Factors Influencing the Nurse Faculty Shortage: A Case Study

Therese M Mendez, University of New Orleans
Factors influencing the nursing faculty shortage: A case study

Therese Mendez, MEd, RN
Introduction

My interest in the experiences of nurse faculty can be traced back to my interest in nursing itself. As a young girl, I remember sitting for hours on the floor of a crowded public hospital’s emergency department watching people rush in and out. Some were screaming, some were crying and others were struck silent with shock, fear or pain. There were others in that emergency department who moved confidently from person to person looking, listening, making decisions, providing care, providing calm and providing compassion. They were the nurses. These women (almost all nurses were women in the late 1960s) had something that I wanted to have. They knew exactly what to do in even the most chaotic situations. They moved confidently and with concern. They calmed the fear. They eased the pain. They made a difference. They were everything I wanted to be. When I was looking to the future and trying to decide what work I should do with my life there was no question what road I would take. I wanted to be a nurse. I wanted to care for patients.

Caring for patients in a hospital is a complicated endeavor requiring coordination between a multitude of complex departments, treatments and outcome assessments. From the pre-admission process to discharge from the hospital, the nurse is responsible for the patient’s care and safety (Louisiana State Board of Nursing, 2004). Hospitalized patients need nursing care. Without adequate nursing oversight and care, the patient is at risk for a variety of adverse outcomes such as medication errors, patient falls, skin breakdown, patient and family complaints, infections and death (Blegen, Goode, & Reed, 1998; Lichtig, Knauf, & Milholland, 1999; Needleman, Buerhaus, Mattke, Steward, & Zelevinsky, 2002). The rate of these adverse outcomes has repeatedly been shown to be inversely related to the number of hours of care
delivered by nurses (e.g., Aiken, Clarke, Sloane, Sochalski & Silber, 2002; Blegen, et al., 1998; Mitchell, & Shortell, 1997; Needleman, et al., 2002). The evidence shows that the patient’s best interests are served by having an adequate number of nurses in the hospital.

The Nursing Shortage

Having an adequate number of nurses at the hospitalized patient’s bedside may no longer be guaranteed in today’s healthcare environment. In 2002, the United States Department of Labor estimated that approximately 150,000 Registered Nurse (RN) positions remained unfilled. This shortage is anticipated to reach a crisis level by 2020 (US Bureau of Labor Statistics, 2008). The United States Department of Health and Human Services, Health Resources and Services Administration (2004) forecasts a 36% shortfall of RNs by 2020. This 36% shortfall translates to over one million RN positions that may remain unfilled.

The current and anticipated nursing shortage is a multi-factorial phenomenon with demographic, economic and social components (White, 2001). The population of the United States is aging. People, in general, are living longer related to improved nutrition, sanitation and medical care (Bunker, Frazier, & Mosteller, 1994). At the same time, the 76 million people born in the United States between the years of 1946 and 1964 (the “Baby Boom”) are currently in their 50s and 60s. These two factors will double the population of retirement age Americans during the next 25 years (CDC, 2007).

As life expectancies have lengthened, the major causes of death have shifted from acute illnesses and infections to chronic and degenerative illnesses (Stroebe, 2000). The CDC (2007) estimates that approximately 80% of older Americans are living with at least one chronic condition. The need for nurses to care for an aging population, living longer with chronic
medical conditions, is not a temporary issue (Slatterly, 2004), but one that will grow with the numbers of Americans reaching the ages of 60, 70, 80 and beyond.

The nursing workforce is aging along with the rest of the population (Kimball & O'Neil, 2001). By 2012, projections indicate that RNs in their 50s will be the largest age group in the nurse workforce (Buerhaus, 2008). The good news is that expert older nurses possess a wealth of experience and critical thinking skills that serve their patients well (Robert Wood Johnson Foundation, 2006). The bad news is that soon, these experienced nurses will be leaving the workforce taking their knowledge with them. Who will replace them?

New nurses come from nursing schools. Nursing school admissions are down. Factors contributing to the decline in nursing school admission include expanded career options for women and poor incentive structures relative to the legal and professional responsibilities related to nursing (Buchan & Aiken, 2008). Nursing stereotype (e.g., glorified maids or orderlies, subservient to physicians) and the traditionally female professional images are the top challenges to men who may consider nursing as a career (American Assembly for Men in Nursing, 2005).

Although fewer people are choosing nursing as a career, nursing schools continue to have a steady although somewhat diminished number of applicants. Unfortunately, even in the midst of a nursing shortage, thousands of qualified nursing school applicants are being turned away. The reasons for denying admission to nursing programs include shortages of clinical education sites, shortages of classroom space and nurse faculty shortages. There is not enough nursing faculty to support the number of qualified nursing school applicants and these applicants are turned away.
Almost 50,000 qualified applicants to nursing programs in the United States, including almost 7,000 master’s and doctoral degree program applicants, were turned away in 2008 (American Association of Colleges of Nursing, 2009). In a 2008 survey done by the American Association of Colleges of Nursing (AACN), 80% of reporting nursing schools indicated that they needed additional faculty. Without nursing faculty, we will not be able to expand the supply of RNs. If we are not able to expand the supply of RNs, the dire predictions of future nurse shortages will become reality. Educated and competent nurses come from nursing schools. Nursing schools need faculty members to teach their students to become nurses. Without adequate nursing faculty, patients will not have the nurses that they need to care for them. Thus, a direct line can be drawn from nursing faculty practice to the patient’s bedside. The need for nurse faculty is clear. My interest in nursing faculty experience is related to my ongoing concern for and experience with the shortage of nurses in today’s healthcare environment.

The Study Participant

The study participant, MK, began her nursing career as a diploma school graduate. She then earned her bachelor’s degree in nursing (BSN) and her master’s degree in public health nursing (MSN) while working full time. She has invested many years in her education. Her clinical expertise ranges from Medical-Surgical nursing, Emergency Department nursing, Intravenous Therapy nursing through Surgical/Trauma Intensive Care (SICU) nursing. She has held positions as a staff nurse, as a charge nurse and in nursing management. Her interest in teaching nursing was her reason for going to graduate school, “…after that I became interested in going back to get the master’s because I wanted to get into teaching nursing.” She has been
interested in teaching and mentoring new nurses throughout her years in the clinical environment.

After explaining my interest in the nursing shortage and nursing faculty shortage, MK agreed to participate in the interview. I met her at her home and recorded her responses to my questions. After transcribing the interview, I removed some information that identified people and events to protect confidential information. I sent a copy of the redacted transcript to MK asking her if the transcript represented her responses and if she would like to add or remove anything from the transcript before any more work was done using the data. She responded that the “Transcripts are right on the money.” (Personal communication, April 7, 2009). She did not have anything to add and did not request that I remove anything more from the transcript. I attempted to analyze the transcript from an outsider’s point of view but found myself shifting from outsider to insider as I read and re-read the transcript. As a nurse, my guiding principal is to question what is best for the patient. The challenges faced by nurse faculty can complicate their attempts to do what is in the best interest of their students and, ultimately, the best interests of the patients they serve.

Nurse Faculty Shortage

The nurse faculty shortage is following the same trajectory as the clinical nurse shortage. Current faculty members are moving closer to retirement. Extensive clinical experience is essential for nursing faculty and this experience takes time. Historically, nurse educators enter the academic setting after years of clinical practice. In 2003, the AACN reported that only 1% of nurse educators were less than 35 years old. The National League of Nursing (NLN, 2005) estimates that approximately 66% of nurse educators plan to retire within
the next 15 years. As with the dwindling nurse workforce, the nurse faculty shortage is compounded by a decreasing number of younger replacement faculty (AACN, 2005).

The drain on nurse faculty is not restricted to aging and approaching retirement. The standard of doctoral preparation for nursing faculty poses a recruitment hurdle for nursing programs. In 2001, only half of full time nurse faculty in schools with baccalaureate and graduate programs held doctoral degrees (Berlin & Sechrist, 2002). Clearly, there are not enough doctorally prepared nurses willing to join the ranks of nurse faculty to meet the demand in the academic environment. There is a great deal of competition for these advanced degree nurses.

The nurse who holds an advanced degree has many employment choices in clinical and other business environments. Many of these nurses do not choose a career in education. There are less stressful, higher paying positions available (Garbee, 2006). A noncompetitive salary structure was cited as one of the most critical issues faced by schools of nursing in their inability to recruit new faculty members and retain current nurse educators (AACN, 2008). Financially, the academic setting is unable to compete for these nurses. The AACN reported (2003) that a master’s prepared nurse in the academic setting had an average annual income of approximately $55,000.00. In contrast, master’s prepared nurses in the private sector working as managers and directors reported an average annual income between $70,000.00 to over $90,000.00. This disparity in financial compensation is a strong pull for qualified nursing professionals to choose positions in the clinical environment over the academic setting, further limiting the pool of potential nurse faculty (Halcomb, Gregg & Roberts, 2007).
Nurses who choose to teach also choose to accept a lower salary than they can earn in the non-academic setting. MK accepted a lower salary but thought that the loss would be offset by the per hour amount:

I took a cut of probably $17,000.00. And I thought it would even itself out because I figured with teaching nursing and managing the students during clinical that per hour it would be more money or about the same. But it ended up that I was putting in more hours teaching nursing than I was in the previous job that I had before.

Preparing lessons, teaching, academic advising, guiding students through the clinical experience while taking responsibility for very ill patients, writing and grading tests can add up to 60 to 80 hour work weeks while earning a noncompetitive salary (Evans, 2005). Who would choose to become nursing faculty?

Expert nurses who enjoy teaching patients, families and other nurses are drawn to the academic setting (Ziehm & Fontaine, 2009). Nurses in clinical practice are acutely aware of the current nursing shortage (e.g., Aiken, et. al, 2002; Buerhaus, Donelan, Ulrich, Norman, DesRoches & Dittus, 2007; Lynn & Redman, 2007) and nurse faculty members are part of nursing’s future. They provide the foundation of patient care now and for the years to come. There is no better place to improve the projected nursing shortage picture than among the ranks of nursing faculty. These motivated nurses deserve support and mentorship to ease their transition from practicing clinicians to nurse faculty.
Mentorship is crucial to successful transition to the nurse faculty role. Unfortunately, the mentoring process for new nurse faculty is frequently informal and random (Ziehm & Fontaine, 2009). All faculty members are new at some point in their careers. Success in the faculty role is greatly facilitated by positive mentorship (Dunham-Taylor, Lynn, Moore, McDaniel & Walker, 2008). Schools experiencing a faculty shortage are at greatest risk for an inadequate mentorship process because they do not have enough faculty mentors to go around. Unfortunately, this shortage of mentors can lead to loss of new faculty which perpetuates the shortage at the school (Dunham-Taylor, Lynn, Moore, McDaniel & Walker, 2008). Nurse faculty members are drawn from the rank of expert clinical nurses and have many opportunities for other employment. With the shortage of nurse faculty members and the availability of employment in the private sector, every effort should be made to provide supportive mentorship to these expert nurses who are willing to become nursing faculty.

The question in MK’s case is with so many new faculty members (15) joining the program at the same time, who would be available to mentor all of these people? Experienced faculty members, no doubt, were busy with all of the duties and tasks related to starting a new semester. These may have been duties and tasks that new faculty could not be expected to manage during their first weeks at the school. If the school is unable to invest the time and resources in mentoring, they may lose the new faculty member, which only contributes to an ongoing shortage. The faculty handbook1 at MK’s school states that the course coordinator is responsible for mentoring “all new clinical faculty.” At the time MK joined the faculty, the

---

1 I will be referencing the handbook from the participant’s place of employment but will not name the university to protect the confidentiality of the participant.
course coordinator had only one year of experience at the school. “You had the course coordinator who was unsure of what her responsibilities were and so it got...it was really difficult during that period.” MK felt uncomfortable in her role as a nurse educator related to lack of education experience and lack of mentorship. This situation left her feeling that she was just “out there.”

Most of it was due to the lack of experience and no mentorship because you were just out there and you were with other people who were just out there. It was me, and the other person who was sort of with me and the coordinator who had one year of experience.

No nurse, whether caring for patients or educating new nurses, should feel he or she is “just out there” without support. Ultimately, the patient may be at risk when the nurse or nurse educator does not have the needed support to provide safe care.

In the clinical arena, the hospital staff nurse cares for patients and does not have the added responsibilities of student management and education. Nurse faculty members in the clinical arena carry the dual responsibilities of caring for patients and instructing students at the same time. This added responsibility for patient care is not an expectation of non-health care faculty (Halcomb, Gregg & Roberts, 2007) and adjusting to this dual responsibility can be eased with mentoring and support from experienced faculty. If a nursing instructor takes six students into the clinical arena and each student is caring for only one patient, the instructor has responsibility for care of the six patients and the six students all of whom are working under the instructor’s nursing license. MK was teaching in an intensive care unit where the nurse to
patient ratio rarely is more than two patients per nurse. MK was responsible for six intensive care patients and the six students.

Adequate nurse to patient ratios have consistently shown to have an effect on safe patient care (e.g., Aiken, et. al, 2002; Blegen, Goode & Reed, 1998; Needleman, et. al, 2002; Yang, 2003). This evidence has led California to mandate the number of patients one nurse can safely manage. California was the first state to mandate staffing ratios and other states have plans to follow California’s lead (Coffman, Seago, & Spetz, 2002). Federal legislation was reintroduced in January 2009 by Senator Daniel Inoye (D. HI) to mandate safe nurse to patient staffing ratios (Registered Nurse Safe Staffing Act of 2009, S-54). As a staff nurse, MK did not have to care for so many patients,

And you have six students with your six patients. You were responsible for the students and you are also responsible for the patients. Whereas when I was in the ICU, I had two patients. And no students. The only time I had more than two patients is if I watched somebody’s patients while they went to lunch for a half an hour. It was a completely different ballgame. You don’t see that when you are in nursing school. When I was in nursing school they kind of had the same role, but when I was in nursing school I didn’t see it like that. You don’t see it like that until you are really into it and then it starts getting more stressful and you get no support from anyone.

MK’s colleagues were busy with their own clinical and classroom responsibilities and were not available for support during her clinical experience. Grouping two new faculty members together in the clinical arena would help with this source of job stress (Halcomb, et.
al, 2007). However, a school already short of faculty would find it difficult to pair instructors in the classroom or clinical areas.

**Academic Advising**

Nursing faculty member responsibility is not limited to preparing coursework, lecturing, grading assignments and taking students into the clinical environment to care for patients. They are also responsible for academically advising students, many of whom they may be meeting for the first time with a nurse faculty advisor. Academic advising is much more than merely assisting students to choose a major. Students in a nursing program have obviously chosen their major course of study. For these students, academic advising should provide support and guidance to students as they work towards meeting their learning and development goals (Pizzolato, 2008).

This support and guidance should be built on a caring relationship between the student and the advisor (Schultz, 1998). It takes time learn about the student and to identify their strengths, the experiences they bring to the classroom and their needs. It is very difficult to evaluate the experiences that the student brings to the learning environment without some prior knowledge of the student and of academic advising. The National League for Nursing’s (NLN) core competencies for nurse educators include effective advisement and counseling strategies that can help learners meet their professional goals (NLN, 2005). Academic advising is not a common study component of most clinically focused graduate nursing programs.

Clinical expertise is critical for nurse faculty, but academic advising is an important component of the faculty role as well. In a study by Boylston and Jackson (2008), adult RN students reported that academic advising and instructional effectiveness were the two highest items of importance in their satisfaction with their school experience. With the support of an
effective academic advisor, the RN students were more likely to graduate (Boylston & Jackson, 2008; Thurber, Hollingsworth, Brown & Whitaker, 1989) and join the ranks of practicing nurses. Faculty who come to the institution without advising experience should be provided with training and support to develop their advising skills.

The nursing school may want to provide advising training and support for their new faculty members and be unable to do so related to lack of experienced faculty advisors or scheduling conflicts. Experienced faculty may be struggling with heavy workloads and unable to pull time away from their own students. This appears to have been the case for MK, “But, you have to take into consideration most of the people who were there had their own classes that they had to teach and they had their own students.” Understanding the workload of other faculty members did not relive the discomfort of advising students without knowledge of the student, the student experience and even the curriculum. The school held an advising meeting but MK was teaching students in the hospital during the session and was unable to attend. MK described her experience with student advising as,

I had my 12 students, these were sophomore students, and I was supposed to be advising them in the next two weeks...pre-advising them for the next semester. It was a little difficult because you were not familiar with the forms. I did not even have the curriculum so I didn’t even know what their curriculum was. What were they supposed to be taking? That was pretty interesting.

When I asked, you know, how can a new faculty member advise students when they are not even familiar with the curriculum? Oh, they said, ‘We will have to get you a copy of the curriculum.” So...we advised the students and hoped we were right with what we
advised. I wasn’t the only one because the other 14 or 15 new faculty people that we had also had to advise the students and nobody had a clue.

MK’s sense of insecurity in the advising role is clear. Insecurity adds stress that can ultimately influence job satisfaction and result in leaving the faculty position (Dunham-Taylor, et. al, 2008). In this situation, the school attempted to provide faculty support for the advising role but was unsuccessful because of teaching schedule conflicts.

Students

A major theme in MK’s interview was her concern for the students. Although she hoped that she had given the student correct information and advice, she was not confident in her ability to effectively advise her group of students. She was also concerned about the quality of education the students were receiving from such a large group of new faculty members who did not have prior education experience. MK was surprised to find that her group had four months in which to write a curriculum, “…we were told that we had to write the curriculum. And I thought that this was kind of messed up too because how am I supposed to write a curriculum when I have no idea how to do it?” She asked for help, “I said, well… can you get somebody…you have to have somebody within the whole nursing school that has some type of education in curriculum development that can give us some pointers and walk us through the steps.” The school promised help with writing the curriculum the next fall. MK was not there when the next fall arrived.

Events out of the ordinary that occur in the patient care area highlights the importance of mentorship for the faculty member and the student involved in the event. Such an event occurred one afternoon while MK was in the clinical area. After the occurrence, the student
thought to be involved in the event was asking if she would be separated from the program and MK could not answer her. MK was unable to locate policy to guide her in the steps to take after an event during clinical. She was concerned about the other students as her attention was taken away from them and their patients as she dealt with the incident.

MK felt that training in classroom and student management would have helped her provide the type of quality educational experience the students needed to develop into competent patient care providers. She did not feel that being an expert clinician alone was enough to give the students what they needed, “if you are a nurse you are not a nurse educator. You can be a nurse and be a nurse educator if you have the background and you have the education and you have somebody mentoring you along the way.”

Strategies to Retain Nurse Faculty

Strategies for recruiting and retaining nurse faculty range from the practical proposal of increasing salaries (AACN, 2008) to a more elusive suggestion to overcome apathy caused by shortages in nursing and nursing education (Proto & Dzurec, 2009). Between these practical and elusive strategies lie the experiences of nurse faculty members working to teach their students how to care for patients in today’s demanding healthcare environment. If we are unable to improve the nurse educator’s work environment, it may become more difficult to recruit and retain current and future faculty.

Ziehm & Fontaine (2009) advise new nurse faculty members to “insist on a through and ongoing orientation” (p. 75). The authors state that reading an orientation manual is not sufficient and suggest that orientation should take no less than six months (Ziehm & Fontaine, 2009). This is excellent advice but I question how an organization experiencing a shortage of
faculty members would be able to spend six months on orienting a new faculty member. In MK’s case, the school’s faculty handbook clearly states that the orientation program for faculty typically lasts one day. When MK joined the nursing faculty, she was one of 15 new nursing instructors. Only one of the 15 had any previous teaching experience. MK herself had graduated from her master’s program in public health nursing only three days prior to reporting to work as a new faculty member. One day does not seem to be enough time for adequate orientation to a brand new role.

MK was not comfortable with the orientation she received. She spent the first week at school not knowing what she was going to teach and,

...doing just about nothing except trying to figure out where do you get a computer from...how do you figure your time? Do you even punch in, punch out? So, we sat around for about a week and I thought, you know, there is no organization here. Because there was no type of orientation.

The question of what MK was going to be teaching appears to have caused her some concern. She has extensive clinical experience in ICU nursing. ICU nurses are highly skilled clinicians and they are qualified to teach basic patient care principles. However, the nursing and organizational skills required to take care of two critically ill patients are completely different from the nursing and organizational skills required to take care of eight less acute patients. Nursing is a complex practice that cannot be standardized across patient populations except with the most basic care principles. Expertise in adult surgical nursing has little in common with expertise in neonatal intensive care nursing. Nurses are rarely interchangeable between specialties.
Another suggestion to relieve nurse faculty workload is to outsource academic advising to trained individuals other than the professional RN faculty (Holcomb, et. al, 2007). Advising students does not require an advanced degree in nursing and outsourcing to a group in Student Affairs, for example, would help relieve some of the workload on the nurse faculty members (Holcomb, et. al, 2007). When asked what she thought of this suggestion, MK said,

That would have helped because I did not go to that nursing school and I wasn’t familiar with their curriculum. I wasn’t familiar with what course was needed and if a course would transfer from another school. Just like if I look at the list and match up anatomy 101, someone else can read and see, oh look, anatomy 101. That doesn’t take an RN. So you could actually give it to someone else, perhaps someone who has a counseling background.

She agreed that outsourcing some of the academic advising would help with faculty workload but did not believe that this was likely to happen. Outsourcing advising to another department sounds like a simple intervention, however current job descriptions would have to be changed or new ones would have to be created and approved. Training needs to be provided and competency assessments are required. No one should be expected to advise students without proper training, not even the nurse faculty members.

Other suggestions to relieve the nurse faculty workload involve job sharing and bringing in visiting faculty from other schools (Allen, 2008; Halcomb, et. al, 2007). These are good suggestions and would be likely to improve the nurse faculty work environment. Unfortunately, one of the problems in the work environment is the shortage of faculty members. Where would these extra nurse educators come from? MK agreed that these
suggestions were good but felt they were not practical in the current environment. When asked about job sharing, she said, “I don't know how that would work because if two faculty members are sharing the job, then who...ah...you still have the same number of students and who is going to take over the rest of the students?” That is a good question. In response to the idea of visiting faculty from other schools, she said,

Well...that is not going to work because all of the nursing schools are short of faculty members. I cannot see another nursing school loaning out their experienced faculty members to another nursing school and then that creates a shortage at their nursing school. And, who is going to pay that faculty member's salary and benefits and living expenses? Who is going to take care of the students that they are not taking care of at their own school? : It's a good idea but when you have faculty...ah...a shortage of faculty members, it is not going to work.

Even the idea of using retired faculty members seems to be somewhat unrealistic. As MK asked, who pays the salary, benefits and living expenses? In today’s economic environment, with university budgets tight and getting tighter as further budget cuts are being made (Pope, 2009), paying for visiting faculty is unlikely.

Limitations

The major limitation of this study is that I have only one participant. It was interesting to note that the participant, MK, met the demographic profile of current nurse faculty and also experienced many of the same problems with mentorship, workload and financial compensation that are discussed in the literature. In light of this, one thing that I would do
differently would be to interview other nurse faculty members from other schools to see what similarities or differences there are in their experiences. Another limitation of this study is that I am a nurse myself and closely identify with the nursing shortage and the difficulty in recruiting and retaining nurse faculty. Without nurse faculty to educate new nurses, the nursing shortage will reach crisis levels in just a few years.

Conclusion

The nursing shortage is growing and the nurse faculty shortage is growing. The causes and effects of the shortage of nurses and nurse faculty have been debated for many years (e.g., Allen, 2008; Buchan & Aiken, 2008; Fagin 1980; Gordon, 1997; Olds & Herr, 1947). The social and demographic pressure driving these shortages will not be reversed in the near future (Buerhaus, 2008). The problems are easy to identify. The solutions are more elusive.
References


American Association of Colleges of Nursing. (2003). *Faculty shortages in baccalaureate and graduate nursing programs. Scope of the problem and strategies for expanding the supply.* Retrieved March 12, 2009 from [http://www.aacn.nche.edu/Publications/WhitePapers/FacultyShortages.htm](http://www.aacn.nche.edu/Publications/WhitePapers/FacultyShortages.htm)


American Association of Colleges of Nursing. (2009). Despite surge of interest in nursing careers, new AACN data confirm that too few nurses are entering the healthcare workforce. Retrieved April 15, 2009 from


