAGE* (2002); see also Rebecca Grant, *The U.S. Is Running Out of Nurses*, ATLANTIC (Feb. 12, 2016, 4:00PM), <https://www.theatlantic.com/health/archive/2016/02/nursing-shortage/459741>.

²⁴ Xiaoming Zhang et al., *United States Registered Nurse Workforce Report Card and Shortage Forecast: A Revisit*, 33 AM. J. MED. QUALITY, 229, 235 (2018).

²⁵ See Rayna M. Letourneau, *Nurses Are Leaving the Profession, and Replacing Them Won’t Be Easy*, CONVERSATION (Sept. 17, 2021, 8:19 AM), <https://theconversation.com/nurses-are-leaving-the-profession-and-replacing-them-wont-be-easy-166325>; accord Joseph P. Williams, *Strapped by Shortage and Hit with Departures, Nurse Corps Swamped by Another COVID Wave*, U.S. NEWS (Aug. 19, 2021, 11:27 AM), <https://www.usnews.com/news/health-news/articles/2021-08-19>.

This Article will first explore the public health emergency caused by the nursing shortage, looking at the state of nursing in the United States before the pandemic, then discuss the catastrophic impact of the global pandemic on the pre-existing nursing shortage. Next, the Article analyzes the multifactorial issues contributing to the nursing shortage, which include the lack of sufficient nursing education programs as well as the profession's high incidence of burnout. Then the Article focuses on how nurses are trained and what is required learning to maintain licensure, pointing out that although every state requires some aspect of nursing jurisprudence education, the legal implications for the nurse are framed as a personal liability concept. Finally, this Article argues that—as a public health and safety measure—nurses' workers' rights need to be a mandatory part of every nursing curriculum and should be mandatory continuing education upon licensure.

II. PUBLIC HEALTH EMERGENCY: THE NURSING SHORTAGE

Nursing is the largest and one of the most versatile occupations within health care, making it an integral partner in the delivery of care.²⁶ In hospitals, nurses serve as “the surveillance system for early detection of complications and problems in care,” which places them “in the best position to initiate actions that minimize negative

19/fourth-covid-wave-swamps-stressed-nurse-corps (“Already shorthanded, the nation’s nurses are fighting burnout along with another surge in coronavirus cases.”).
²⁶ The terms “nurse(s)” or “nursing” in this Article focuses primarily on registered nurses but includes all care providers requiring licensure by the state board of nursing. The Institute of Medicine defines registered nurses (RNs) in the following way:

The essential core of their nursing practice is to deliver holistic, patient-centered care that includes assessment and monitoring, administering a variety of treatments and medications, patient and family education and serving as a member of an interdisciplinary team. Nurses care for individuals and families in all phases of the health and wellness continuum as well as provide leadership in health care delivery systems and in academic settings. There are over 57 RN specialty associations in nursing and others newly emerging.

FUTURE OF NURSING 2011, *supra* note 12, at 39. For a description of other types of providers in the nursing profession, see *id.* at 38-42.

outcomes for patients.”²⁷ Outside of the hospital, nurses are a key component to the public health infrastructure, providing essential care and environmental health services to underserved populations in community settings.²⁸ For these reasons, a shortage of nurses poses a serious risk to the general public.

Although periodic shortages have existed throughout nursing’s brief history,²⁹ the modern nursing shortage can be traced back to a 1998 study about the effect of the aging nursing workforce on the nursing supply in the United States. Researchers in that study, which was published in 2000, warned that without significant intervention to increase the supply of new nurses, there would not be enough nurses to replace the one million nurses projected to retire beginning in 2015. Without action, researchers warned, a large national nursing shortage would develop by 2020.³⁰

A. Projections Shift but the Impact of a Shortage Worsens

Private and public entities responded to these warnings by launching national efforts aimed at averting the projected crisis by recruiting new talent into nursing and improving data collection to better understand the causes and impacts of the nursing shortage.³¹

²⁷ Linda H. Aiken et al., *Education Levels of Hospital Nurses and Surgical Patient Mortality*, 290 JAMA 1617, 1617 (2003).

²⁸ For an illustration of the work of community health nurses Carolina Sandoval and Lisa Ayers, see FUTURE OF NURSING 2011, *supra* note 12, at 60-63.

²⁹ KIMBALL & O’NEIL, *supra* note 23, at 14 (“Since the midpoint of the last century nursing supply has generally followed a cycle of abundance coming on the heels of shortage, each occurrence seeming to be unique, but viewed over decades, appearing very much alike.”). For a brief history of shortages in the nursing profession since the mid-1930s, see Jean C. Whelan, *Where Did All the Nurses Go?*, UNIV. PA.: PENN NURSING, <https://www.nursing.upenn.edu/nhhc/workforce-issues/where-did-all-the-nurses-go/> (last visited Jan. 16, 2021). For a discussion surrounding the nursing shortages of the 1960s and 1980, see Thomas Hale, *Why the Nursing Shortage Persists*, 270 NEW ENG. J. MED. 1092 (1964); Linda H. Aiken et al., *The Nurse Shortage*, 317 NEW ENG. J. MED. 641 (1987).

³⁰ Peter I. Buerhaus et al., *Implications of an Aging Registered Nurse Workforce*, 238 JAMA 2948, 2948 (2000).

³¹ The Robert Wood Johnson Foundation (“RWJF”) and Johnson & Johnson are two notable private entities that contributed significantly to nursing’s progress at the turn of the century. Two examples of these efforts include the Campaign for Nursing’s Future, which was launched by Johnson & Johnson in 2002 to improve nursing recruitment, and the Interdisciplinary Nursing Quality Research Initiative, which was

Coincidentally, during this same period, the national movement to improve the quality and safety of health care in the United States began to take shape.³² Health care shifted “to meet new economic challenges and to adopt improvements and innovations in patient care,” and, as a result, nursing—“the single largest component of the health care workforce”—underwent many extraordinary changes to adapt to the shifting landscape.³³

As mounting evidence conclusively linked better patient outcomes to the increased availability and quality of nurses,³⁴ a broader effort was made not only to increase the supply of nurses, but also to elevate standards in nursing education.³⁵ These efforts worked

launched in 2005 by the RWJF to develop the research base quantifying nursing’s impact on the quality of care received by patients. See *The Johnson & Johnson Campaign for Nursing’s Future Celebrates Fourteen Years*, JOHNSON & JOHNSON NURSING (Feb. 23, 2016), <https://nursing.jnj.com/the-johnson-johnson-i-campaign-for-nursings-future-i-celebrates-fourteen-years>; Robert Wood Johnson Found., *Advancing Quality and Safety*, CHARTING NURSING’S FUTURE, Jan. 2013, at 7, 7-8. For an overview of the Initiative’s strategy, goals, and impact, see Mary D. Naylor et al., *The Interdisciplinary Nursing Quality Research Initiative*, MED. CARE, Apr. 2013, at S1, S1.

³² The Institute of Medicine’s report titled *To Err Is Human: Building a Safer Health System* is credited as having sparked the patient safety movement of the early 2000s. See generally INST. MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (2000); see also Anne Marie Palatnik, *To Err IS Human*, NURSING CRITICAL CARE, Sept. 2016, at 4, 4 (“The Institute of Medicine (IOM) released their landmark report, *To Err Is Human*, in 1999 and reported that as many as 98,000 people die in hospitals every year as a result of preventable medical errors. . . . The public and the healthcare industry were completely engaged with the report at the time.”).

³³ NAT’L ADVISORY COUNCIL ON NURSE EDUC. & PRAC., REPORT NO. 6, MEETING THE CHALLENGES OF THE NEW MILLENNIUM: CHALLENGES FACING THE NURSING WORKFORCE IN A CHANGING ENVIRONMENT 2 (2008) [hereinafter NACNEP No. 6].

³⁴ See Aiken et al., *supra* note 27, at 1623 (finding “significantly better patient outcomes in hospitals with more highly educated [registered nurses] at the bedside”); Linda H. Aiken et al., *Hospital Nurse Staffing and Patient Mortality, Nurse Burn Out, and Job Dissatisfaction*, 288 JAMA 1987, 1992 (2002) (finding that “[t]he effectiveness of nurse surveillance [in hospitals] is influenced by the number of registered nurses available to assess patients on an ongoing basis”); Jack Needleman, *Nurse-Staffing Levels and the Quality of Care in Hospitals*, 346 NEW ENG. J. MED. 1715, 1715 (2002); accord Kristin M. Mannino, *The Nursing Shortage: Contributing Factors, Risk Implications, and Legislative Efforts to Combat the Shortage*, 15 LOY. CONSUMER L. REV. 143, 151-52 (2003).

³⁵ NACNEP NO. 6, *supra* note 33, at 5 (“[P]roducing more nurses quickly will not meet the overall needs of the health care system. Both newly educated nurses and those already in the workforce need educational and practice opportunities to better prepare them to meet the new challenges in the health care environment.”).

to increase the nursing supply, as well as (and perhaps more importantly) dramatically expand nursing's role in the delivery of health care.³⁶ Additionally, the sudden increase in demand for health-care services caused by health-care reform in 2010,³⁷ led to the proliferation of advanced practice nurses within the nursing workforce.³⁸ The nursing profession's rapid expansion since the turn of the century undoubtedly improved the overall quality of and access to health care in this country.³⁹ However, a health-care system with an increased reliance on nurses works only to deepen the public health impact of a nursing shortage.

³⁶ See Margaret Flinter et al., *Registered Nurses in Primary Care: Strategies that Support Practice at the Full Scope of the Registered Nurse License*, in JOSIAH MACY JR. FOUND., REGISTERED NURSES: PARTNERS IN TRANSFORMING PRIMARY CARE 89, 91 (Teri Larsen ed., 2017) (“National nursing workforce trends and employment opportunities suggest a growing recognition of the opportunities for and value of RN roles in primary/ambulatory care as well as in outpatient surgery, specialty care, long-term care, public health departments, and positions within the larger healthcare industry, such as insurers/payers.”).

³⁷ In March 2010, the nation witnessed “the broadest changes to the health care system since the 1965 creation of the Medicare and Medicaid programs” in the passage of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and the Health Care Education Affordability Reconciliation Act, Pub. L. No. 111-152, collectively known as the Affordable Care Act (“ACA”). FUTURE OF NURSING 2011, *supra* note 12, at 2. The ACA “enabled millions more people to seek care at a time when more than half of Americans ha[d] at least one chronic condition and many ha[d] multiple illnesses and complex healthcare needs.” *Conference Conclusions and Recommendations*, in JOSIAH MACY JR. FOUND., *supra* note 36, at 23, 23. For more information about the ACA, see *Affordable Care Act (ACA)*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/affordable-care-act> (last visited Nov. 30, 2021).

³⁸ Advanced practice nurses receive advanced clinical preparation through a master's degree, a post-master's certificate, and or a doctorate degree. Although “specific titles and credentials vary by state approval processes, formal recognition and scope of practice as well as by board certification,” advanced practice nurses will “fall into four broad categories: Nurse Practitioner, Clinical Nurse Specialist, Nurse Anesthetist, and Nurse Midwife” FUTURE OF NURSING 2011, *supra* note 12, at 41. As a point of reference, the number of nurse practitioners entering the workforce “mushroomed from 6,600 in 2003 to 20,000 in 2015.” Thomas Bodenheimer & Diana Mason, *Introduction*, in JOSIAH MACY JR. FOUND., *supra* note 36, at 11, 11.

³⁹ See NAT'L ADVISORY COUNCIL ON NURSE EDUC. & PRAC., REPORT NO. 10, THE ROLES OF NURSES IN PRIMARY CARE 8 (2012) (“The cornerstone of effective primary care is ready access to care. . . . Nurses have been pivotal to addressing the primary care shortage and increasing access to primary care.”); see also Bodenheimer & Mason, *supra* note 38, at 11 (“[N]urses—nurse practitioners and registered nurses (RNs)—are poised to rescue primary care.”).

Despite the varied attempts by policymakers and other stakeholders to ameliorate the nursing shortage, it has endured for more than two decades. The modern nursing shortage, as researchers predicted at the turn of the century, has been more complex than previous shortages.⁴⁰ Many efforts made over the last twenty years have, indeed, improved the nursing supply.⁴¹ Intervening economic factors like the Great Recession have also provided a much-needed boost in the nursing supply, causing shortage projections to shift at times.⁴² These fluctuations in the nursing supply led one group of

⁴⁰ KIMBALL & O'NEIL, *supra* note 23, at 14 (“The nursing supply crisis of today and of the next two decades is driven by a richer and broader set of factors, making it more complex than previous periods of over- and undersupply in nursing. In order to develop effective initiatives to address the nursing shortage, it is essential to understand what new realities exist and how they interact to shape the overall environment of nursing today.”).

⁴¹ See Thomas Bodenheimer & Laurie Bauer, *The Future of Primary Care: Enhancing the Registered Nurse Role*, in JOSIAH MACY JR. FOUND., *supra* note 36, at 57, 71 (“[F]rom 2000 to 2010, the number of RNs entering the workforce each year doubled.”). It must be noted that since 2000, the nursing workforce has swelled from 2.5 million to almost 4 million today. See Lisa M. Haddad et al., *supra* note 1.

⁴² The Great Recession was the name given to the sudden downturn in the U.S. economy that began in December 2007 and “lasted longer than the average (ten months) of all previous recessions since World War II.” Peter I. Buerhaus et al., *The Recent Surge in Nurse Employment: Causes and Implications*, 28 HEALTH AFFS. 657, 658 (July 2009). As unemployment rates climbed, the nursing supply, particularly in hospitals, grew because the economic downturn forced many nurses to delay retirement, while inducing non-practicing nurses to return to the workforce. *Id.* In many cases, nurses increased their work hours or sought supplemental employment in hospitals. Peter I. Buerhaus et al., *State of the Registered Nurse Workforce as a New Era of Health Reform Emerges*, 35 NURSING ECON. 229, 230 (2017); accord NAT'L ADVISORY COUNCIL ON NURSE EDUC. & PRAC., REPORT NO. 9, THE IMPACT OF THE NURSING FACULTY SHORTAGE ON NURSE EDUCATION AND PRACTICE 8-9 (2010) [hereinafter NACNEP NO. 9]. It must be noted that even at the height of the recession-driven bump in the nursing supply, leading authorities understood that the nursing shortage would persist. Buerhaus et al., *The Recent Surge in Nurse Employment: Causes and Implications*, *supra*, at 657 (“Recession effects that have eased the shortage of hospital nurses must be viewed as temporary, lest they distract policymakers from continuing to address longer-term indicators.”); accord TRI-COUNCIL FOR NURSING, Joint Statement from the Tri-Council for Nursing on Recent Registered Nurse Supply and Demand Projections (July 14, 2010) [hereinafter TRI-COUNCIL FOR NURSING], <https://img1.wsimg.com/blobby/go/3d8c2b58-0c32-4b54-adbd-efe8f931b2df/downloads/6-2010-Recent-RN-Supply-Demand-Projections.pdf?ver=1555011464001> (“Given the fluctuations in the economy, no

researchers to revisit a 2012 study projecting that, by 2030, there would be approximately 900,000 nursing needs across the country. Published in 2018, the revisited study revealed a decrease of approximately 400,000 in projected nursing needs by 2030, which was due, in part, to estimations of “a lower demand and a higher supply” in 2016.⁴³ However, the demand for nurses outpaced any growth in the nursing supply during this period,⁴⁴ and by February 2020, nothing prepared the nursing workforce for the unprecedented surge in demand for health-care services caused by the COVID-19 pandemic.

B. Converging Crises: The Global Pandemic’s Effect on Nursing

In its 2009 report to the Secretary of the U.S. Department of Health and Human Services and the U.S. Congress, the National Advisory Council in Nurse Education and Practice (“NACNEP”) called upon policymakers to take specific action to ensure the preparation of the nursing workforce for any large-scale disaster response.⁴⁵ The NACNEP summarized the nation’s need to prioritize nursing’s emergency response preparedness in the following way:

American nurses have always responded selflessly to assist in times of natural and manmade disasters, and

one can accurately project how long the nation will take to recover and exactly when old workforce patterns may re-emerge.”).

⁴³ Zhang et al., *supra* note 24, at 234. *See also id.* at 229 (“Much has changed since then with there now being reports of a surplus in the RN workforce. This drastic turnaround has prompted the study team to reexamine the RN labor force utilizing the same models they used previously to forecast future RN supply and demand.”).

⁴⁴ *See* TRI-COUNCIL FOR NURSING, *supra* note 42 (“Baby Boomers are entering their retirement years and their demand for care is escalating, the nursing workforce is aging rapidly, and healthcare reform will soon provide subsidies for 32 million citizens to more fully utilize the healthcare system.”). Still, it should be noted that gains in the nursing supply during this time engendered great optimism that the end of the modern shortage was in sight. *See* David M. Cutler, *Nursing Our Way to Better Health*, 322 JAMA 1033, 1033 (2019) (“Fortunately, nursing supply is now expanding rapidly, and the fact that nurses can be trained more rapidly than physicians makes any shortage likely to be short-lived.”).

⁴⁵ NAT’L ADVISORY COUNCIL ON NURSE EDUC. & PRAC., REPORT NO. 7, CHALLENGES FACING THE NURSE WORKFORCE IN A CHANGING ENVIRONMENT 15 (2009) (“Nurses are critical to the effective delivery of all healthcare and public health services, and they are integral to surge capacity, emergency planning, and response.”).

the country will look to nurses to respond to any future disasters. In order for nurses to be well prepared for disaster response, not only must guidelines and recommendations be in place, but nurses must also be properly trained to ensure that they can recognize and respond to emergency events. Nurses should be able to demonstrate an understanding of the event and its impacts on individuals and resources. They should understand their facility's and community's emergency response plans, their roles as healthcare providers, and their facility's role as part of the overall response effort.⁴⁶

However, when the World Health Organization ("WHO") declared COVID-19 a pandemic more than a decade later,⁴⁷ whatever actions resulted from the NACNEP's recommendations were insufficient to deal with the magnitude of the surge in demand for health-care services. The nursing workforce "selflessly" responded to the devastation in a health-care system that was wildly unprepared.⁴⁸

Although authorities confirmed the country's first case of COVID-19 in Washington State, New York City emerged as the epicenter of the pandemic, accounting for approximately five percent

⁴⁶ *Id.* at 20.

⁴⁷ Ghebreyesus, *supra* note 17. For a timeline of key developments in the global response to the COVID-19 pandemic, see *Listing of WHO's Response to COVID-19*, WORLD HEALTH ORG. (2021), <https://www.who.int/news/item/29-06-2020-covidtimeline>.

⁴⁸ See Sarah Kliff, *U.S. Hospitals Prepare for Coronavirus, With the Worst Still to Come*, N.Y. TIMES (Mar. 12, 2020), <https://www.nytimes.com/2020/03/12/us/hospitals-coronavirus.html?searchResultPosition=58>; Linda Bell, *Just-In-Time Learning During a Crisis*, 29 AM. J. CRITICAL CARE 270, 270 (2020) ("While not every city, hospital, or nursing unit is currently functioning in contingency or crisis mode, many places are experiencing a healthcare crisis unlike any other in current memory. Patients become acutely ill rapidly and require a very high level of care. We are bombarded in the news with stories of 'not enough'—not enough staff, not enough personal protective equipment (PPE), not enough ventilators, not enough testing, and on and on."); see also Donald G. McNeil Jr., *The U.S. Now Leads the World in Confirmed Coronavirus Cases*, N.Y. TIMES (Mar. 26, 2020), <https://www.nytimes.com/2020/03/26/health/usa-coronavirus-cases.html> ("The United States, which should have been ready, was not. This country has an unsurpassed medical system supported by trillions of dollars from insurers, Medicare and Medicaid. Armies of doctors transplant hearts and cure cancer.").

of the world's confirmed cases by late March 2020.⁴⁹ Hotspots of viral transmission were reported across the country in the weeks that followed.⁵⁰ As the flood of critically ill patients overwhelmed those regions,⁵¹ public and private entities worked to shore up the nursing supply in those regions.⁵² On the front line, clinical advisories and institutional policies were continuously and rapidly evolving as scores of critically ill patients flooded emergency rooms and other designated care units.⁵³ Nurse-led innovation undoubtedly saved countless lives

⁴⁹ Jesse McKinley, *New York City Region is Now an Epicenter of the Coronavirus Pandemic*, N.Y. TIMES (Mar. 22, 2020), <https://www.nytimes.com/2020/03/22/nyregion/Coronavirus-new-York-epicenter.html>. For a timeline of COVID-19 developments in 2020, see *A Timeline of COVID-19 Developments in 2020*, AM. J. MANAGED CARE (Jan. 1, 2021), <https://www.ajmc.com/view/a-timeline-of-covid19-developments-in-2020>.

⁵⁰ See, e.g., Katy Reckdahl et al., *New Orleans Faces a Virus Nightmare, and Mardi Gras May Be Why*, N.Y. TIMES (Mar. 26, 2020), <https://www.nytimes.com/2020/03/26/us/coronavirus-louisiana-new-orleans.html?searchResultPosition=261>; Mary M. Chapman et al., *Coronavirus Sweeps Through Detroit, a City That Has Seen Crisis Before*, N.Y. TIMES (Mar. 30, 2020), <https://www.nytimes.com/2020/03/30/us/coronavirus-detroit.html?searchResultPosition=312>; Ellen Barry, *Days After a Funeral in a Georgia Town, Coronavirus 'Hit Like a Bomb'*, N.Y. TIMES (Mar. 30, 2020), <https://www.nytimes.com/2020/03/30/us/coronavirus-funeral-albany-georgia.html?searchResultPosition=326>.

⁵¹ See, e.g., Brian M. Rosenthal et al., *Coronavirus in N.Y.: 'Deluge' of Cases Begins Hitting Hospitals*, N.Y. TIMES (Mar. 20, 2020), <https://www.nytimes.com/2020/03/20/nyregion/ny-coronavirus-hospitals.html?searchResultPosition=180>; Michael Rothfeld et al., *13 Deaths in a Day: An 'Apocalyptic' Coronavirus Surge at an N.Y.C. Hospital*, N.Y. TIMES (Mar. 25, 2020), <https://www.nytimes.com/2020/03/25/nyregion/nyc-coronavirus-hospitals.html?searchResultPosition=253>.

⁵² Travel nurse agencies recruited nurses from regions yet-to-be overwhelmed by the pandemic and facilitated their temporary employment in these COVID-19 hot zones. See Julie Bosman, *As Hospitals Fill, Travel Nurses Race to Virus Hot Spots*, N.Y. TIMES (Dec. 2, 2020), <https://www.nytimes.com/2020/12/02/us/covid-travel-nurses.html>. State governments assisted with this mobilization of the national nursing workforce by relaxing certain licensing requirements so that nurses licensed in other jurisdictions could practice in those COVID-19 hot zones. See *State Response to COVID-19*, NCSBN (Jan. 28, 2022, 10:00 AM), https://www.ncsbn.org/State_COVID-19_Response.pdf.

⁵³ See, e.g., Diana Brickman et al., *Rapid Critical Care Training of Nurses in the Surge Response to the Coronavirus Pandemic*, 29 AM. J. CRITICAL CARE e104, e107 (2020) (describing “the process by which [a New York hospital] transformed available nursing resources in order to care for a high volume of patients with COVID-19”).

by both expanding the capacity of hospitals to absorb the surge in volume, as well as concurrently redesigning established standards of care to meet the needs of these patients.⁵⁴ Because little was known about the novel virus, clinicians were forced to medically manage an unknown disease process as they simultaneously learned about it.⁵⁵

Nurses in acute care settings like emergency rooms, intensive care units, and medical wards, struggled to manage an insurmountable surge of COVID-19 patients while other segments of the nursing workforce suffered economically and faced furloughs as hospitals shifted resources away from nonemergency procedural areas.⁵⁶ For

⁵⁴ See, e.g., Erica Djen et al., *Safety Champions: An Innovative Role During an Evolving Pandemic*, CRITICAL CARE NURSE, Oct. 2021, at 72, 72 (2021) (developing a “safety champion” role among the existing team of nurses to serve as an effective mechanism to disseminate evidence-based best practices and frequent changes in COVID-19 policy unit-wide as the pandemic response evolved); accord Mary K. Wakefield & David R. Williams, *Preface*, in NAT’L ACAD. MED., THE FUTURE OF NURSING 2020–2030: CHARTING A PATH TO ACHIEVE HEALTH EQUITY, at xiii, xiv (Mary K. Wakefield et al. eds., 2021) [hereinafter FUTURE OF NURSING 2020–2030] (“This report’s release in 2021 comes as the United States and the world have suffered great loss, but also are buoyed by the promise of lessons learned, including witnessing the nursing profession’s commitment to health, nursing innovations that improved health care in real time for patients and families impacted by COVID-19, and nurse-driven adaptations in education and practice that will likely drive lasting changes in both.”).

⁵⁵ See Emma Goldberg, *Theses Doctors Have Specialties. Fighting Coronavirus Wasn’t One of Them.*, N.Y. TIMES (Mar. 23, 2020), <https://www.nytimes.com/2020/03/23/health/coronavirus-doctors-specialists.html?searchResultPosition=209>; Cornelia Griggs, *A New York Doctor’s Coronavirus Warning: The Sky is Falling*, N.Y. TIMES (Mar. 19, 2020), <https://www.nytimes.com/2020/03/19/opinion/coronavirus-doctor-new-york.html?searchResultPosition=138> (“Doctors across the globe are sharing information, protocols and strategies through social media, because our common publishing channels are too slow.”); see also Apoorva Mandavilli, *The Coronavirus Patients Betrayed by Their Own Immune Systems*, N.Y. TIMES (Apr. 1, 2020), <https://www.nytimes.com/2020/04/01/health/coronavirus-cytokine-storm-immune-system.html?searchResultPosition=354>.

⁵⁶ Ellen Gabler et al., *During a Pandemic, an Unanticipated Problem: Out-of-work Health Workers*, N.Y. TIMES (Apr. 3, 2020), <https://www.nytimes.com/2020/04/03/us/politics/coronavirus-health-care-workers-layoffs.html?searchResultPosition=393> (“The job cuts, which stretch from Massachusetts to Nevada, are a new and possibly urgent problem for a business-oriented health care system whose hospitals must earn revenue even in a national crisis.”); accord William M. Sage, *The Future of Nursing 2020–2030: Meeting America Where We Are*, in FUTURE OF NURSING 2020–2030, *supra* note 54, at 423, 424 (“Even as the pandemic raged, nurses with outstanding professional skills

acute care nurses, caring for highly infectious patients under unprecedented and uncertain conditions has taken a tremendous toll on their physical and mental health.⁵⁷ As of the writing of this Article, COVID-19 variants continue to strain an exhausted and emaciated nursing workforce.⁵⁸ The pandemic's full impact on the nursing workforce and long-term projections of the nursing supply remains to be seen.⁵⁹

III. THE CAUSES OF THE NURSING SHORTAGE

A multitude of complex factors contribute to the nursing shortage. This section will explore the major factors that contribute to the persistence of the nursing shortage. First, it explains how sustained shortages in nursing education programs have hampered the pipeline of future nurses. Then, it analyzes the root causes and detrimental effects of high-stress practice settings.

A. Nurse Faculty Shortages: Impeding the Pipeline of Future Nurses

The demand for nurses continues to intensify as the 78 million baby boomers in this country age because, as they age, their incidence

suffered economic hardship as reduced demand for nonemergency, specialized medical care and surgical procedures resulted in furloughs and layoffs.”).

⁵⁷ See generally Tessa A. Thomas et al., *COVID-19 and Moral Distress: A Pediatric Critical Care Survey*, 30 AM. J. CRITICAL CARE e80 (2021); Edie Brous, *Crisis Standards of Care*, AM. J. NURSING, July 2021, at 51, 51.

⁵⁸ See Madison Muller, *'We're Overwhelmed': Nurses Across the U.S. Protest Covid Working Conditions*, BLOOMBERG (Jan. 13, 2022, 5:15 PM), <https://www.bloomberg.com/news/articles/2022-01-13/us-nurses-strike-to-highlight-working-conditions-during-covid-as-omicron-surges> (quoting an emergency room nurse as saying, “It’s shocking how sick people are. They’re still getting sick and dying of Covid today. That hasn’t changed.”); Andrew Jacobs, *'Nursing Is in Crisis': Staff Shortages Put Patients at Risk*, N.Y. TIMES (Oct. 20, 2021), <https://www.nytimes.com/2021/08/21/health/covid-nursing-shortage-delta.html>.

⁵⁹ See Jonathan Levin, *U.S. Hospital Staff Shortages Hit Most in a Year on Covid Surge*, BLOOMBERG L. (Jan. 5, 2022, 12:36 PM), <https://www.bloomberg.com/news/articles/2022-01-05/one-in-five-u-s-hospitals-face-staffing-shortages-most-in-year>; Letourneau, *supra* note 25; Williams, *supra* note 25 (“Already shorthanded, the nation’s nurses are fighting burnout along with another surge in coronavirus cases.”). *But see generally* Nicole Fauteux, *COVID-19: Impact on Nurses and Nursing*, AM. J. NURSING, May 2021, at 19.

of suffering from multiple chronic diseases increases. This increased incidence of comorbidities, in turn, intensifies the complexity of nursing care needed to treat these patients.⁶⁰ This rising demand for medically complex care means that efforts to enhance the nursing supply must ensure that nurse education standards sufficiently meet the moment.⁶¹ However, a chronic shortage of nurse educators has diminished the capacity to infuse new nurses into the workforce.⁶²

The National League for Nursing reported of an “unmet demand” for placement in nursing programs dating back to 2005.⁶³ Subsequent studies revealed that despite a growing deficit in the nursing supply, nursing schools across the country turned away tens of thousands of applicants due to insufficient capacity.⁶⁴ In 2009, in its first of two reports about the nurse faculty shortage, the NACNEP identified recruitment challenges and an aging nurse faculty workforce among the key factors underlying the shortage and made a series of recommendations to abate the problem.⁶⁵ In its subsequent report, issued ten years later, the NACNEP reviewed the response to its initial recommendations and determined that those recommendations, while necessary and still supported by the current NACNEP membership,

⁶⁰ See Buerhaus et al., *State of the Registered Nurse Workforce as a New Era of Health Reform Emerges*, *supra* note 42, at 237 (“Three in four people over age 65 have multiple chronic diseases, which will increase the overall demand for RNs as well as the complexity and intensity of nursing care that will be required to manage this medically complicated population.”).

⁶¹ Position Statement of the Nat’l League for Nursing, Bd. of Governors on Transforming Nursing Education (May 9, 2005), https://www.nln.org/docs/default-source/uploadedfiles/about/archived-position-statements/transforming052005.pdf?sfvrsn=ac2bdc0d_0 (“Because health care is dramatically evolving to address the quality chasm (Institute of Medicine, 2001), the practice environment is complex, and it demands new competencies of nurses that, in turn, demand transformation of nursing education programs and educational practices.”).

⁶² See NACNEP NO. 9, *supra* note 42, at 9 (“A major contributing factor to the nation’s nursing shortage is a shortage of nursing faculty in U.S. schools of nursing.”); *accord Fact Sheet: Nursing Shortage*, AM. ASS’N COLL. NURSING (Sept. 2020), <https://www.aacnnursing.org/Portals/42/News/Factsheets/Nursing-Shortage-Factsheet.pdf> (“Compounding the problem is the fact that nursing schools across the country are struggling to expand capacity to meet the rising demand for care.”).

⁶³ Kathy Kaufman, *Executive Summary*, in NAT’L LEAGUE FOR NURSING, NURSING DATA REVIEW: ACADEMIC YEAR 2005–2006 at 1, 1 (2008).

⁶⁴ NACNEP NO. 9, *supra* note 42, at 9-13.

⁶⁵ *Id.* at 34-36.

“were not sufficient in setting a course correction to increase and improve the nurse faculty workforce.”⁶⁶

B. Burnout: A Threat to Patient Safety and a Contributor to the Shortage

Burnout is “a syndrome characterized by high emotional exhaustion, high depersonalization (i.e., cynicism), and a low sense of personal accomplishment” that is “caused by a chronic imbalance of high job demands and inadequate job resources.”⁶⁷ When burnout affects nurses, it can pose a significant threat to patient safety.⁶⁸ Nurse burnout can also have a detrimental effect on the nurse’s health and wellbeing,⁶⁹ which can drive individuals out of the workforce.⁷⁰

⁶⁶ NAT’L ADVISORY COUNCIL ON NURSE EDUC. & PRAC., REPORT NO. 17, PREPARING NURSE FACULTY, AND ADDRESSING THE SHORTAGE OF NURSE FACULTY AND CLINICAL PRECEPTORS 10 (2020) [hereinafter NACNEP NO. 17]; *accord Fact Sheet: Nursing Shortage, supra* note 62 (“Though AACN reported a 5.1% enrollment increase in entry-level baccalaureate programs in nursing in 2019, this increase is not sufficient to meet the projected demand for nursing services, including the need for more nurse faculty, researchers, and primary care providers.”).

⁶⁷ Dalia Sofer, *Restoring a Burned-Out Workforce*, AM. J. NURSING, Feb. 2020, at 16.

⁶⁸ Lakshmana Swamy et al., *Impact of Workplace Climate on Burnout Among Critical Care Nurses in the Veterans Health Administration*, 29 AM. J. CRITICAL CARE 380, 381 (2020) (“Burnout affects the quality of patient care and is associated with an increased incidence of medical errors and reduced patient satisfaction.”); *accord* INST. OF MED., KEEPING PATIENTS SAFE: TRANSFORMING THE WORK ENVIRONMENT OF NURSES 1, 2 (Ann Page ed., 2004) (“Research is now beginning to document what physicians, patients, other health care providers, and nurses themselves have long known: how well we are cared for by nurses affects our health, and sometimes can be a matter of life or death.”); *see generally* Shweta Singh, *The Nexus Between Nurse Burnout, Missed Care and Patient Outcomes* (2019) (Ph.D. dissertation, University of Pennsylvania), <https://repository.upenn.edu/edissertations/>.

⁶⁹ Swamy et al., *supra* note 68, at 381 (“Clinicians with burnout are more likely to suffer from substance abuse and depression and to experience suicidal ideation.”); *Is Nurse Burnout on the Rise? Startling Statistics on Nurse Well-Being*, WELL-BEING INDEX (Feb. 24, 2021, 9:42 PM), <https://www.mywellbeingindex.org/blog/is-nurse-burnout-on-the-rise-startling-statistics-on-nurse-well-being> (“Nurses suffering from burnout show many signs and tend to be so fatigued that they struggle to cope or perform normal job duties. They may feel alienated, emotionally distant or numb about their usual activities, and both job satisfaction and job performance may suffer.”).

⁷⁰ Swamy et al., *supra* note 68, at 381 (“[B]urnout increases the risk of clinician turnover and compounds health system costs through decreased efficiency and

The impact of workplace demands can have other deleterious effects on the health and well-being of nurses, such as anxiety, depression, compassion fatigue, and even suicidal ideation.⁷¹ A recent longitudinal study of nurse suicide in this country revealed that nurses were more likely to die of suicide than the general population and that the increased risk of suicide was related to workplace stressors.⁷² Like burnout, these adverse conditions can also compromise patient safety.

Pre-pandemic studies showed that “[a]s many as half of the nursing workforce [were] experiencing burnout” caused by work-related stress.⁷³ More than two years (and counting) into the pandemic, “[n]urses [have been] coping with unrealistic workloads; insufficient resources and protective equipment; risk of infection; stigma directed at health care workers; and the mental, emotional, and moral burdens of caring for patients with a new and unpredictable disease.”⁷⁴ The following explores some of the work-related stressors underlying nurse burnout, specifically looking at the workplace conditions of various practice settings, as well as the ethical challenges confronting nurses that cause moral suffering.

I. Workplace Conditions

Although nursing may be one of the most versatile occupations within healthcare, all nurses, regardless of their practice setting, will

productivity and staff shortages.”). See generally Lesly A. Kelly et al., *Impact of Nurse Burnout on Organizational and Position Turnover*, 69 NURSING OUTLOOK 96 (2021); Mary A. Blegen et al., *Newly Licensed RN Retention*, 47 J. NURSING ADMIN. 508 (2017).

⁷¹ FUTURE OF NURSING 2020–2030, *supra* note 54, at 302.

⁷² Judy E. Davidson et al., *A Longitudinal Analysis of Nurse Suicide in the United States (2005–2016) with Recommendations for Action*, 17 WORLDVIEWS ON EVIDENCE-BASED NURSING 6 (2020).

⁷³ Kelly et al., *supra* note 70, at 96 (citing a report from 2017); see also Swamy et al., *supra* note 68, at 383 (finding that one third of ICU nurses surveyed between 2016 and 2017 reported burnout).

⁷⁴ FUTURE OF NURSING 2020–2030, *supra* note 54, at 301-16. In sharing her COVID-19 experience with the New York Times, Nurse Kimberly Wills O’Connell reported: “In one twelve-hour shift we had six patients die under the age of fifty, and as quickly as they got those beds cleaned, there was more patients there.” Lucy King & Jonah M. Kessel, *We Know the Real Cause of the Crisis in Our Hospitals. It’s Greed*, N.Y. TIMES: OPINION VIDEO (Jan. 19, 2022), <https://www.nytimes.com/2022/01/19/opinion/nurses-staffing-hospitals-covid-19.html?smid=em-share>.

encounter challenges in their work that are physically, mentally, and emotionally taxing. Therefore, all nurses, regardless of their practice setting, are susceptible to burnout and other adverse conditions.⁷⁵ The following discusses the most common workplace stressors for nurses, which include (i) excessive workloads and staff shortages, (ii) occupational hazards, and (iii) pervasive hostility.

i. Excessive Workloads and Inadequate Staffing

The nursing workforce has struggled to meet the need as the demand for complex health-care services has burgeoned. The insufficient nursing supply has resulted in standards of care that tolerate excessive workloads; nurses are expected to manage patient loads that are increasing in number and complexity.⁷⁶ As a result, nurses are forced to make consequential decisions about where to allocate their time, attention, and other resources.⁷⁷

Nurses are also expected to compensate for shortages in support staff. In addition to providing direct care to increasing patient loads, nurses must take on “‘non-nursing duties,’ such as stocking rooms and transporting patients [when] the facility doesn’t have enough workers.”⁷⁸ The decisions to understaff nurses and to operate with inadequate resources are made at the organizational level by

⁷⁵ See, e.g., E. Brie Thumm et al., *Burnout of the U.S. Midwifery Workforce and the Role of Practice Environment*, HEALTH SERVS. RSCH., 2021, at 1, 1, <https://doi.org/10.1111/1475-6773.13922> (finding practice environment as a main driver of nurse midwife burnout).

⁷⁶ See generally Katelyn Kuwata, *Spread Too Thin: The Case for Federally Mandated Minimum Nurse-to-Patient Ratios in Hospitals*, 49 LOY. L.A. L. REV. 635 (2016).

⁷⁷ See Statement of Nurse Kerry Noonan, in King & Kessel, *supra* note 74 (“If you push me past my limit, past my capacity of being able to multitask, something is going to get missed. And, when I say ‘something,’ I’m talking about your mother, I’m talking about your father, I’m talking about your husband and wife.”).

⁷⁸ Andrew Wallender et al., *Health-Care Strike Risk Runs High as Hundreds of Labor Deals End*, BLOOMBERG L. (Jan. 24, 2022, 5:00 AM), <https://news.bloomberglaw.com/daily-labor-report/health-care-strike-risk-runs-high-as-hundreds-of-labor-deals-end>; Muller, *supra* note 58 (“We don’t have food service people . . . we don’t have supply chain people to deliver our most critical supplies, we don’t have people to repair our equipment But every job that doesn’t get done by somebody else ends up falling to the bedside nurse. We’re overwhelmed.”) (quoting a nurse discussing his experience).

employers and exacerbate work-related stressors.⁷⁹ Chronic understaffing and resource shortages cause nurses to feel unsupported in their workplace.⁸⁰ This perceived lack of support can lead to decreased work satisfaction and increased rates of burnout and other adverse conditions—further fueling nurse turnover.⁸¹

In contrast, because American health care is a profit-driven system,⁸² when nurses do more with less, it translates to decreased costs for employers.⁸³ The financial benefit of higher productivity at

⁷⁹ See Alison M. Trinkoff et al., *Chapter 39. Personal Safety for Nurses*, in *PATIENT SAFETY AND QUALITY: AN EVIDENCE-BASED HANDBOOK FOR NURSES* 2, 2-473 (2008).

⁸⁰ *Fact Sheet: Nursing Shortage*, *supra* note 62 (“Insufficient staffing is raising the stress level of nurses, impacting job satisfaction, and driving many nurses to leave the profession.”). *But see* Bernadette Mazurek Melnyk et al., *Critical Care Nurses’ Physical and Mental Health, Worksite Wellness Support, and Medical Errors*, 30 *AM. J. CRITICAL CARE* 176, 182 (2021) (“[N]urses who perceived high levels of wellness support from their organizations were more than twice as likely to have better health than nurses who reported not having supportive worksites.”).

⁸¹ See Wallender et al., *supra* note 78. In the early 2000s, state legislatures took aim at improving working conditions for nurses by passing laws that included a prohibition of mandatory overtime in hospitals, increased whistleblower protections, and, in California, mandatory staffing ratios. See Theresamarie Mantese et al., *Nurse Staffing, Legislative Alternatives and Health Care Policy*, 9 *DEPAUL J. HEALTH CARE L.* 1171, 1179-80 (2006). Federal efforts to increase the nursing supply included the introduction of several bills to regulate minimum nurse staffing levels, but despite overwhelming evidence that patient safety is inextricably tied to nurse staffing ratios, safe nurse staffing failed to become law. See *id.*; see also Shannon Peoples, *The Current Nursing Shortage: Will the Registered Nurse Safe Staffing Act Help?*, 72 *UMKC L. REV.* 809, 822-28 (2004); Mannino, *supra* note 34, at 156-57. To date, there exists no federal legislation regulating the number of patients a nurse can care for at once. See *National Campaign for Safe RN-to-Patient Staffing Ratios*, NAT’L NURSES UNITED, <https://www.nationalnursesunited.org/ratios> (last visited Jan. 17, 2022).

⁸² Ryan Crowley et al., *Financial Profit in Medicine: A Position Paper from the American College of Physicians*, 174 *ANNALS INTERNAL MED.* 1447, 1447 (2021) (“In the United States, the 20th century saw increased corporate influence in health care, marked in part by investments, mergers, and acquisitions, in addition to profit maximization. These changes led to scrutiny of physician self-referral and enrichment of pharmaceutical companies; even nonprofit hospitals received criticism for losing sight of their community-oriented missions.”).

⁸³ See Sage, *supra* note 56, at 424 (“The value of nursing has often been obscured by hospital accounting practices that treat nurses as undifferentiated though dominant contributors to organizational ‘labor costs’—relegating them to the expense side of the ledger.”); accord Wallender et al., *supra* note 78 (“Hospitals have little incentive to hire more nurses during a shortage, since they don’t generate the kind of lucrative

a lower labor cost can create “[p]ressures within organizations to downsize, [to] use nurses employed under alternative arrangements (pool and traveling staff), and [to shorten] the turnaround time for patient care” by pressuring physicians to prescribe early discharge from clinical settings and by mandating that nurses take on “higher patient loads.”⁸⁴ This incentive to maximize profits can, in many instances, compete with an organizational desire to prioritize the needs of its nurses.⁸⁵

For example, nurses in clinical settings like hospitals typically work 12-hour shifts with lunch and rest breaks built into their shift.⁸⁶ It was, until recently, a standard practice in the health-care industry to calculate wages by simply deducting the allotted break time from the nurse’s total shift time.⁸⁷ However, to meet the demands of their increasing workloads, nurses frequently cut their breaks short or skipped them entirely.⁸⁸ Although federal law required employers to compensate nurses for those missed and interrupted breaks,⁸⁹ employers automatically deducted those hours from wage computations without making any meaningful effort to ensure that

payments from insurance companies that other clinicians do, said David Coppins, CEO of IntelyCare, a staffing platform that directly employs 30,000 nurses. That’s been compounded by the fact hospital executives have been slow to listen to staffing complaints, he said.”).

⁸⁴ See Trinkoff et al., *supra* note 79, at 2-473.

⁸⁵ See Sage, *supra* note 56, at 428 (“A fundamental shift is required in how hospital management perceives nurses, and in how those perceptions are translated into strategic planning, budgeting, and operations.”); accord Trinkoff et al., *supra* note 79, at 2-477 (“Lower staffing ratios for nurses and higher patient loads have both been shown to result in increased exposure to hazardous conditions and insufficient recovery time.”).

⁸⁶ *Love-Hate Relationship: Nurses & the 12-Hour Shift*, AMN HEALTHCARE: BLOG (Aug. 18, 2016), <https://www.amnhealthcare.com/amn-insights/nursing/blog/love-hate-relationship-nurses-the-12-hour-shift/> (“Twelve-hour nursing shifts began in the 1970s and caught on; nurses liked working fewer days, and hospitals found that it made scheduling easier because they could assign fewer shifts per nurse.”).

⁸⁷ See U.S. DEPARTMENT OF LABOR, WAGE & HOUR DIVISION, FACT SHEET NO. 53, THE HEALTH CARE INDUSTRY AND HOURS WORKED 3 (July 2009) [hereinafter FACT SHEET NO. 53].

⁸⁸ See, e.g., Brian Cubbison, *Hospital Workers Sue for Lunch Money*, SYRACUSE.COM (Jul. 22, 2009, 7:51 PM), https://www.syracuse.com/news/2009/07/hospital_workers_sue_for_lunch.html.

⁸⁹ See 29 C.F.R. § 785.11 (“Work not requested but suffered or permitted is work time [that must be compensated].”).

nurses took their full break.⁹⁰ The nurses' uncompensated labor worked to maximize the employer's profit under this scheme.

Following a "spate of lawsuits" filed by nurses and other health care workers seeking to be fairly compensated for work performed, the American Hospital Association, in partnership with Jones Day and the American Society for Healthcare Human Resources Administration, warned its stakeholders that "[h]ospitals and other healthcare entities c[ould] no longer afford to overlook wage and hour compliance issues."⁹¹ Employment-side law firm Littler Mendelson issued its own warning to the healthcare industry, describing "the scope of the problem" in the following way: "What started in 2008 as a localized outbreak by a single law firm filing class and collective actions against hospital systems in Rochester, New York challenging automatic 30-minute pay deductions for meal periods has now become an epidemic."⁹² This framing of the collective effort of nurses seeking enforcement of statutory wage protections as an infectious agent conveys an unabashed prioritization of profits over the basic needs of nurses and other health care workers.

ii. Occupational Exposures and Other Hazards

There are inherent risks involved in nursing that cause nurses to have a high prevalence of occupational injuries.⁹³ In delivering care to the sick, nurses must come into close proximity with infectious

⁹⁰ Cubbison, *supra* note 88. *But see* FACT SHEET NO. 53, *supra* note 87, at 3 ("When choosing to automatically deduct 30-minutes per shift, the employer must ensure that the employees are receiving the full meal break." (citing 29 C.F.R. § 785.19)).

⁹¹ Jones Day, Am. Hosp. Ass'n & Am. Soc'y for Healthcare Human Res. Admin., Wage and Hour Compliance Webinar: Key Issues Affecting the Healthcare Industry 1 (Nov. 12, 2009), <https://www.aha.org/system/files/content/00-10/09JDwagehrcompissues.pdf>.

⁹² Gregory C. Keating et al., *The Littler Report: Wage and Hour Class Actions in the Healthcare Industry*, LITTLER, Mar. 2012, at 1.

⁹³ Michelle A. Dressner & Samuel P. Kissnger, *Occupational Injuries and Illnesses Among Registered Nurses*, MONTHLY LAB. REV. (Nov. 2018), <https://www.bls.gov/opub/mlr/2018/article/occupational-injuries-and-illnesses-among-registered-nurses.htm>; *see also* *Healthcare: Overview*, OCCUPATIONAL SAFETY & HEALTH ADMIN., <https://www.osha.gov/healthcare> (last visited Apr. 24, 2022).

agents.⁹⁴ Nurses also risk physical injury related to common occupational hazards like slip and falls, needle sticks, and lifting patients.⁹⁵ As a result, “[nurses] have experienced some of the highest injury and illness rates in the healthcare and social assistance sector.”⁹⁶

Although these occupational hazards may be inherent to the nurses’ duties, it is important to recognize and understand how understaffing and shortages of other critical resources exacerbate the nurse’s risk of occupational injuries.⁹⁷ Organizations that employ nurses have the power—and a legal obligation—to mitigate these known risks.⁹⁸ Yet, as discussed above, there is financial benefit to increasing nursing workloads that may affect an employer’s prioritization of the needs of its nurses.⁹⁹ Nurses are expected to carry out their duties in “high-demand and low-control work environments,”¹⁰⁰ and these conditions, in turn, influence the level of support nurses perceive in their workplace. Once again, this perceived lack of support contributes to higher incidences of turnover and can even drive individuals out of the workforce.

“[T]he extent to which nurses’ jobs put them at risk of physical harm due to lack of adequate PPE and severe staffing shortages” has been laid bare in the wake of the COVID-19 pandemic.¹⁰¹ More than a thousand nurses died from occupational exposure to COVID-19 in

⁹⁴ See *Healthcare: Infectious Diseases*, OCCUPATIONAL SAFETY & HEALTH ADMIN., <https://www.osha.gov/healthcare/infectious-diseases/> (last visited Apr. 24, 2022); accord Carl H. Coleman, *Beyond the Call of Duty: Compelling Health Care Professionals to Work During an Influenza Pandemic*, 94 IOWA L. REV. 1 (2008).

⁹⁵ Dressner & Kissnger, *supra* note 93; *Healthcare: Safe Patient Handling*, OCCUPATIONAL SAFETY & HEALTH ADMIN., <https://www.osha.gov/healthcare/safe-patient-handling/> (last visited Apr. 24, 2022).

⁹⁶ Dressner & Kissnger, *supra* note 93.

⁹⁷ See Trinkoff et al., *supra* note 79, at 2-477 (“Lower staffing ratios for nurses and higher patient loads have both been shown to result in increased exposure to hazardous conditions and insufficient recovery time.”).

⁹⁸ The Occupational Safety and Health Act of 1970 imposes a duty on covered employers to provide a workplace free of hazards known to cause harm. Pub. L. No. 91-596, 84 Stat. 1590 (codified as amended at 29 U.S.C. § 651 *et seq.*). Furthermore, “[p]ressures within organizations to downsize, use nurses employed under alternative arrangements (pool and traveling staff), and the turnaround time for patient care (early discharge, higher patient loads) are examples of factors that are determined at an organizational level.” Trinkoff et al., *supra* note 79, at 2-473.

⁹⁹ See *supra* Section III.B.1.i.

¹⁰⁰ FUTURE OF NURSING 2020–2030, *supra* note 54, at 305.

¹⁰¹ FUTURE OF NURSING 2020–2030, *supra* note 54, at 306.

the first year of the pandemic alone.¹⁰² Nurses on the front line delivered care to COVID-19 patients under constant threat to their own health and safety, as well as the health and safety of their loved ones.¹⁰³ Despite the tremendous risk of occupational exposure to COVID-19 faced by nurses in the early days of the pandemic, employers enjoyed the right of determining whether a nurse's COVID-19 diagnoses would be classified as an occupational exposure.¹⁰⁴

In my own experience as a nurse on the front line of COVID-19, for example, the hospital implemented a policy that employee COVID-19 infections were presumed to be community exposure unless the nurse could show that they provided direct care without PPE to a patient with a documented COVID-19 positive status. Colleagues who fell ill with COVID-19 were required to make a showing sufficient to rebut that presumption to access worker's compensation benefits—in addition to coping with a symptomatic infection and the potential spread of the virus within their household.¹⁰⁵

iii. Incivility, Bullying, and Workplace Violence

Incivility in the workplace is characterized as “an affront to the dignity of a coworker,” and “can take the form of rude and discourteous actions, of gossiping and spreading rumors, and of

¹⁰² *Lost on the Frontline*, GUARDIAN (Aug. 11, 2020), <https://www.theguardian.com/us-news/ng-interactive/2020/aug/11/lost-on-the-frontline-covid-19-coronavirus-us-healthcare-workers-deaths-database>.

¹⁰³ See Jill L. Guttormson et al., *Critical Care Nurses' Experiences During the COVID-19 Pandemic: A U.S. National Survey*, 31 AM. J. CRITICAL CARE 96, 100 (2022) (“It’s very stressful and I feel uncertain about the effectiveness of PPE and my family’s safety as I care for patients with COVID-19 . . . I have to continue to work[,] and I am proud to be a nurse but if I lose someone it will not be worth it.”).

¹⁰⁴ See Joyce E. Cutler, *California Nurses Battered by Covid Seek Workers' Comp Equity*, BLOOMBERG L. (Apr. 7, 2022, 10:30 AM), <https://news.bloomberglaw.com/coronavirus/california-nurses-in-covid-era-push-for-workers-comp-equity>.

¹⁰⁵ California has recently introduced a bill to create rebuttable presumptions that “infectious diseases, cancer, musculoskeletal injuries, post-traumatic stress disorder (PTSD), and respiratory diseases” including COVID-19 that manifest in nurses (and other healthcare workers) are caused at work. S.B. 213, 2021–2022 Leg., Reg. Sess. (Cal. 2021). If the bill passes, California will join Minnesota in “conclud[ing] that nurses’ infectious diseases and PTSD are suffered at work.” Cutler, *supra* note 104.

refusing to assist a coworker.”¹⁰⁶ Bullying, on the other hand, is defined as “repeated, unwanted harmful actions intended to humiliate, offend, and cause distress in the recipient.”¹⁰⁷ Bullying actions in the health-care setting “include, but are not limited to, hostile remarks, verbal attacks, threats, taunts, intimidation, and withholding of support.”¹⁰⁸ Incivility tends to lead to bullying, and both are pervasive in nursing, particularly in clinical settings.¹⁰⁹ Indeed, “there is an expected culture within nursing in which young or new nurses will encounter bullying, gossip and belittling, intimidation, hostility, exclusion, and hazing from other staff nurses, supervisors, and managers.”¹¹⁰ It is well documented that this culture of incivility and bullying leads to mental health issues, burnout, and departure from the profession.¹¹¹

Workplace violence is defined as “any act or threat of physical violence, harassment, intimidation, or other threatening disruptive

¹⁰⁶ Position Statement from the Pro. Issues Panel on Incivility, Bullying, and Workplace Violence, Am. Nurses Ass’n 2 (July 22, 2015) [hereinafter ANA Position Statement],

<https://www.nursingworld.org/~49d6e3/globalassets/practiceandpolicy/nursing-excellence/incivility-bullying-and-workplace-violence--ana-position-statement.pdf>.

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ See generally Eliza S. Vanderstar, *Introduction to the Symposium on Workplace Bullying: Workplace Bullying in the Healthcare Professions*, 94 EMP. RTS. & EMP. POL’Y J. 455 (2004).

¹¹⁰ FUTURE OF NURSING 2020–2030, *supra* note 54, at 313. I began my nursing career in the intensive care unit in 2010. It was constantly said throughout nursing school and into residency that “nurses eat their young.” Bullying and incivility were part and parcel of the nursing process. Twelve years later, I still hear my nurse colleagues use the phrase.

¹¹¹ In 2005, and in recognition “that the deepening nurse shortage could not be reversed without work environments that support excellence in nursing practice,” the American Association of Critical Care Nurses (“AACN”)—the world’s largest specialty nursing organization—published the *AACN Standards for Establishing and Sustaining Healthy Work Environments: A Journey to Excellence*. Dana Wood & Connie Barden, *A Message from the American Association of Critical-Care Nurses*, in AACN STANDARDS FOR ESTABLISHING AND SUSTAINING HEALTHY WORK ENVIRONMENTS: A JOURNEY TO EXCELLENCE 1 (2d ed. 2016). The AACN’s seminal work “uniquely identified previously discounted systemic behaviors that [could] result in unsafe conditions” and “called for the creation and continual fostering of healthy work environments as an imperative for ensuring patient safety and optimal outcomes.” *Id.*

behavior that occurs at the work site.”¹¹² Verbal aggression is recognized as a form of workplace violence because it is a risk factor for physical violence.¹¹³ Among all occupations, health-care workers experience the highest rates of injuries from assaults at work.¹¹⁴ Nurses and nursing assistants are the health-care workers most at risk of experiencing violence in the workplace.¹¹⁵ Perpetrators of violence against on-duty nurses include patients and their family members, physicians and other practitioners, as well as nurses and other colleagues.¹¹⁶

In 2015, responding to the labeling of nursing’s workplace hostility issues as an epidemic, the American Nurses Association (“ANA”) announced that “the nursing profession w[ould] no longer tolerate violence of any kind from any source.”¹¹⁷ The ANA called upon nurses and employers to commit to creating “a culture of respect.”¹¹⁸ Nurses were reminded of their obligations under the ethics code to “create an ethical environment and culture of civility and kindness, treating colleagues, coworkers, employees, students, and others with dignity and respect.”¹¹⁹ Employers were reminded of their obligations under the Occupational Safety and Health Act of 1970 (“OSH Act”) to provide a workplace free of hazards known to cause harm.¹²⁰ Specifically, the ANA identified workplace violence as a known hazard that employers were obligated to abate under the OSH Act.¹²¹

¹¹² *Healthcare: Workplace Violence*, OCCUPATIONAL SAFETY & HEALTH ADMIN., <https://www.osha.gov/healthcare/workplace-violence> (last visited Apr. 24, 2022).

¹¹³ Edie Brous, *Workplace Violence*, AM. J. NURSING., Oct. 2018, at 51, 54.

¹¹⁴ OCCUPATIONAL SAFETY & HEALTH ADMINISTRATION, NO. 3148-06R, GUIDELINES FOR PREVENTING WORKPLACE VIOLENCE FOR HEALTH CARE AND SOCIAL SERVICE WORKERS 2 (2015) (“For healthcare workers, assaults comprise 10-11% of workplace injuries involving days away from work, as compared to 3% of injuries of all private sector employees.”).

¹¹⁵ Brous, *supra* note 113, at 51.

¹¹⁶ See Beth Ulrich et al., *Critical Care Nurse Work Environments 2018: Findings and Implications*, 39 CRITICAL CARE NURSE, no.2, at 67, 76 tbl.4 (2019).

¹¹⁷ ANA Position Statement, *supra* note 106, at 1.

¹¹⁸ *Id.* at 6.

¹¹⁹ *Id.* at 1.

¹²⁰ *Id.* at 6-7 (citing Occupational Safety & Health Act of 1970, Pub. L. No. 91-596, 84 Stat. 1590 (codified as amended at 29 U.S.C. § 651 *et seq.*)).

¹²¹ *Id.*

Despite these codified health and safety protections, workplace violence remains pervasive in health care.¹²² A 2018 survey of 8,080 critical care nurses found that when “asked if [the participant] had experienced verbal abuse, physical abuse, sexual harassment, and/or discrimination in the past year while working as a nurse, 80% reported experiencing verbal abuse at least once, 47% reported experiencing physical abuse at least once, 46% reported discrimination, and 40% reported sexual harassment.”¹²³ In sum, “86% of the respondents experienced at least 1 of the negative incidents.”¹²⁴ These workplace hostilities pose a grave threat to the physical and mental well-being of nurses and “accelerates the rate at which nurses leave the workforce.”¹²⁵

Worse yet, it is estimated that “incidents of assault [in health-care settings] are substantially underreported by as much as 50% because of a lack of workplace reporting policies, a lack of confidence in the reporting system, and fear of retaliation.”¹²⁶ Nurses practicing in community settings similarly face an increased risk of violence and aggression. For example, because nurses that deliver care in patients’ homes “often work alone in dynamic environments characterized by potentially high-risk situations, they are at risk of verbal and physical assault while in the community or people’s homes.”¹²⁷ Studies suggest that “[t]he incidence of workplace violence in home nursing is likely underreported because of factors including the perception that violence is part of the job and the moral conflict nurses face between duty to their patients and duty to report an incident of violence.”¹²⁸

¹²² In an opinion video for the New York Times, editors Lucy King and Jonah M. Kessel interviewed several nurses to document the challenges they face in delivering care. King & Kessel, *supra* note 74. In discussing the pervasiveness of workplace violence, Nurse Sharnette Johnson shared, “I had a guy try to kick me in my stomach while I was pregnant.” *Id.* Nurse Kimberly Wills O’Connell expressed her frustration with how nurses are expected to accept workplace violence as part of the job, saying: “[I]t’s like, ‘Well yeah, I got punched in the head tonight,’ and any other job would be like, ‘What are you talking about?!’” *Id.*

¹²³ Ulrich et al., *supra* note 116, at 73.

¹²⁴ *Id.*

¹²⁵ Brous, *supra* note 113, at 51 (“Such violence can convert nurses into patients—or worse, lead to their permanent disability or even death.”).

¹²⁶ FUTURE OF NURSING 2020–2030, *supra* note 54, at 314.

¹²⁷ *Id.*

¹²⁸ *Id.*

2. *Moral Distress and Ethical Challenges*

Nurses across all practice settings face ethical challenges that can result in moral suffering. Moral suffering refers to the anguish felt by nurses when facing moral dilemmas.¹²⁹ Moral distress is a kind of moral suffering that occurs when nurses are unable to provide the quality of care they believe the patient needs due to work-related impediments or other constraints.¹³⁰ Although the limited resources in health care make moral distress inherent to nursing, the consequences of chronic excessive workloads are a sustained moral suffering that can affect the nurse's health and well-being and may lead to burnout.¹³¹

Moral injury, on the other hand, is an extreme degree of moral suffering.¹³² It occurs “when there is a ‘betrayal of what’s right, by someone who holds legitimate authority . . . in a high stakes situation.’”¹³³ Moral injury is a trauma that has been described as “a deep soul wound that pierces a person’s identity, sense of morality, and relationship to society.”¹³⁴ Although much has been reported about the trauma facing nurses on the front line of the COVID-19 pandemic,¹³⁵

¹²⁹ *Id.* at 311.

¹³⁰ Kathleen A. DiGangi et al., *I’ve Got the Power: Nurses’ Moral Distress and Perception of Empowerment*, 30 AM. J. CRITICAL CARE 461, 464 (2021) (“Nurses experience moral distress when they feel disempowered or impeded in taking the ethically right course of action.”).

¹³¹ *Id.* at 462 (“Nearly one-half of all nurses leave their unit or the nursing profession entirely owing to moral distress.”); see also Marian Altman & Sarah Delgado, *Nurse Strong: Recognizing and Addressing Moral Distress*, AM. ASS’N CRITICAL-CARE NURSES, <https://www.aacn.org/docs/EventPlanning/WB0065/recognizing-and-addressing-moral-distress-presentation-1slide-py23dipv.pdf> (last visited Apr. 18, 2022) (discussing “inadequate staffing” as a cause of moral distress).

¹³² FUTURE OF NURSING 2020–2030, *supra* note 54, at 311.

¹³³ *Id.*

¹³⁴ Simon G. Talbot & Wendy Dean, *Physicians Aren’t ‘Burning Out.’ They’re Suffering From Moral Injury*, STAT (July 26, 2018), <https://www.statnews.com/2018/07/26/physicians-not-burning-out-they-are-suffering-moral-injury>.

¹³⁵ In February 2021, the New York Times published a short film called *Death, Through a Nurse’s Eyes*. The film was designed to allow viewers “to experience the brutality of the pandemic from the perspective of nurses inside a Covid-19 intensive care unit.” Alexander Stockton & Lucy King, *Death, Through a Nurse’s Eyes*, N.Y. TIMES: OPINION (Feb. 24, 2021), <https://www.nytimes.com/2021/02/24/opinion/covid-icu-nurses-arizona.html?action=click&module=RelatedLinks&pgtype=Article>.

it must be understood that moral suffering, including moral injury, was the norm well before 2020.¹³⁶

As explained in Section III.B.1.i. above, our profit-driven health-care system rewards organizational level decision-making that favors higher productivity at lower labor costs. Therefore, when a nurse's excessive workload prevents them from meeting a patient's basic need, it can feel like their employer is betraying what they know to be right. In an interview with the *New York Times*, Nurse Marlena Pellegrino, a nurse of thirty-five years, shared the following example of how an excessive workload caused her such significant moral suffering that it led her to question whether she should remain in the profession:

I could not get into [my patient's] room for over two hours. When I did get into the room, she had tears in her eyes, she was crying and holding onto me. And, when I looked in her bed, she was soiled in urine. I felt like I did a bad job. I felt less than the nurse that I know that I am, and I started to cry all the way home. Can I make another shift? Can I do this again tomorrow, get in my car and drive here and do this again?¹³⁷

The immense trauma of the COVID-19 experience has left scores of nurses looking to end their bedside career.¹³⁸ As Nurse Marci Keating, a nurse of twenty-four years, explains it: "I will never work in a hospital setting again. I will never subject myself to that sort of frustration, and I will never be part of what is being done to patients in the hospital that way."¹³⁹

¹³⁶ Lisa Bonsall, *Beyond Burnout—The Moral Injury of Health Care Today*, NURSINGCENTER BLOG (Dec. 11, 2020), <https://www.nursingcenter.com/ncblog/december-2020/moral-injury>.

¹³⁷ King & Kessel, *supra* note 74.

¹³⁸ See Guttormson et al., *supra* note 103, at 101 ("The overall experience of the COVID-19 pandemic led some nurses to question their decision to become a nurse . . . raising potential concerns about large numbers of nurses leaving critical care or the nursing profession.").

¹³⁹ See the statement of Marci Keating in King & Kessel, *supra* note 74.

IV. PUBLIC SAFETY MEASURES: EDUCATIONAL STANDARDS AND LICENSURE REQUIREMENTS

The regulatory framework surrounding nurse licensure is designed to protect the public.¹⁴⁰ State boards of nursing (“BON” or “Board”), which are authorized by the jurisdiction’s nurse practice act,¹⁴¹ safeguard the public’s health and welfare by ensuring that individuals are competent and fit for licensure.¹⁴² Because competence requires that individuals meet specific educational standards necessary to operate safely within the scope of their license, “approval of nurse education programs is an integral part of [the Board’s] mission of public protection.”¹⁴³

The Board evaluates the nursing program’s facilities and resources, administration and faculty, curriculum and clinical agreements, and policies and procedures before granting approval.¹⁴⁴ In most jurisdictions, the Board will also require nursing programs to obtain national accreditation.¹⁴⁵ The Board will continue regular monitoring of nursing education programs after approval and, in many cases, periodically conduct program-site visits.¹⁴⁶

In most jurisdictions, the Board is comprised of a specific mix of professional members with various types of practices and one or more members from the public.¹⁴⁷ The jurisdiction’s nurse practice act

¹⁴⁰ Sibyl Shalo, *Protecting the Public from Bad Nurses*, AM. J. NURSING., Mar. 2009, at 25, 26.

¹⁴¹ See *About U.S. Nursing Regulatory Bodies*, NCSBN, <https://www.ncsbn.org/about-nursing-regulatory-bodies.htm> (last visited Apr. 18, 2022).

¹⁴² See *Nursing Regulation*, NCSBN, <https://www.ncsbn.org/boards.htm> (last visited Jan. 25, 2022).

¹⁴³ Nancy Spector et al., *NCSBN Regulatory Guidelines and Evidence-Based Quality Indicators for Nursing Education Programs*, J. NURSING REGUL., July 2020, at S1, S3 (2020). Note, the board of nursing in New York does not regulate or monitor nursing education. *2020 Education Survey*, NCSBN: MEMBER BD. PROFILES 4 (Mar. 9, 2021, 3:40 PM), <https://www.ncsbn.org/2020EducationMBPResponsesfinalbookmarks.pdf>.

¹⁴⁴ Spector et al., *supra* note 143, at S6.

¹⁴⁵ *2020 Education Survey*, *supra* note 143, at 5.

¹⁴⁶ Spector et al., *supra* note 143, at S6 (“The monitoring process consists of overseeing NCLEX pass rates and may include other metrics such as student retention and/or graduation rates.”).

¹⁴⁷ For a specific breakdown of the compositions of the various BONs, see *2020 Board Structure Survey*, NCSBN: MEMBER BOARD PROFILES (Mar. 12, 2021, 12:56 PM),

vests in the Board the authority to conduct administrative reviews of complaints lodged against licensed nurses and, if necessary, impose discipline up to revocation of licensure.¹⁴⁸ The Board is also responsible for ensuring that licensed nurses meet continuing education requirements to maintain active licensure in the jurisdiction.¹⁴⁹

Because the nursing workforce encompasses providers of various license levels, pre-licensure education ranges from diploma programs through doctorate degrees.¹⁵⁰ Nursing programs are designed to prepare the individual to pass their intended licensing exam and, thereafter, be able to provide competent care within the scope of their license.¹⁵¹ Standards of nursing education have evolved to adapt to nursing's expanded role within health care over the last twenty years. These standards focus on preparing nurses to understand the complex physiological and psychosocial processes affecting the

<https://www.ncsbn.org/2020BoardStructureMBPResponsesfinal31221bookmarks.pdf>.

¹⁴⁸ Press Release, An Explanation of NCSBN's Authority and Discipline Regarding Licensed Nurses (June 29, 2020), <https://www.ncsbn.org/2020-AuthorityDisciplineStatement.pdf> ("Individual state BONs regulate and oversee nursing practice in the U.S. by enforcing the nursing laws of their state. BONs uphold their nurse practice acts and are charged with disciplining nurses who violate them.").

¹⁴⁹ For a comprehensive list of nursing continuing education requirements by state, see *State Nursing Requirements*, AAACEU.COM, https://www.aaaceus.com/state_nursing_requirements.asp (last visited Apr. 24, 2022).

¹⁵⁰ For a list of pathways in nursing education, see *Educating Nurses for the Future*, in *FUTURE OF NURSING 2020–2030*, *supra* note 54, at 192. Pathways in education leading to a registered nurse license are explained as follows:

The profession of registered nurse (RN) has three main entry routes: diploma programs, associate degree programs, and baccalaureate programs. All three routes prepare students to take the NCLEX-RN exam, the entry-level requirement to become an RN. In the 2018 National Sample Survey of Registered Nurses, roughly 49 percent of new RNs earned an associate degree, 40 percent earned a baccalaureate degree, and 11 percent earned a diploma. However, among practicing nurses, roughly 64 percent had earned at least a baccalaureate degree or higher A baccalaureate degree is required to pursue graduate education.

NACNEP NO. 17, *supra* note 66, at 10.

¹⁵¹ See *NCLEX & Other Exams*, NCSBN, <https://www.ncsbn.org/nclex.htm> (last visited Jan. 25, 2022).

health of specific patient populations.¹⁵² To ensure that nurses understand the boundaries of their scope of practice, educational standards also require that nurses learn the “legal rights and responsibilities” of their nursing license.¹⁵³ The objective of these legal lessons is to ensure that nurses understand the laws controlling their license and the myriad of laws designed to keep the public safe, such as mandatory reporting obligations and statutory duties of care.¹⁵⁴

V. PRIORITIZING NURSES’ WORKERS’ RIGHTS: A PUBLIC HEALTH AND SAFETY MEASURE

Federal law codifies the worker’s right to fair wages,¹⁵⁵ to safe and healthy working conditions,¹⁵⁶ to organize and collectively bargain,¹⁵⁷ and to be free of specific kinds of discrimination.¹⁵⁸ Workers’ rights laws in some states can provide even broader protections. These laws secure foundational protections for workers by obligating employers to provide workplaces that meet prescribed

¹⁵² See *supra* Section III.A.; see, e.g., Robert Wood Johnson Found., *supra* note 31, at 8 (“In 2005, RWJF’s desire to enhance quality and safety education at both the undergraduate and graduate levels led to the funding of a multiyear project to develop a nursing school curriculum on quality and safety and teaching nursing faculty to include these issues in nursing education, known as *Quality and Safety Education for Nurses (QSEN)*. The project has identified core quality and safety competencies and integrated them in curricula with the aim of preparing future nurses with the knowledge, skills, and attitudes needed to engage in improvement efforts.”).

¹⁵³ Alene Burke, *Legal Rights and Responsibilities: NCLEX-RN, REGISTERED NURSING.ORG* (Jan. 18, 2022), <https://www.registerednursing.org/nclex/legal-rights-responsibilities>.

¹⁵⁴ See *id.* (“Some of the most commonly occurring legal issues that impact on nursing and nursing practice are those relating to informed consent and refusing treatment as previously detailed, licensure, the safeguarding of clients’ personal possessions and valuables, malpractice, negligence, mandatory reporting relating to gunshot wounds, dog bites, abuse and unsafe practices, for example, informed consent, documentation, accepting an assignment, staff and client education relating to legal issues, and strict compliance with and adherence to all national, state, and local laws and regulations.”).

¹⁵⁵ Fair Labor Standards Act of 1938, Pub. L. No. 75-718, 52 Stat. 160 (codified as amended at 29 U.S.C. § 201 *et seq.*).

¹⁵⁶ Occupational Safety & Health Act of 1970, Pub. L. No. 91-596, 84 Stat. 1590 (codified as amended at 29 U.S.C. § 651 *et seq.*).

¹⁵⁷ National Labor Relations Act of 1935, Pub. L. No. 74-198, 49 Stat. 449 (codified as amended at 29 U.S.C. §§ 151–169).

¹⁵⁸ Civil Rights Act of 1964, Pub. L. No. 88-352, tit. VII, 78 Stat. 241 (codified as amended at 42 U.S.C. § 2000e-2).

standards. Because workers “forfeit a degree of control over their lives in exchange for the wages necessary to live,” these laws serve to empower workers in the “starkly unequal relationship” between workers and their employers.¹⁵⁹

Nurses enjoy many of the protections afforded by these laws as workers in this country. Because nurses deliver care in “high-demand and low-control work environments,”¹⁶⁰ these laws serve to balance the “starkly unequal relationship” with their employers.¹⁶¹ Balancing the relationship between nurses and their employers should be a matter of public concern given the inextricable link between the nurses’ working conditions and patient outcomes. Yet, nurses are not required to understand their rights under these laws despite the physically, mentally, and emotionally taxing working conditions pervasive in health care.¹⁶²

Nurses are never required to show competency in understanding their rights as workers before entering the workforce. As a result, the nursing workforce is woefully unprepared to deal with the adverse working conditions that are naturally borne from our profit-driven health-care system. The Board’s failure to require workers’ rights education in nursing is a grave regulatory oversight because the myriad of workers’ rights laws can empower nurses to advocate for better working conditions that, in turn, keep the public safe. Thus, to safeguard the public’s health and welfare, boards of nursing should require workers’ rights education as part of the pre-licensure curriculum and require a showing of continued workers’ rights competency through post-licensure continuing education.

¹⁵⁹ Kyle K. Moore, *Labor Rights & Civil Rights: One Intertwined Struggle for All Workers*, ECON. POL’Y INST.: WORKING ECON. BLOG (June 1, 2021, 12:57 PM), <https://www.epi.org/blog/labor-rights-and-civil-rights-one-intertwined-struggle-for-all-workers> (“Most American workers are employed ‘at will,’ meaning they can be fired by their employer at the employer’s discretion as long as the given reason does not violate federal law.”).

¹⁶⁰ FUTURE OF NURSING 2020–2030, *supra* note 54, at 305.

¹⁶¹ Moore, *supra* note 159 (“Most American workers are employed ‘at will,’ meaning they can be fired by their employer at the employer’s discretion as long as the given reason does not violate federal law.”).

¹⁶² To comply with statutory notice requirements, covered employers need only to post notices of these rights in the workplace. It has been my personal experience that employers post these notices in low-traffic areas of the hospital. For example, my last employer posted these signs in the basement of the hospital, which was not a designated patient-care area.

VI. CONCLUSION

Nurses are integral to the delivery of quality health care in this country. They set aside their own needs and fears to provide care and other social services to people across a multitude of settings, taking on the burdens and stresses of others. However, the burgeoning demand for complex health-care services has left the nursing workforce scrambling to meet those needs. For decades, experts have warned of a public health emergency posed by an existing nursing shortage caused by an aging population with increasingly complex health-care needs, coupled with a shortage of nursing education programs, and exacerbated by deeply ingrained retention issues.

The health-care industry has done little to mitigate the work-related stressors that are known to drive nurse turnover. Instead, as a cost-reducing measure, employers ask nurses to do more with less. Nurses are expected to endure the harsh working conditions pervasive in health care despite evidence showing that poor working conditions can lead to poor patient outcomes.

There are various worker protection laws designed to empower nurses, as workers in this country, to advocate for better working conditions. Yet, despite the inextricable link between poor working conditions and compromised patient safety, licensing bodies do not require nurses to understand their rights in the workplace. This has resulted in a nursing workforce that is woefully unprepared to deal with the adverse working conditions that are naturally borne from our profit-driven health-care system. Thus, as a public health and safety measure, workers' rights education should be required for nursing licensure.