United in Care

BY HEATHER BOERNER

How much of the so-called **generation gap in nursing** is based on truth, and how much on a fiction perpetuated by management to split up nurses? The answer is complicated, but one thing is clear: Nurses of all ages have more in common than not.

WE ALL DO IT. Complain about or stereotype fellow nurses younger or older than ourselves because of their age. Part of it is natural. In every workplace and any profession, there are bound to be some generational differences among employees. And in registered nursing, which has seen a resurgence of interest among young workers as well as more experienced RNs delaying retirement, there may be as many as four generations of nurses working alongside one another. That fact, coupled with the frantic pace of medical and technological advancement, can sometimes make the so-called generation gap among nurses seem like the Grand Canyon.

But how much of the thinking that there are inherent differences in nursing due to an RN's age is based on fact and how much on myth? How much of it is constructed and encouraged by management as a way to prevent solidarity and create wedge issues between groups of nurses to keep us arguing amongst ourselves? How many of these differences are exacerbated by workplace stresses and issues that would not pose a problem (or less of one) if staffing were adequate or technologies actually complemented instead of supplanted nursing care? How much of our infighting is over insufficient resources in a healthcare system that does not value nursing care and prioritizes profits over patients?

We would argue that, while it's instructive to note differences, it's more constructive for nurses to find common ground and work toward shared goals. All RNs want to be able to give the best, safest care to their patients, to help people heal or stay healthy and comfort them at a scary and vulnerable time in their lives. Any assumptions or prejudices we may carry about our colleagues based on their age are exactly that, assumptions and prejudices. Yes, sometimes they can be accurate, but often they are not. Or in reality, their situation and the circumstances or reasons behind it are more complicated than you realize. You may be surprised by where a fellow RN, younger or older, stands on an issue after a thoughtful conversation with her or him.

In the pages that follow, we tackle some of the most common myths about the generation gap and examine what holds up and what doesn't, as well as try to give examples of nurses who have worked together to overcome their differences. As Cathy Kennedy has seen from her years of running a nurse mentorship program for the California Nurses Foundation, having the opportunity for new and experienced nurses to meet and talk out their own biases benefits everyone.

"What we see in this program is that there are good and bad things about being on both sides of the generation gap," said Kennedy, a neonatal ICU RN in Sacramento and project director of the nurses foundation. "We talk to nurses old and young all the time, and all of us are trying to find some similarities and how we can learn from each other. A really experienced nurse will help a less experienced nurse learn what to look for in her patients, and younger nurses who are more tech savvy can help get us up to speed on those things!"

RN Cathy Kennedy (left) of the California Nurses Foundation runs programs to teach senior nurses how to mentor new and returning nurses.

Older nurses are resistant to change. Younger nurses are too eager to go along with management.

YOUNGER GENERATIONS ALWAYS THINK that their elders are reluctant to change, that they just want everything to stay the same and stay in their comfort zone. Sometimes that's true on an individual basis, but we can't think of any field that moves and changes faster than nursing and healthcare. When you stop to consider all the advances in medicine, equipment, and technology that have come to pass over the last 30 years, you'd have to agree that RNs who have decided to and managed to stay at the bedside during this time are an adaptive and quick-learning sort.

What senior nurses do resist, however, are new, "flavor-of-the-month" hospital initiatives that neither improve patient care nor address the real issue of hiring enough RNs to maintain safe staffing levels and good working conditions. Rather, these initiatives are intended to save the hospital money by restructuring nursing so that fewer nurses are needed, usually by making existing staff work faster and harder or by having nurses supervise lesser-trained and lower-paid personnel. More and more studies are finding that better staffing levels go hand in hand with higher RN satisfaction levels, fewer medical errors, and generally better care.

Veteran nurses know this, so they are rightfully skeptical of any change that does not address the core issue of safe staffing. It's easier for hospital management to portray their opposition as a "young versus old" or "new guard, old guard" dynamic instead of spending the money to improve staffing. By doing so, management is also able to distract nurses from uniting to focus on solving the real problem of inadequate staffing. "It's a ploy to tear us apart, and we have never benefited as a group from being divided," said Jean Ross, a Minnesota RN and a co-president of National Nurses United. "Nurses of all ages want the same thing, which is to have enough dedicated RNs and other staff to do the work the way we know it should be done. That's all we've ever wanted."

On the flip side, if newer nurses don't speak up automatically whenever management issues a misguided patient care policy or tries to violate the contract, they can't be all to blame. It's natural for people who are not only young but also new to a profession to be more hesitant to challenge authority figures. Nurses who have been around the block a few times must therefore take the time to help newer nurses find their voice and build their confidence as patient advocates. This is where experienced nurses and particularly nurse activists can step in and help RNs understand how to work within the union to solve problems and make improvements, to stand up for themselves, their patients, and their coworkers. Elizabeth Pataki, a retired Sacramento RN and former CNA/NNU board member, remembers pulling new grads aside and teaching them how to file assignment despite objection reports (ADOs) against the hospital when they were overworked,

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and encouraging them to push back when management wanted them to do charting after their shifts but without overtime.

"They're overwhelmed and intimidated," she said. "They can't have overtime, they're told to chart later, after their shift, and we as experienced RNs have to be there and teach them that it's OK to say, 'No, not on our time.' We have to teach them that if they accept a patient when they're already overworked, they're putting the hospital and their license at risk. Someone needs to be there to tell them to do an ADO, and who knows how to do it. That changes the dynamic on the floor. There's more floor togetherness."

Older nurses are afraid of technology, and younger nurses are too dependent on it.

ALL OF US UNDERSTAND that electronic medical records and certain new technologies in healthcare settings are not going away. But that doesn't mean that registered nurses should blindly accept any new technologies that hospitals introduce without pushing back on those that may hurt their nursing practice, particularly those that try to supersede their professional nursing judgment or dumb down their nursing skills. All nurses, young or old or in between, must think critically about the proper and improper uses of technologies in their work settings.

Older nurses are not necessarily stumped by new technologies. Technology has become so pervasive in our society (just look at how many people of all ages own smartphones) that it's hard to find someone who does not have a basic proficiency with computers. Consider that a nurse who is 50 years old now would only have been 27 years old in 1990, and personal computers have been around a lot longer than that. And people have varied interests; some are just drawn more naturally to technology. Some nurses in their 50s who have actively kept up on technology, done reading, or taken classes may know more about it than a 20-something who has no inherent interest in it and whose technology use is primarily limited to her phone.

That said, younger nurses do tend to be more familiar with and faster on the computer than their older colleagues, said nurses we interviewed. They may know more keyboard shortcuts, know how to toggle between windows, or jump around a screen more quickly using the tab key than nurses who rely on the mouse to navigate. They may have more experience with the user interface of various software programs simply because they were exposed to and required to use those programs in high school and college.

But nurses of all ages report that hospitals' electronic charting systems can be inadequate and infuriating to navigate, simply because these programs were not designed by RNs with RNs as end users in mind. Who wants to have to click through three different windows, hunt down the third tab, and scroll down 25 items in a drop-down menu just to indicate a particular lab result? That's right, nobody.

Senior nurses may just be (rightfully) more resistant to these technologies because they have experience with or remember a simpler or more effective way of doing things. (Raise your hand if you have used and love paper flow sheets!) They understand exactly how the introduction of these technologies has changed nursing for better and for worse because they have something to compare it to.

And, as natural disasters like Hurricane Sandy or Hurricane Katrina have shown us, some nurses point out that there may be times when there is no technology, let alone electricity available, and the only thing standing between a patient and a bad outcome is the nurse's own assessment skills and experience.

"Among all those computers and machines, there's a person," Linda Condon, a 30-year ER nurse at Morton Hospital in Massachusetts, remembered telling a new grad. "I don't care if the heart monitor looks good. I can tell you that something really bad is going to happen by looking at that patient. That patient tells me so much more than the machine on the wall." As Condon says, technology will come and go, but the focus on the patient is essential.

Older nurses are mean and burned out.

TOM ATKINS, A 56-YEAR-OLD NICU RN at Alta Bates Summit Medical Center in Berkeley, has worked part time for years. Through the grapevine, he has heard that younger RNs don't understand why he won't take a full-time position, and that the hospital is implying to them that nurses like him are not totally dedicated to nursing. They don't want to work hard, is the argument. The reality is just a little different. Atkins suffers from back injuries and pain incurred over his decades of nursing, and he knows his body cannot handle nursing full time. "It's easy for a new nurse to say, 'I'm willing to work all the time,'" said Atkins. "I was that way, too. But it's hard to hear. I just feel like, 'How can you know what it's like to be a nurse all these years and the toll it can take on you, emotionally, psychologically, and physically, if you're right out of school?"

Normally, whether someone works full or part time wouldn't be an issue, but the RNs at Atkins' facility are in protracted contract negotiations and management is demanding to eliminate part-timers as well as their benefits. If the younger nurses bought into the hospital's negative stereotype of older part-time nurses, they would not be as likely to support Atkins—which is exactly what the hospital wants, since doing so would save money by cutting more experienced part-timers like him.

Most often, however, inadequate RN staffing is the number one reason nurses of all ages may be short with coworkers, act in an unfriendly or unapproachable manner, or not take the time to help someone less experienced. When you are stretched too thin caring for too many patients whose lives are in your hands, you would understandably treat anything extraneous to your patient assignment as an obstacle just to survive your shift.

"Safe staffing ratios are the answer, but the industry deliberately short staffs, squeezes the remaining staff by imposing unconscionable workloads and makes increased productivity demands," said DeAnn McEwen, a veteran ICU RN at Long Beach Memorial Medical Center in Southern California as a co-president of CNA/NNOC as well as vice

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president of NNU. "What happens is that the employer tries to turn one set of nurses against the other, instead of the two sides joining together and confronting the bullies."

And short staffing makes it nearly impossible to slow down enough for more experienced nurses to really mentor new RNs into the field. Hospitals used to, as a matter of course, allow at least three months' time for veteran RNs to precept new grads as a transition into nursing. But that practice has either been eliminated or drastically shortened to just a couple of weeks or even less. It also used to be that new nurses would not have full patient loads during their preceptorships, and hospitals would compensate experienced RNs for their extra teaching duties. Those practices have also become rare.

"The nurse who is not nice to the new nurse is stressed out," said Condon. "Patient care loads are high. [Here in Massachusetts,] we don't have ratios. And then you add in a new nurse you're supposed to precept or mentor. This doubles your patient load, because now you're responsible not only for your overload of six or seven patients, but you're trying to keep an eye on the six or seven patients the young nurse has. It sends your stress level beyond. That's when they snap at the young ones."

Jacqueline Schubert, an RN at her first job in Florida, said that she's worked hard to gain the trust of the experienced RNs on her floor, and tries to remember that when RNs are brusque with her, it's usually the job, not her, that's caused the tension.

"You run into a few personalities who are tired and overworked," she said. "The two things that have kept me sane through my first year are honesty, and never ever taking things personally."

When nurses work with proper levels of staffing, studies show that they have higher satisfaction job rates. In other words, safe staffing levels equal happy nurses. So nurses working together to ensure adequate staffing, whether through passing ratios laws or bargaining to secure safe RN-to-patient ratios in our contracts, would go a long ways towards making the workplace more pleasant for everyone.

In contract negotiations, older nurses only care about retirement benefits. Younger nurses only care about wages.

PERHAPS NOWHERE MORE than in contract negotiations does management attempt to pit the interests of older nurses against younger nurses in an effort to destroy unity. This can take many forms, from trying to establish two-tier wage and benefit systems for existing nurses and new hires, to employer claims that, with limited resources, it can better fund retirement or bring up wages for newer nurses, but not both.

Older nurses closer to retirement are understandably more concerned with things like pensions and retiree health insurance because they will be relying on those benefits soon. Younger nurses don't necessarily plan to stay at a hospital long enough to become vested in the retirement plan. Younger nurses, with perhaps mounds of student loan debt and eager to collect their first "real" paychecks, are understandably focused on salaries and getting enough hours. Because they tend to be single and healthy, the extra cost of paying toward their health insurance benefits (a common takeaway at many bargaining tables) may seem minimal and not something worth fighting management over, while the same takeaway can mean hundreds more in monthly out-of-pocket costs for older RNs whose spouses and children also depend on them for health benefits.

But this doesn't mean that newer nurses don't care at all about health and retirement benefits (almost all would probably say they plan to have a family, and nobody escapes aging) and older nurses don't care at all about wages. And it especially doesn't mean that they can't work together to present a unified front to management.

When the contract at Condon's hospital came up recently, her bargaining team took this approach: "If it's important to half of the bargaining unit, let's fight for it."

"It all becomes a matter of the group within itself," said Condon. "The leaders in the group need to step up and say, we need to protect the young and take care of the old."

Younger nurses haven't paid their dues and have no appreciation for the historic battles previous generations of nurses fought to have what they enjoy today.

ATKINS, THE NICU RN, admits it sometimes bothers him that his hospital will hire into his unit brand-new RNs with no previous medical-surgical floor experience—something that was unheard of when he graduated from nursing school in 1980. Condon, likewise, is skeptical of hiring new nurses into trauma or other specialty settings. When you add in the fact that patients are so much sicker and their cases more complex than they were five, 10, or 20 years ago, veteran RNs often feel new nurses today may not have had the chance to build a solid foundation for their practice.

For most of the history of nursing, new grads started on med-surg floors, where they learned the basics of placing an IV, recognizing the signs of trouble, and treating patients. But in recent years, hospitals have been hiring new grads directly into specialties and sometimes even masters degree nurses into nurse manager positions.

Young nurses sometimes don't understand why this is a strain. "I understand where my professor and all others who've said it before her are coming from," wrote Ani Burr, a recent RN grad in her first

Two RN mentors at a California Nurses Foundation seminar.

job in a pediatric unit, in a column for ScrubsMag.com. "Adult med-surg is where the skills are, it's where you're bound to see just about everything. I understand it, but I don't believe it's necessary."

Joshua Thieben is a 32-year-old RN who has worked about 10 years in the ICU at Long Beach Memorial Medical Center in Southern California. Thieben was hired as a new grad directly into critical care and sees nothing wrong with the practice. After all, because he believes that it allows continuity of learning for new nurses who already know what kind of specialty they'd like to pursue. Still, he concedes that there are some pitfalls and that the hires need to be done selectively. For example, new grads should be aware of the kind of stress they will be put under by entering a specialty unit straight out of school. And he said that many RNs' time management skills would be better honed if they had had a chance to practice on a general medical-surgical floor first.

The most veteran nurses may disagree with Burr and Thieben's point of view, but the times, they are achangin'. Short of lobbying to alter the hiring practices of their employers, what experienced RNs can do is help their younger colleagues lay that nursing foundation. Younger RNs can do their part, said Thieben, by taking more of an interest in what their most experienced colleagues have to teach them. Humility is important for anyone starting a new career, and new RNs are no different. Graduating nursing school, getting your RN license, and passing orientation doesn't mean that you'll be totally prepared for the many surprises you'll encounter on the job. Signal to your older colleagues that you are there to learn by paying attention and resisting the urge to retreat into your phone to text or check Facebook. Take the time to make friends with the senior nurses in your unit. They really do want to share their knowledge and skills, and it helps if younger nurses approach them with honesty, modesty, and without attitude. "The bottom line is, both sides need to be more open," said Thieben.

Thieben remembers one time helping a group of less-experienced nurses who were trying to rapidly infuse a patient and could not get the device to work. He used a pressure bag to deliver the fluids to the patient, a trick he learned from a senior nurse on the unit. "When I grabbed the pressure bag, they all looked at me like I was crazy," he said. "But it worked and they all said, 'That's genius. Where did you learn that?' So I told them one of the older nurses taught me how they used to do it when they didn't have a Level 1 [infuser]."

And as for helping younger RNs appreciate all the hard work that's helped make possible what they enjoy today, that's an age-old struggle for every generation. Again, experienced nurses need to step up and share that history to preserve it, but not do it in an overbearing or condescending way. How many of us have rolled our eyes at our parents' "When I was your age…" stories?

As an RN leader, McEwen speaks to as many nursing practice groups as she can and often incorporates some nursing history into her presentations so that new grads can better understand that the standards they now enjoy, such as health insurance and holiday time off, are the result of organizing—not the benevolence of the hospital. New RN orientation meetings are a great opportunity for this type of education.

"We welcome new nurses," said McEwen. "We don't want them to feel pushed around and not welcome. It's not us. It's the working conditions, where the employer is not staffing to meet the needs of the learner, the patient or the instructor. All of us in the learning environment want to succeed."

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THE DOCTOR IS *NOT* IN

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cheerleading for how the Watsons and telemedicine practitioners are the solution for medical errors, improving overall quality, and cutting healthcare costs.

A physician walking the rounds in a hospital might only see five or 10 patients a day. Put that same doctor at a desk with a computer monitor miles or continents away, and they might see 300 patients a day. How many doctors do you think the CEOs will need in this future?

One last example from the retail grocery industry. When product scanners were introduced, a lot of checkers thought it would make their jobs easier. It did, required fewer of them and downsized their skills as well.

Today, walk into any Safeway and notice the growing number of fully automated check-out registers with no live workers and no ability to respond to individual problems—in other words, just another grocery commodity. That's what the doc behind the doc on the stick might give a little more thought to.

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