Editorial

Maslow’s Hierarchy of Needs—Revisited

At the community center where I practice we are experiencing a re-design project. The goals are twofold: to create a healthcare center that revolves around the client and to increase the productivity of the staff. The client will benefit from decreased time in the center and will leave with appointments, referrals, etc. The staff (e.g., nurse or medical assistant) will be in the examining room to assist the physician or nurse practitioner. The time saved will allow more clients to be seen. A proposed change may be that the providers will receive bonuses for the number of clients seen. Inherent in this model is that monetary bonuses are an incentive for everyone.

In college many years ago I studied Maslow’s Hierarchy of Needs. Interesting as it was, I could not relate to the levels, which are as follows:

5. Self-actualization
4. Self-esteem
3. Love and belonging
2. Safety, security
1. Shelter, food, air, water

When I chose nursing as a profession I knew the salary was not high. Money was not my career goal. I, as all my fellow nursing students, wanted to make a difference and help people. My first pay check showed my hourly rate as $5.10. Today the hourly rate for new graduates is from $25.00 to $75.00.

Institutions where nurses practice and teach assume that money motivates all nurses. I propose that motivators for nurses may be different depending on where the nurse is on Maslow’s hierarchy. The current nursing shortage, for which there is no end in sight, has attracted prospective student nurses from varied levels of Maslow. Single mothers taking educational loans are investing today for the financial pay back. They have children to raise and many bills to pay. They are on level one or level two on the model.

Why do some prospective students of nursing choose a 4-year BSN degree over the 2-year AD? The initial pay is the same. Advancement? in education? in management? The monetary gains will not be as great in these specialties as they would be working as an advanced practice staff nurse. Perhaps the motivators for these nurses are at the third and fourth level. These nurses do not work better or harder for more money; they work better and harder for clients because it increases their sense of belonging and self-esteem.

Nurse practitioner students whom I precept will take a pay cut when they graduate from $45.00 to $30.00 an hour. Clearly their motivators are not monetary.

It may be an effective retention strategy for departments of nursing to offer different
Incentives or bonuses. For nurses struggling at levels one and two, more money is an effective motivator. Nurses who have satisfied their physiological needs and have financial security may not find more money as a motivator. To them, more time for their leisure or families may be an incentive, or more opportunities for continuing education. Nurses who are at levels three and four may be more satisfied working with very complex clients, whereas nurses at levels one and two may prefer less complex clients with shorter lengths of stay.

In the hectic healthcare world, it may be very productive for managers and administrators to consider each nurse from Maslow’s perspective. Nurses could be assisted to increase their introspection on what really motivates them. This knowledge for the employing institution and the individual nurse could prove to be a more satisfying model for all and improve retention and quality of care.

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Letter to the Editor

Another face of alive and lifeless
When I read the editorial “Alive but Lifeless” (Nursing Forum, 36[3]) some ideas drove me to respond that alive itself is life worthy. I wish to use my grandmother’s case as an illustration.

My grandmother-in-law, 93, has lost all visual and hearing functioning, lives in an old age home where the nurses, social workers, and other helpers are very responsible and committed to providing a quality of elderly care in a family-visible approach. With this approach, the family members are invited to participate in planning for her continuing care. The mission is to (a) reveal the family members’ voices and needs toward my grandmother’s old age care; (b) actively encourage family participation; (c) ensure my grandmother has adequate family support in her final life journey.

Although my grandmother is very physically fragile and unresponsive to both verbal and nonverbal communication from both healthcare providers and family members, she is alive. From the healthcare givers’ perspective, she is regarded as fully human and they treat her respectfully and politely. From our family’s view, she is one of our beloved family members and we try our best to prolong her life and offer her ongoing psychosocial support.

My grandmother is alive and her life is worthy; even we cannot speak for her and understand her wishes about how she likes to plan and use her remaining time. I am quite certain that the old age management for her is full of passions and sincerity provided by both profession and family in a partnership approach. As we do believe her life is worthy, we still work for her and never give up. Therefore, I was delighted to read the above-mentioned editorial and wish to add another face for it as well.

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