

History of Nursing

Karen J. Egenes

LEARNING OUTCOMES

After reading this chapter you will be able to:

- Discuss the importance to a profession's understanding of its own history.
- Identify the contributions of selected leaders in the development of U.S. nursing.
- Trace the origins and purposes of major professional nursing organizations.
- Describe the influences of war on the development of nursing.
- Discuss the influences of faith traditions on the development of nursing.
- Analyze the impact of government on the growth of health care and the development of nursing.
- Explore the development of advanced practice roles in nursing.

History can be defined as a study of events from the past leading up to the present time. However, the study of history focuses on not just the chronology of events, but also the impact and influence those events continued to have throughout time. Over the passage of time, events unfold and trends emerge. These historical trends, in turn, influence or shape the destiny of an

individual or a group. The development and evolution of the nursing profession is intricately connected to historical influences throughout the ages, beginning in antiquity. The study of the history of nursing helps us to better understand the societal forces and issues that continue to confront the profession. Understanding the history of nursing also allows nurses to gain an appreciation of the role the profession has played in the healthcare system of the United States (Donahue, 1991). The purpose of this chapter is to provide an overview of the history of nursing with an emphasis on nursing in the United States, describe the influence of societal trends on the development of nursing as a profession, and identify the contributions of selected leaders in U.S. nursing.

Nursing in Antiquity

In primitive societies, the decision to be a caregiver was often made for a person long before he or she had the ability to make such a choice. For example, among the members of the Zuni tribe, if an infant was born with a part of the placenta covering the face, it was taken as a sign that he or she had been marked as one who was destined to be a caregiver (Henly & Moss, 2007). In many societies, the provision of nursing care was a role that was assigned to female members. Because women traditionally provided nurturance to their own infants, it was assumed these same caring approaches could be extended to sick and injured community members as well. Yet in other societies, care of the sick was a role assigned to medicine men, shamans, or other male tribesmen.

Because no formal education in the care of the sick was available, the earliest nurses learned their art through oral traditions passed from generation to generation, from observations of others caring for the sick, and many times, through a process of trial and error. Those who acquired a reputation for expert care of the sick with a succession of positive outcomes were often sought after to provide care to friends and relatives. In this way, they established themselves in a practice of nursing care.

Available evidence indicates that nurses first formed themselves into organized groups during the early Christian era. The nursing ideals of charity, service to others, and self-sacrifice were in harmony with the teachings of the early Christian church. The role of **deaconess** gave women a meaningful way of participating in the work of the church. Deaconesses were often Roman matrons or widows with some educational background who were selected by the church's bishops to visit and care for the sick in their homes. Fabiola was a deaconess who is credited with the establishment and operation of the first Christian hospital in Rome. The deaconess Phoebe is often cited as the first "visiting nurse" because of the expert home nursing care she provided (Nutting & Dock, 1907).

KEY TERM

Deaconesses: Women with some educational background who were selected by the church to provide care to the sick.



Throughout antiquity, the preferable, and often safest, nursing care was provided in one's own home, where one was cared for by family members, clansmen, or friends. Care in a hospital was sought only by those who had no family members nearby, such as persons whose work took them away from their homes, or persons who had been ostracized or who were destitute. Early hospitals were begun by members of religious communities—nuns and monks who devoted their lives to the care of the sick. One example is the convent hospital at Beaune in France, where the sick were cared for in beds that lined the walls surrounding the main altar of the convent's church. Another example was the Hôtel-Dieu in Paris, a hospital operated by the Augustinian sisters, which was founded by the bishop of Paris in 651 A.D. Since its founding, the hospital has had an unbroken record of care “for all who suffer.” The detailed records that survive from this hospital provide many interesting insights into the state of medical and nursing care during the Middle Ages. More than one patient was placed in each bed, with the feet of one patient opposite the face of another. Because patients received no diagnosis upon admission, a patient with a leg fracture might be placed in the same bed with a patient with smallpox and another with tuberculosis (Robinson, 1946).

Nursing in Early Modern Europe

In England, in the wake of the Protestant Reformation, monasteries and convents were closed and their lands were seized. Care of the sick fell to “common” women, often those of the lower classes who were too old or too ill to find any other type of work. Hospital records of the day report that nurses were often sanctioned for fighting, use of foul language, petty theft, and extortion of money from patients (Pavey, 1953). The sick who lacked families to tend to their needs were warehoused in almshouses and municipal hospitals, overseen by attendants who lacked any knowledge of nursing care. Charles Dickens, a Victorian-era author who championed social reform, described the poor conditions of nursing care through his characters Sairey Gamp and Betsey in his novel *Martin Chuzzlewit*. Dickens's nurses were often drunk while on duty, engaged in intimate relationships with their patients, and took delight in their patients' deaths (Dolan, 1968).

During the first half of the 19th century, a variety of British social reformers advocated for the formation of groups of religious women to staff the existing hospitals. To answer this need, in 1840, Elizabeth Fry, a Quaker who had earlier fought for prison reform in England, founded the Protestant Sisters of Charity. Members of this sisterhood received only a rudimentary education in nursing; their only practical nursing experiences consisted of observing patients at two London hospitals.

The nurses of St. John's House, an English Protestant sisterhood founded in 1848, lived together as a community under the direction of a clergyman and a lady

superintendent. Pupils paid 15 pounds sterling for a training program that was 2 years in length, but were then required to work for St. John's House for 5 years in return for room and board, and a small salary. Although they received instruction in nursing in the Middlesex, Westminster, and King's College hospitals in London, they nursed for only a few hours each day, spending the remainder of their time engaged in religious instruction and prayer (Pavey, 1953).

On the European continent, Theodor Fliedner, a German Lutheran pastor, in an attempt to create a role for women in the church, established a Deaconess Home and Hospital at Kaiserswerth, a city in Germany on the Rhine River. Pastor Fliedner had traveled to England, where he was impressed with the work of Elizabeth Fry. Together with his wife, Frederike, Pastor Fliedner founded a deaconess training program. Although the deaconesses' primary instruction was in nursing, they also received education in religious instruction and in the provision of social services. According to the plan of Pastor Fliedner, deaconesses took no vows, but instead promised to continue to carry out their work as long as they felt called to this role. In return, the deaconesses were cared for by their mother house, which provided them with a permanent home. Although they were sent on assignments, they remained under the protection of their home organization (Garrison, 1954).

KEY TERM

Nightingale, Florence: The founder of professional nursing in England.

Florence Nightingale and the Origin of Professional Nursing

Into this setting entered **Florence Nightingale**, the woman who would not only reform nursing as it existed at that time, but also lay the foundation for nursing as a profession. Florence Nightingale was born into a wealthy British family. For their honeymoon, her parents embarked on an extensive tour of Europe. Their first child, Parthenope (the Greek name for Naples), was born while they visited Naples, and their second child, Florence, was born in the Italian city of that name. When the family returned to England, Mr. Nightingale took charge of the education of his daughters. Florence was educated in Greek and Latin, mathematics, natural science, ancient and modern literature, German, French, and Italian (Nutting & Dock, 1907).

It was assumed that Florence would follow the traditional path dictated for women of the upper class during the Victorian era, which included marriage and the rearing of a family. Although Florence was courted by various wealthy suitors, she rebuffed their approaches, stating she instead believed she had been called to dedicate her life to the service of humanity. Nightingale's parents at first were appalled by her desire to care for the sick, because such work was considered improper for a woman of her class. As steadfast members of the Church of England, they were even more shocked at her suggestion that she might seek admission to a convent of Irish Catholic nursing sisters. With time they consented to

her attendance for a 2-week period at Pastor Fliedner's Deaconess Home and Hospital in Germany. In July 1851, she was able to return to Kaiserswerth for 3 months, during which time she worked with the deaconesses, learned basic information about patient care, and observed the Fliedners' methods of instruction in nursing.

When Nightingale returned to England, she was appointed superintendent of the Upper Harley Street Hospital, a small hospital for sick and elderly women of the upper class who had experienced financial difficulties. During her time in this position, she also made a journey to Paris to observe the hospital work of the Catholic Sisters of Charity, and volunteered as a nurse at the Middlesex Hospital during a cholera epidemic there.

In 1854, the Crimean War broke out, in which Russia waged war against the combined armies of England, France, and Turkey. Nightingale was appalled to learn that the mortality rate for British troops was 41 percent. More disturbing was the fact that whereas the French had nursing nuns to care for their troops, the British army lacked any kind of nurses. In fact, most British soldiers were dying from disease rather than from injuries incurred on the battlefield. From her travels, observations of nursing care provided in hospitals abroad, and practical experiences in nursing, she had a far greater knowledge of the elements of skilled nursing care than the majority of medical workers of her time (Pavey, 1953).

Using her political influence, Nightingale sought permission for her and a band of ladies drawn from the upper class to travel to the Crimea and to care for the sick and wounded. Because Nightingale believed that dirt, rather than microscopic pathogens, were the cause of disease, she embarked on a campaign to thoroughly scrub the soldiers' barracks and hospital wards, and to let in sunshine and fresh air. Within months, the number of deaths decreased dramatically. Nightingale, who had learned the principles of statistics from her father's tutelage, carefully documented the results of her care and used these as the basis for further interventions (Woodham-Smith, 1951). Through her work, she laid the foundation for modern evidence-based practice.

When Nightingale returned to England, she was hailed as a heroine. The British people, in recognition for her work, established a trust fund to be used at her discretion. Through this Nightingale Fund, she established the Nightingale School of Nursing at **St. Thomas' Hospital** in London for the education of professional nurses. The school differed from earlier forms of nursing education because student nurses received classes in theory coupled with clinical experiences on hospital wards. In addition, a set curriculum guided the students' experiences, so that during their program, they received training in various aspects of nursing care for patients in many of the hospital's specialty areas. Because the Nightingale School had the Nightingale



KEY TERM

St. Thomas' Hospital: A hospital in London where Florence Nightingale established the Nightingale School of Nursing.

Fund as its financial base, students' experiences were planned by Nightingale and her instructors (Baly, 1997; Seymer, 1960). Emphasis was placed on the proper education of the nurse, rather than on the needs of the hospital.

Origins of Professional Nursing in the United States

Within a decade of Nightingale's return from the Crimea, the United States experienced the outbreak of civil war. When the war began, there was no provision for military nurses in either the Union or the Confederacy. At the time, there were no nursing schools, no "trained" nurses, and no nursing credentials. The title "nurse" was also rather vague, and could refer to an officer's wife who accompanied her husband to the battlefield, a woman who came to care for a wounded son or husband and remained to care for others, a member of a Catholic religious community in a hospital that cared for military personnel, or a volunteer. It is estimated that more than 3,000 women served as nurses during the Civil War, caring for sick or wounded soldiers on the battlefields, in field hospitals, in hospitals removed from battle sites, or even in their own homes. These female volunteer nurses went to the war with only the most basic knowledge of nursing care derived from their personal experiences caring for loved ones. They learned about the care of battle-related injuries and illnesses through their own wartime experiences (Livermore, 1888). Table 1-1 identifies some of the nurses who provided care to soldiers during the Civil War.

Influences of the U.S. Civil War

The Civil War nurses listed in Table 1-1 laid the foundation for professional nursing in the United States. The work they performed changed the public's perception of work by women outside of their homes. Many Civil War nurses had left their husbands and/or families to serve in situations that had not previously been considered a proper "place" for ladies. The work of the Civil War nurses also changed public opinion about women's work in health care. Women, who had volunteered as nurses during the Civil War, had come to realize the value of formal education in the care of the sick. Some of them became instrumental in the establishment of the first nurse training schools (schools of nursing) in the United States. In 1868, just 3 years after the end of the war, Samuel Gross, MD, president of the American Medical Association, strongly endorsed the formation of training schools for nurses (Larson, 1997).

The Effects of Social Change in the United States

Following the Civil War, cities in the United States experienced a rapid growth. Fueled by the rise of industries, many persons from rural areas flocked to cities to find work in factories. Hordes of immigrants from Eastern and Southern Europe

TABLE 1.1 CIVIL WAR NURSES

DOROTHEA DIX (1802–1887), superintendent of Union Army nurses during the war. She was a teacher and reformer of mental hospitals who, at the outbreak of the war, was charged with recruitment of nurses and supervision of nursing activities.

KATE CUMMINGS (1836–1909), a nurse for the Confederate Army. During the war, she kept a diary that she later published. Her book presents a realistic record of Confederate hospitals and nursing.

JANE WOOLSEY (1830–1900), a volunteer nurse for the Union Army, she became a superintendent of a Union hospital in Virginia. She later published her memoirs, which describe medical practices, the work of nurses, and the lives of wounded soldiers. Following the war, she helped to found the nurse training school at Presbyterian Hospital in New York City.

CLARA BARTON (1821–1912), a volunteer nurse who served in battlefield hospitals and prisoner of war camps. Following the war, she founded and became the first president of the American Red Cross.

WALT WHITMAN (1819–1892), a poet who worked as a volunteer nurse in a Union military hospital in Washington, D.C. He later memorialized in his poetry the work of wartime nurses in the care of wounded and dying soldiers.

HARRIET TUBMAN (1820–1913), born into slavery, escaped to Philadelphia. During the war she nursed soldiers using herbs and other home remedies.

MARY LIVERMORE (1820–1905), a teacher and abolitionist who served as a volunteer nurse. As director of the Northwestern branch of the U.S. Sanitary Commission, she directed the solicitation and distribution of food and medical supplies to military hospitals.

LOUISA MAY ALCOTT (1832–1888), an author and volunteer nurse for the Union Army. Her book *Hospital Sketches*, which was based on letters she had written home from an army hospital, aroused public awareness of the work of nurses in the grim environments of military hospitals.

MARY ANN “MOTHER” BICKERDYKE (1817–1901), a nurse for the Union Army. Before the war she had studied botanic medicine. She is renowned for her work in founding, cleaning, and sanitizing Union military hospitals in the face of opposition from Union officers. She also collected food and medical supplies for Union military hospitals.

came to the cities to meet the factories’ insatiable appetite for manpower. In fact, the population of many U.S. cities nearly doubled during each decade from 1880 until 1920. Crowded living conditions in the burgeoning cities often fostered the spread of disease. Because these new arrivals to cities often lacked family members with sufficient resources to care for them in time of illness and need, their only option was to seek care in municipal almshouses.

In many large cities in the United States, the sick wards of the almshouses evolved into public hospitals. Conditions in these municipal institutions in the United States were equal to the horrors in England that were described by Dickens.

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A group of reform-minded citizens who visited public charitable facilities in New York City during the 1870s reported that much of the nursing care was provided by drunkards and former convicts. It was reported that prostitutes sentenced in the city's courts were given the choice of going to prison or going into hospital service. No nurses were on duty at night; instead, the patients were supervised by night watchmen (Pavey, 1953).

Establishment of the First Nurse Training Schools

The success of the Nightingale School of Nursing became known around the world. Social activists in many countries wrote to Nightingale with requests for her to send one of her graduates to found a nurse training school and hospital in their city. It was not long before social reformers and some physicians in the United States espoused the idea that provision of safe nursing care was important and could best be delivered by persons who had received a formal education in nursing. Small groups of public-minded women grew increasingly concerned about the welfare of the patients housed in the massive hospitals and almshouses, and worked to establish nurse training schools to sanitize the institutions and to give patients care far better than that rendered by the untrained and politically chosen attendants then employed (Schryver, 1930).

The first permanent school of nursing in the United States is reputed to be the **nurse training school of Women's Hospital of Philadelphia**, which was established in 1872. The staff of the hospital was predominantly female physicians, who sought to open the field of nursing to a better-quality type of woman. Following

the Nightingale model, the school had a set curriculum, paid instructors, equipment for the practice of nursing skills, provision for student experiences in other Philadelphia hospitals, and a nurses' library.

In the same year, a training school for nurses was founded at the New England Hospital for Women and Children, another hospital with a staff composed of female physicians. Located in Boston, the school was founded and administered by two physicians, Dr. Susan Dimrock, who had been educated in Switzerland and was familiar with the educational methods of Kaiserswerth, and Dr. Marie Zakrzewska, who taught bedside nursing. **Linda Richards**, who is purported to be the first educated nurse in the United States, was a graduate of this program. Another notable graduate was **Mary Mahoney**, the first African American graduate nurse (Dolan, 1968). Table 1-2 describes some of the early leaders in nursing from this era.

Unfortunately, physicians' support for the formal education of nurses was absent in the establishment of other

KEY TERM

Nurse training school of Women's Hospital of Philadelphia: Established in 1872, reputed to be the first permanent school of nursing in the United States.

KEY TERM

Richards, Linda: Purported to be the first educated nurse in the United States, a graduate of the New England Hospital for Women and Children in Boston.

KEY TERM

Mahoney, Mary: The first African American graduate nurse.

TABLE 1.2 EARLY LEADERS IN NURSING

LINDA RICHARDS (1841–1930), awarded the title “America’s first trained nurse.” She was the first graduate of the year-long nurse-training program at the New England Hospital for Women and Children. She established the first nurse-training program in Japan, and then returned to the United States to found nurse-training programs in Michigan, Massachusetts, and Pennsylvania.

ISABEL HAMPTON ROBB (1860–1910), superintendent of nurses at the Illinois Training School and the Johns Hopkins School for Nurses. She became the first president of the Society of Superintendents of Training Schools for Nurses (forerunner of the National League for Nursing) and the Associated Alumnae Association (forerunner of the American Nurses Association).

SOPHIA PALMER (1853–1920), a founder of the New York State Nurses Association and campaigner for nurse licensure in New York. She became the first editor of the *American Journal of Nursing*. She authored a history of nursing, as well as other nursing textbooks and journal articles.

LAVINIA DOCK (1858–1956), a lecturer, author, and activist. Her campaign for women’s suffrage and participation in anti-war protests sometimes led to her arrest. She authored many nursing textbooks and, because of her leadership in the International Council of Nurses, served as editor for the *American Journal of Nursing’s* Foreign Department.

MARY ADELAIDE NUTTING (1858–1948), the appointed head of the Department of Nursing and Health at Teachers College of Columbia University. She became the world’s first professor of nursing.

ISABEL MAITLAND STEWART (1878–1947), a professor of nursing at Teachers College of Columbia University. She worked tirelessly for the establishment of a standardized nursing curriculum. She insisted on the need for nursing research to give the profession a solid scientific base.

LILLIAN WALD (1867–1940), from her work providing home nursing care and teaching home nursing to immigrant women on New York City’s Lower East Side, she went on to found the Henry Street Settlement and the first Visiting Nurse Association.

MARY BRECKENRIDGE (1881–1965), a nurse midwife. She founded the Frontier Nursing Service to provide maternity services to women in the Appalachian mountains of eastern Kentucky. Nurses visited families on horseback. This service significantly lowered the maternal mortality rate of the region served.

early nurse training schools. Indeed, for many years a number of eminent physicians were opposed to any education for nurses other than the most basic training (Goodnow, 1953). Despite this, in 1873, three notable nurse training schools were established: the Bellevue Hospital Training School in New York City, the Connecticut Training School in New Haven Hospital, and the Boston Training School in Massachusetts General Hospital. It is significant that these schools were founded through the efforts of committees of laywomen, rather than physicians.

Conditions in Nurse Training Schools

In 1883, 10 years after the first training schools were founded, the number of training schools across the country had grown to 35. The majority of these schools were located on the east and west coasts, with isolated schools located in large cities across the nation's heartland. However, unlike the Nightingale School, training schools in the United States were economically dependent upon the hospitals in which they were located. Because of this, the needs of the hospital took precedence over the students' educational needs.

Hospital boards and physicians soon realized the economic advantages of the use of student labor, under the aegis of "clinical training," in the delivery of care to hospitalized patients. Because students tended to be compliant and obedient, the care they provided was cheap, efficient, and more cost effective than if graduate nurses had been hired by hospitals. The student nurses in effect traded their labor for the opportunity to be educated in a profession. Students worked 12-hour shifts with little or no clinical supervision. Some were required to sleep on hospital wards in beds that adjoined those of their patients. Classes were irregularly scheduled and were often cancelled when students were needed to staff the wards. Some hospitals earned additional funds by sending students to care for patients in private homes, a setting in which students were typically overworked and lacked both supervision and access to instruction (Kalisch & Kalisch, 1995).

By 1900, the number of schools had increased to 432. Many of these schools had been founded in state mental hospitals, tuberculosis sanatoria, and other "specialty" hospitals that provided very limited experiences. Still other schools were founded in hospitals with fewer than 25 beds, which because of their size, provided less than adequate clinical experiences (Baer, 1990).

Following the completion of their training, only a select handful of graduates were offered hospital positions as supervisors and clinical faculty. The majority of graduates found employment in the homes of clients who could afford their services. The need for these private duty nurses was great because the majority of infants were delivered in the home, and some surgical procedures were performed there. In addition, many medical conditions, such as typhoid fever and pneumonia, were treated in the home setting. Often a private duty nurse slept in the same room as her patient, and was also responsible for laundry chores and meal preparation. Despite these harsh work conditions, nursing offered women a socially acceptable means of self-support and economic independence.

Advances in Science and Medicine

The 19th century was marked by vigorous intellectual activity and the expansion of knowledge in the sciences. These advances profoundly influenced both medicine and the burgeoning profession of nursing. By the beginning of the 20th

century, the symptoms and natural life histories of many diseases had been identified. Because of advances in the development of microscopes, in some cases, the causative organisms of disease had been identified as well. Newly developed instruments aided in the assessment of bodily function. Through the development of antiseptic agents and anesthesia, complicated surgical procedures were possible. Increasingly the practice of medicine was based on scientific knowledge and aimed to both control and cure disease.

The expansion of scientific knowledge and the increased use of complex technological procedures were linked to the growth of schools of nursing. The work of curing patients was best carried out in hospitals where physicians and surgeons had access to modern technology. With the expansion of medical care, educated nurses were needed to aid in the care and treatment of patients with increasingly more complex conditions and needs.

The Origins of Public Health Nursing

At the end of the 19th century, the field of public health nursing was instituted, which provided a third area in which nurse graduates could find employment. District nursing originated in England during the 1860s. Through funding from wealthy philanthropists, nurses provided care to “sick poor” persons in their homes, and also provided food and medical supplies. In 1886, the idea spread to the United States, and two district nurse associations were established in Boston and Philadelphia. In 1893, **Lillian Wald** originated settlement house nursing, an offshoot of district nursing, among the immigrant populations on the lower east side of New York.

Following her graduation from the New York Hospital Training School, Wald taught a home nursing class in a neighborhood populated by recent immigrants. One day a young child came to her, asking for her aid in the care of his mother who had given birth only 2 days before. He escorted her to a dreary apartment where she found the young mother lying on a bed in a pool of blood. Wald was so moved by this scene that she made the commitment to care for the destitute immigrant population of her city. With funding provided by women of the upper class, she and a classmate, Mary Brewster, moved into a small apartment in the neighborhood, offering nursing care to recent immigrants who sought their help. They were soon joined by other nurses and by social workers. Within 2 years, they helped to found the Henry Street Settlement House to provide both home nursing care and a variety of social services to New York’s immigrant population (Wald, 1934).

In an attempt to demonstrate the positive outcomes that could be realized by a public health nurse in a school setting, in October 1902 Wald sent one of her Henry Street nurses, Lina Ravanche Rogers, to work for a month in the New York public schools. At that time, any child could be barred from school if the teacher

KEY TERM

Wald, Lillian: A public health nurse who founded Henry Street Settlement House to provide home nursing care to the immigrant populations on the lower east side of New York.

believed there was reason for the exclusion. However, no attempt was made to determine whether there was a medical cause for the exclusion, nor was any attempt made to secure treatment for the child if this were necessary. The school nurse experiment was so successful in reducing the number of absences among schoolchildren that by December 1902, Lina Rogers was appointed to the Board of Health and 12 additional nurses were employed to aid her provision of school health services.

Wald was the first person to use the term *public health nursing* to describe the work of nurses in patients' homes as well as in other community settings. This field of nursing gained such prominence that in 1912 the National Organization for Public Health Nursing (NOPHN) was founded to set standards and to plan for the expansion of community-based nursing services (Randall, 1937).

The Origins of Nursing Associations

The World's Fair and Colombian Exposition was held in Chicago from May until October 1893 to celebrate the 400th anniversary of Columbus' arrival in the New World. Various conventions and conferences were held at the exposition, including the International Congress of Charities, Correction and Philanthropy. A section of this conference was chaired by Isabel Hampton. Prominent nurses presented papers on topics related to nursing. Of concern to the nurses gathered was the fact that at that time, only one-tenth of the persons who practiced nursing in the United States were graduates of hospital nurse training schools. The other 90 percent, who received equal pay for their care of the sick, had little or no formal education in nursing. Nurse licensure was considered vital to the protection of the public by providing a distinction between educated nurses and uneducated nurses. Nurse leaders voiced their concerns about the need for licensure, called for nurses to unite to advance their new profession, and proposed strategies to unite nurses.

KEY TERM

Nurses' Associated Alumnae of the United States and Canada: Originally founded in 1896 with the intent of achieving licensure for nurses; became the American Nurses Association (ANA).

In 1896, the **Nurses' Associated Alumnae of the United States and Canada**, which later became the American Nurses Association (ANA), was founded with the intent of achieving licensure for nurses. This escalating concern for nurse licensure led to the formation of state nurses' associations that were committed to the attainment of nurse registration through the passage of a nurse practice act in each state of the union.

Other goals of the association included the establishment of a code of ethics, promotion of the image of nursing, and provision of attention to the financial and professional interests of nursing (American Nurses Association & National League of Nursing Education, 1940).

Another concern voiced was the lack of educational standards in nursing. The programs offered in nurse training schools varied in length from a few months

to 3 years, and curricula and entrance requirements varied greatly. This issue was of particular concern to the 18 superintendents of nurse training schools who attended the Congress. As a result of their conversations, they joined together in 1893 to form the **American Society of Superintendents of Training Schools of Nursing**, a national nursing organization focused on elevating the standards of nursing education. This association later became the National League for Nursing Education, and still later, the National League for Nursing (NLN).

KEY TERM

American Society of Superintendents of Training Schools of Nursing: A national nursing organization founded in 1893 to elevate the standards of nursing education; later became the National League for Nursing Education, and ultimately, the National League for Nursing (NLN).

Licensure for Nurses

In 1901, New York, New Jersey, Illinois, and Virginia were the first states that organized state nurses' associations with the goal of enacting a nurse practice act for their states. In 1903, North Carolina passed the first nurse licensure act in the United States. By 1921, 48 states, as well as the District of Columbia and the territory of Hawaii, had enacted laws that regulated the practice of professional nursing. These early versions of nurse practice acts provided for licensure as a "registered nurse" (Birnbach, in Schorr & Kennedy, 1999).

Although the passage of these acts marked a tremendous milestone in the professionalization of nursing, a serious weakness of the early nurse practice acts was that they were permissive laws, rather than mandatory. They were "permissive" in that only nurses who were licensed were permitted to use the title "registered nurse." Thus, untrained persons were not prohibited from practice as nurses as long as they did not use the title "registered nurse."

This deficiency caused hardships for registered nurses during the Great Depression of the 1930s. Because the states lacked mandatory nurse licensure, any person was legally able to work as a "nurse" for pay. Thus licensed graduate nurses competed with uneducated "nurses" for the few available positions. The American Nurses Association argued that if only licensed nurses were allowed to practice, there would be enough work for each of them. Mandatory licensure laws, which made it unlawful for any person to practice nursing without a valid nursing license, were not passed by states until the late 1940s.

Effects of the Great Depression on Nursing

The stock market crash of 1929 plunged the United States into the throes of the Great Depression. Although every group of workers was devastated by the collapse of the nation's economy, nurses were particularly affected. Most nurses were independent practitioners, self-employed in private duty work in patients' homes. However, the patients who once employed private duty nurses were now unable to pay for this service.

Nurses who attempted to move from private duty work in patients' homes to hospital settings encountered problems in this venture. The depression years saw reductions in the number of hospital beds occupied. Patients who were forced to seek medical care were often without financial resources. Most hospitalized patients were in hospitals with training schools that used their students for bedside care. Hospitals without training schools were usually staffed with uneducated attendants. It is estimated that of the hospitals with training schools, 73 percent had no graduate nurse employees, and of these, only 15 percent had four or more graduate nurse employees. Graduate nurses who engaged in bedside patient care were looked down on as nurses not able to succeed in private duty work. After much debate, some hospital administrators decided to accept the services of unemployed registered nurses in exchange for a room, meals, and laundry, but offered the nurses no salary (Kalisch & Kalisch, 1995).

The National Recovery Act, passed by the U.S. Congress in 1933 in an effort to find employment for those without work, did not apply to unemployed nurses. The law stated, "The Agreement . . . shall not apply to professional persons employed in their profession" (President's Re-employment Agreement, 1933). In response to the implications of the National Recovery Act for the nursing profession, the Board of Directors of the American Nurses Association issued the following position statements:

1. Any plan for economic recovery must consider the thousands of unemployed graduate registered nurses.
2. In all cases, the most effective type of nursing service should be made available to patients.
3. Wherever possible, the nurse should be employed on the basis of an 8-hour day or 48-hour week.
4. The salaries of nurses should be kept above sustenance levels.
5. Nurses caring for acutely ill patients should not be expected to work more than 8 hours out of 24.

By 1933, the 8-hour day for hospital nurses was gaining ground. This schedule for nurses gained support because it helped to alleviate the problem of unemployment of nurses. When nurses were on duty for 8 hours instead of 12 hours, three nurses, rather than two, could work during each 24-hour period.

A milestone was reached in 1933 when the federal government announced that a program offered through the Civil Works Service would provide funds for bedside nursing care in the homes of recipients of unemployment relief. The care would be paid for from Federal Emergency Relief Administration funds at a set rate per visit, not to exceed the established rate charged by accredited visiting nurse associations in the local district. The program also included the use of graduate nurses for instruction to home workers, health education programs,

instruction in hygiene, preventative measures, care of infants and children, first aid, and nutrition. This program served to interest many nurses in the specialty area of public health nursing (The NRA and Nursing, 1933).

Nursing and Times of War

Times of war have increased both the nation's need for nurses and the public's recognition of nurses' work in saving lives. Educated nurses first served as army nurses in 1898, in the Spanish-American War. At the outbreak of the war, nurse training schools had been educating nurses for nearly 20 years. Congress authorized the Surgeon General to hire as many nurses as would be needed. At first, the educated nurses had difficulty winning acceptance from medical officers, but because they had been approved by the Surgeon General, their presence was tolerated. However, as the war progressed, their skills in caring for ill and wounded soldiers won recognition, and army doctors came to depend on them. More than 1,500 nurses entered the army during the war. Table 1-3 presents information about some of the early military nurses in our country's history.

TABLE 1.3 MILITARY NURSES

CLARA MAAS (1876–1901), following service in the Spanish-American War, participated in a study to determine the cause of yellow fever. She allowed herself to be bitten by a mosquito known to have bitten infected patients, contracted the disease, and died a few days later.

JANE DELANO (1862–1919), credited with the creation of American Red Cross Nursing. She recruited nurses for army service in World War I through the American Red Cross. While touring Red Cross hospitals in France following the Armistice, she contracted an ear infection and died a few days later.

ANNIE GOODRICH (1866–1954), a professor at Teachers College of Columbia University. During World War I, she organized and served as dean of the Army School of Nursing. Following the war, she served as the first dean of the Yale University School of Nursing.

JULIA STIMSON (1881–1948), during World War I, served as chief nurse of the American Expeditionary Forces. Following the war, she served as dean of the Army School of Nursing and was appointed the first superintendent of the Army Nurse Corps. During World War II she recruited nurses for military service.

FLORENCE BLANCHFIELD (1882–1971), superintendent for the Army Nurse Corps during World War II. She was one of a few women to reach the rank of colonel. Following the war, she worked for passage of the bill that granted army and navy nurses the pay, benefits, and privileges prescribed for commissioned officers.

LUCILE PETRY (1902–1999), served as head of the Cadet Nurse Corps during World War II. This program provided a free nursing education to women who agreed to provide military service until the end of the war.

In 1901, an Act of Congress established a permanent Army Nurse Corps, followed in 1908 by the establishment of the Navy Nurse Corps. However, military nursing did not achieve prominence until 1917, when the United States entered World War I. At the beginning of the war there were fewer than 500 nurses in the Army Nurse Corps. However, by the war's end, aided by reserve nurses from the American Red Cross National Nursing Service, the number had increased to over 21,000 army nurses and 1,386 navy nurses. During the war, over 10,000 U.S. nurses served overseas.

In 1914, when war first broke out in Europe, Jane Delano was appointed Director of Nursing Services for the American Red Cross Department of Nursing. Because the American Red Cross was regarded as the unofficial reserve for the military in times of national emergency, it became Delano's responsibility to recruit nurses for the Army Nurse Corps, Navy Nurse Corps, and U.S. Public Health Service, as well as to equip nurses for duty overseas. Traditionally, only graduates of nurse training school were eligible for military service. However, as the war progressed and the supply of nurses became depleted, society women, filled with a spirit of patriotism but unwilling to commit to a formal educational program in nursing, increasingly pressured the government for the right to serve as volunteer nurses. Although various schemes were developed to conserve the supply of nurses through the uses of volunteer nurses' aides, nurse leaders remained resolute that only educated nurses could serve as military nurses.

In an effort to recruit college-educated women into military nursing, in 1918 Vassar College offered its campus as a training camp to provide a 12-week pre-clinical program in basic science and basic nursing skills as part of a nursing program for college women. Upon successful completion of the Vassar Training Camp program, the college women were assigned to select nurse training schools as regular students for the completion of their education in nursing. During that summer, 432 women from 115 colleges and representing 41 states participated in the Vassar program. Their enthusiasm spread interest in nursing across U.S. college campuses. Many graduates of the Vassar Training Camp became leaders in nursing education during the following decades.

In a related effort, the Army School of Nursing was founded in 1918, with Annie Goodrich, a former faculty member from Teachers College of Columbia University, as its dean. Following the model used by the best civilian hospitals of the time, Goodrich's goal in founding the school was to provide patients in military hospitals with quality care provided by student nurses supervised by educated faculty. The school's curriculum was 3 years in length, with 9 months credit awarded to college graduates. Most clinical experiences were provided in army hospitals, with affiliations in civilian hospitals for pediatrics and other experiences. There were 500 students in the class of 1921, the first class to graduate from the Army School of Nursing. Although the school had been planned to be

a permanent institution, it was closed in 1933 because of financial constraints imposed by the Great Depression. However, the Army School of Nursing was well organized and offered a high standard of nursing education that served as a model for nurse training schools in the civilian sector (Jensen, 1950).

In 1940, as a second world war threatened, the American Nurses Association and other nursing organizations established the Nursing Council of National Defense to recruit more student nurses as well as to assess the number of graduate nurses who might be available for military service. The council worked closely with the American Red Cross in attempts to recruit registered nurses for military service. When a national inventory of nursing personnel conducted by the National Nursing Council revealed an acute shortage of nurses, the council joined with U.S. Representative Frances Payne Bolton of Ohio in the sponsorship of the first bill passed by Congress that provided government funding for the education of nurses for national defense. This bill was followed closely by the **Bolton Act of 1942**, which created the U.S. Cadet Nurse Corps, a program to prepare nurses as quickly as possible to meet the needs of the armed forces, civilian and government hospitals, and war industries. The entire nursing education of students enrolled in this program, including tuition, housing, uniforms, books, and monthly stipends, was subsidized by the federal government. Students were required to promise to work in either civilian or military nursing roles that were deemed essential to the national defense for the duration of the war. The Bolton Act further stipulated that the length of study for members of the Cadet Nurse Corps be reduced from 36 months to 30 or fewer months. By the beginning of 1944, students in the Cadet Nurse Corps began reporting to military hospitals for the clinical experiences that composed their senior year. The Bolton Act had a widespread influence on nursing education, mandating standards for nursing education programs and the removal of school policies that discriminated against students' gender, marital status, ethnicity, or race.

During the war, over 77,000 nurses, more than two-fifths of the active nurses at the time, served in the armed forces. Despite these valiant efforts, the number of nurses in military service remained inadequate. In his address to Congress in January 1945, President Roosevelt requested a national draft of nurses. Although the leading nursing organizations were supportive of a national service act for all men and women, they opposed a law aimed specifically at nurses. Discussion about the bill ended with the Allies' victory in Europe.

During times of war, the profession of nursing has attained a positive image and has enjoyed the highest level of respect from members of the lay public (Kalisch & Kalisch, 1981). During World War II, the great need for nurses caused the U.S. government to provide the resources that were needed to both increase



KEY TERM

Bolton Act of 1942: Legislation that created the U.S. Cadet Nurse Corps, a program subsidized by the federal government and designed to quickly prepare nurses to meet the needs of the armed forces, civilian and government hospitals, and war industries.

the supply of nurses and improve the quality of nursing education. Nurse leaders seized on this opportunity to advance not only military nursing, but also the profession in general.

Collective Bargaining in Nursing

Following World War II, the United States experienced one of its most drastic shortages of nurses. Many nurses who returned from the war sought the idealized role of wife and mother. Until the 1960s, nurses who worked in hospitals were expected to resign from their positions when they married. In addition, returning military nurses who had experienced such profoundly autonomous roles during the war were now reluctant to return to the subservient role of staff nurse in a hospital.

During the years that immediately followed the end of the war, despite the acute nursing shortage, nurses were paid far less than elementary school teachers, the professional group to whom nurses were most often compared. In fact, a study conducted in 1946 by the California Nurses Association found that the majority of staff nurses were paid only slightly more than hotel maids and seamstresses.

During the 1940s, Shirley Titus, Executive Director of the California Nurses Association, lobbied for economic empowerment for nurses. At the American Nurses Association convention of 1946 she successfully argued for nurses' rights to economic security through collective bargaining, insurance plans, benefit packages, and access to consultation from state nurses associations. In 1949, the American Nurses Association approved state nurses associations as collective bargaining agencies for nurses. However, a 1947 revision of the Taft-Hartley Labor Act exempted not-for-profit institutions such as hospitals from the requirement to enter into labor negotiations with their employees to address workplace grievances. Because the American Nurses Association had adopted a "no-strike" policy, and hospitals were not required to enter into labor negotiations with nurse employees, nurses often had no means to improve their work conditions other than by threats of mass resignation. Although hospitals were not required to enter into collective bargaining agreements with nurses, many times nurses working collectively were able to pressure their employers into voluntary labor agreements.

In 1966, the American Nurses Association rescinded its no-strike clause, opening the way for nurses' strikes for improvements in work conditions and salaries. Although relatively few strikes by nurses have occurred, when they have, nurses have ensured that care for those in need continued to be provided. Both nurses and members of the general public are often opposed to the idea of nurses entering into labor negotiations with employers, which they view as "unprofessional." However, collective bargaining has provided nurses with both increased economic security and a greater voice in decisions that affect patient care (Stafford, Taylor, Zimmerman, et al 2000).

Advances in Nursing Education

The apprentice system used in nursing education was often criticized by academicians and external review agencies because of its lack of intellectual rigor and its exploitation of student labor. In 1919, a Committee for the Study of Nursing Education, supported by the Rockefeller Foundation, was established to examine the state of both public health nursing and nursing education. The committee's published report, the **Goldmark Report** (1923), recommended that nursing education should have educational standards, and that schools of nursing should have a primary focus on education, rather than on patients. The report further recommended that nursing education be moved to universities, and that nurse educators receive the advanced education that was required for their roles. Although some changes in nursing education were implemented after the publication of the Goldmark Report, the changes were neither far-reaching nor permanent. Hospital administrators resisted change in nursing education that would eliminate the "free" labor provided by nursing students.

In 1926, the Committee on the Grading of Nursing Schools was organized to analyze the work of nurses and to study the educational preparation of student nurses. The committee's published report, *Nurses, Patients, and Pocketbooks*, became known as the Burgess Report (1928). The committee recommended that admission criteria be adopted for applicants to schools of nursing, and that hospital nursing schools focus on education rather than provision of patient care. The report further decried a hospital's use of funds collected for care of the sick to finance its nurse training school. Unfortunately, the recommendations of the Burgess Report were also largely ignored.

A third evaluation of nursing education, *The Future of Nursing*, authored by Esther Brown (1948), was funded by the Carnegie Foundation. Like the two previous reviews, Brown recommended that schools of nursing strive for autonomy from hospital administration, improve the quality of their programs, recruit faculty with baccalaureate or graduate degrees, and use discretion in the selection of sites to be used for students' clinical experiences. To relieve the acute shortage of nurses that followed World War II, Brown strongly advocated the employment of married nurses and the recruitment of men into nursing. Brown further recommended that nursing practice be based on principles from the physical and social sciences.

The years that followed World War II saw a significant increase in the number of students who sought college degrees. This trend was coupled with dramatic changes in health care as technological advances increasingly led to specialized practice in medicine and nursing (Kalisch & Kalisch, 1995). However, during the 1950s and 1960s, the number of baccalaureate programs in nursing grew at a

KEY TERM

Goldmark Report: Published in 1923, this report recommended that nursing education develop educational standards, schools of nursing adopt a primary focus on education and be moved to universities, and nurse educators receive advanced education.

very slow rate. The vast majority of schools of nursing continued to be hospital-based diploma programs. Many of the diploma nursing programs had improved in quality as a result of the Brown Report, as well as measures instituted by the National League for Nursing, such as the publication of a standardized curriculum and the establishment of a process of voluntary accreditation. However, the diploma programs continued to be dependent on hospitals for financial support, and continued to give higher priority to the service needs of the hospitals rather than to their students' educational needs.

In response to the acute nursing shortage that followed World War II, an associate degree in nursing (ADN) was initiated. The ADN program was conceived by **Mildred Montag** as the topic of her doctoral dissertation. It was initiated on an experimental basis in 1951 to provide a large number of nurses in a relatively short time period. It was intended that the ADN nurse would practice solely at the bedside and would have a significantly narrower scope of practice than the traditional registered nurse. The

KEY TERM

Montag, Mildred: Developed the concept for associate degree in nursing programs.

ADN programs were tested for 5 years (1952–1957) and successfully produced nurses who were proficient in technical skills and could successfully function as registered nurses despite the fact that their program was only 2 years in length (Haase, 1990). The number of ADN programs increased as the number of community colleges increased. The ADN programs provided a pathway to the nursing profession for men, married women, mature students, and other groups who had traditionally been excluded from admission to nursing programs. By the end of the 1970s, the number of graduates from ADN programs exceeded the number of graduates from baccalaureate programs and diploma programs. As the number of ADN programs increased, the number of diploma programs rapidly declined.

In 1965, the American Nurses Association published the document *Educational Preparation for Nurse Practitioners and Assistants to Nurses*, which became known as the ANA position paper. This document reaffirmed the stand that nursing education should occur in institutions of higher education, rather than in hospitals. In addition, the position paper stated that the minimum preparation for beginning professional nurses should be a baccalaureate degree, the minimum preparation for beginning technical nurses should be an associate degree, and the educational preparation of nursing assistants should be a short, intensive pre-service program in an institution that offered vocational education (ANA, 1965). Although the ANA position paper arose from the association's concern that societal changes and advances in technology required significant changes in nursing education, publication of this document led to an enduring rift in the profession and has discouraged movement toward the baccalaureate degree as the requirement for entry level into practice for professional nursing.

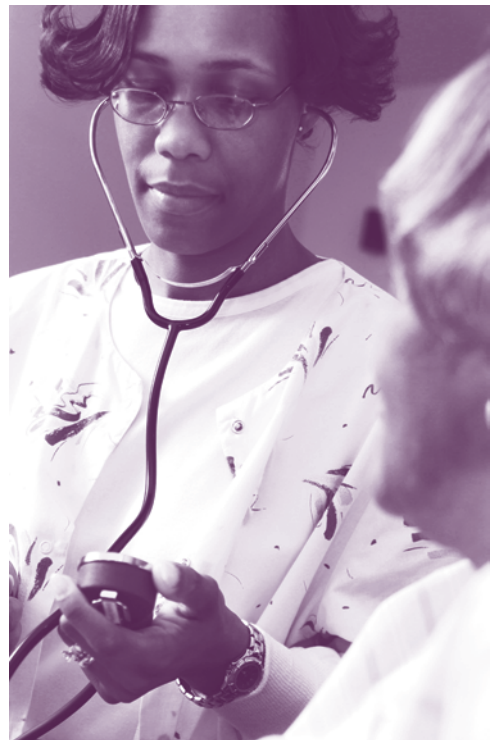
During the first half of the 20th century, the number of baccalaureate and graduate programs in nursing increased slowly. The slow rate of growth of

collegiate programs can be partly attributed to the nursing profession's uncertainty about the curriculum these programs should follow and the ways in which they should differ from diploma programs. At the beginning of the 1960s, only 14 percent of all basic students in nursing were enrolled in baccalaureate programs. In addition, there were only 14 higher degree programs in nursing to prepare the faculty needed to staff schools of nursing. A study commissioned in 1963 by the Surgeon General of the U.S. Public Health Service revealed that faculty in all schools of nursing, including baccalaureate programs, lacked the minimal educational preparation required for teaching. The published report of the study, *Toward Quality in Nursing, Needs and Goals*, recommended increased federal funding for nursing programs, and led to the passage of the Nurse Training Act of 1964 (Kalisch & Kalisch, 1995). This federal assistance was particularly important in the development of graduate programs in nursing. Prior to this time, nurses were often required to seek graduate degrees in education or in related disciplines. The 1970s saw a rapid increase in graduate programs focused on clinical specialties and laid the basis for an expansion in advanced practice roles in nursing.

Advances in Nursing Practice

The growth of master's degree programs in nursing opened many new advanced practice roles for nurses, including the roles of clinical specialist, nurse practitioner, researcher, and nurse administrator. Clinical nurse specialists have expertise in a defined clinical area. They are educated to provide expert care to patients who have complex health problems that require specialized care, to serve as role models for staff nurses, to provide consultation to nurses from other clinical areas, and to identify and research clinical problems associated with patient care. By the 1970s, clinical specialist roles had been developed in a variety of nursing practice areas including psychiatric/mental health nursing, cardiac nursing, oncology nursing, and community health nursing.

During the 1960s, concern for extending access to primary care services to traditionally underserved populations led to the evolution of the nurse practitioner role. It was long believed that the role of the nurse could be expanded and that nurses with specialized education could perform many of the primary care functions traditionally performed by physicians, but at a substantially lower cost. The title *nurse*



Caption?

practitioner was first used in a demonstration project at the University of Colorado, which was designed to prepare nurses to deliver well child care in ambulatory care settings. By the 1970s nurse practitioner preparation increasingly occurred in graduate programs in nursing. Provision of primary care by nurse practitioners became widely accepted by the general public.

The expansion of nurses' roles necessitated changes in the extant state nurse practice laws. At times, the extended roles for nurses, especially prescriptive authority for nurses, were met with criticism and opposition by medical associations. Nurses in advanced practice roles honed their skills in political activism as they fought for the changes in legislation that were required for roles for which they had been educated.

Advances were also made in nursing research. Over time, nurse leaders had struggled to establish nursing as a discipline that was separate and unique from medicine. However, this could be accomplished only when nursing developed its own unique theory base and body of knowledge. In addition, technological advances in medicine called for concurrent advances in clinical nursing practice, which could best be developed and validated through research. The journal *Nursing Research*, which was first published during the 1950s, provided a great impetus to nursing scholarship. The National Institutes of Health, Division of Nursing Research, was initiated in 1956. This body provided extramural grants for nursing research projects, and primarily funded proposals focused on applied research aimed to improve nursing practice. Nursing research further spawned the development of nursing theory by nurse scholars such as Martha Rogers, Hildegard Peplau, Imogene King, Myra Levine, and Dorothy Orem. Prior to the work by these nurse theorists, frameworks for nursing research had often been "borrowed" from other disciplines. The new emphasis on the development and refinement of nursing theories allowed nursing to be established as a distinct discipline.

As early as the mid-1930's hospital and public health nursing administration were identified as areas of graduate study for nurses. It was acknowledged that nursing administration required a specialized set of knowledge and skills, and as such, in the 1950's the W. K. Kellogg Foundation funded 13 universities in order to establish graduate nursing programs that prepared nurses for hospital nursing administration. This emphasis continued into the 1970's as nursing administration was increasingly recognized as a practice area and certification for the specialty of nursing administration was established. However, the increasing emphasis on clinical specialization in nursing during the 70's and early '80's eventually resulted in decreased numbers of nurses enrolling in educational programs that were focused on nursing administration (Simms, 1989). Today nursing administration is recognized as an advanced practice role requiring graduate education to adequately prepare nurses to lead in complex health care practice and educational settings.

Summary

From the beginnings of mankind, persons have been designated, called, or educated to perform the functions we now refer to as nursing care. The history of nursing has been distinctly linked to a tradition of caring. Nurses have felt a true responsibility to reach out to those in need and to advocate on their behalf. See Contemporary Practice Highlight 1-1 for a further illustration of this call to caring.

The history of nursing reveals a pattern of recurrent issues that the profession has been required to confront over time. Some of these issues have included maintenance of standards for the profession, autonomy for nurses, and maintenance of control of professional nursing practice. Over time, the profession has also addressed phenomena such as nursing shortages, new categories of health-care providers, and ethical dilemmas. Each decade has brought new insight into ways the profession can better meet these challenges.

Nurses of the future must continue to monitor changes in technology, advances in scientific knowledge, and changes in society and in the health care delivery system. Perhaps through study of the challenges of the past we will have the insights to best meet our future.

CONTEMPORARY PRACTICE HIGHLIGHT 1-1

Susan Reverby. (1987). A caring dilemma: Womanhood and nursing in historical perspective. *Nursing Research*, 36(1), 5-11.

Susan Reverby, a noted historian, argues that "caring" is the central dilemma of U.S. nursing. She asserts that the history of nursing is intimately entwined with the history of U.S. womanhood. She believes that throughout history, nurses have viewed caring as the basis of their practice. Indeed, nurses believe it their "order," or mandate, to care if they are to fulfill the proper role of a professional nurse. However, nurses have difficulty fulfilling this mandate in a society that refuses to value caring.

In her historical research article, she traces the history of the "mandate" to care from Florence Nightingale, through the origins

of U.S. nurse training schools, to the present day. In her analysis, she suggests that nursing continues to be plagued by the dilemma of "altruism versus autonomy" and offers implications of this dilemma for modern professional nursing practice. Too often nurses have equated the "order" to care and empower others with the need for self-immolation. She suggested that nurses need "to create a new political understanding for the basis of caring and to find ways to gain the power to implement it (p.10)" and in the process gain an understanding of how to practice altruism *with* autonomy.

Key Terms

- **American Society of Superintendents of Training Schools of Nursing:** A national nursing organization founded in 1893 to elevate the standards of nursing education; later became the National League for Nursing Education, and ultimately, the National League for Nursing (NLN).
- **Bolton Act of 1942:** Legislation that created the U.S. Cadet Nurse Corps, a program subsidized by the federal government and designed to quickly prepare nurses to meet the needs of the armed forces, civilian and government hospitals, and war industries.
- **Deaconesses:** Women with some educational background who were selected by the church to provide care to the sick.
- **Goldmark Report:** Published in 1923, this report recommended that nursing education develop educational standards, schools of nursing adopt a primary focus on education and be moved to universities, and nurse educators receive advanced education.
- **Mahoney, Mary:** The first African American graduate nurse.
- **Montag, Mildred:** Developed the concept for associate degree in nursing programs.
- **Nightingale, Florence:** The founder of professional nursing in England.
- **Nurse training school of Women's Hospital of Philadelphia:** Established in 1872, reputed to be the first permanent school of nursing in the United States.
- **Nurses' Associated Alumnae of the United States and Canada:** Originally founded in 1896 with the intent of achieving licensure for nurses; became the American Nurses Association (ANA).
- **Richards, Linda:** Purported to be the first educated nurse in the United States, a graduate of the New England Hospital for Women and Children in Boston.
- **St. Thomas' Hospital:** A hospital in London where Florence Nightingale established the Nightingale School of Nursing.
- **Wald, Lillian:** A public health nurse who founded Henry Street Settlement House to provide home nursing care to the immigrant populations on the lower east side of New York.

Reflective Practice Questions

1. What are some of the issues that the profession of nursing has confronted in the past? What solutions were proposed or implemented? What can we learn from these successful (or unsuccessful) efforts?
2. What contributions has military nursing made to the entire profession? What current nursing practices are the legacy of military nursing?

3. Although advanced practice nursing roles were formally introduced to the profession during the latter half of the 20th century, it has been argued that nurses began to function in expanded roles long before that time. Give examples of expanded roles assumed by nurses (community health nurses, military nurses) early in the 20th century.
4. What do you envision for the profession of nursing 50 years from now? What current trends in nursing practice do you believe will be the basis for future practice?

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