The History of Nursing

2 Course Hours

Course # 20-53155

COURSE DESCRIPTION

The history of nursing from primitive times to the current day has passed through many fascinating phases and some interesting patterns and trends. Although history never repeats itself with complete duplication, there are patterns and trends affected by historically unique forces and factors that have led to paths similar to that seen in earlier years yet uniquely different. This course details the history of health care, nursing, and nursing education from primitive times to the current day.

The content includes the transition of health care from sorcery and superstition to science, from care within the household to care in hospitals, and from care provided by unskilled and uneducated nurses to the current trend that reflects the need for the academic preparation of our professional colleagues. The course content also includes information about nursing leaders, such as Florence Nightingale, Sister Helen Bowden, Isabel Hampton Robb, Jane Delano, Lavinia Dock, and Linda Richards; landmark publications such as *A Manual of Nursing, New Haven Manual of Nursing, A Curriculum for Schools of Nursing, A Curriculum Guide for Schools of Nursing, Goldmark Report, Nursing Schools Today and Tomorrow*; nursing organizations and associations such as the American Society of Superintendents of Training Schools for Nurses, the National League for Nursing, and the American Nurses Association; and governmental initiatives including the *Bolton Act* and the Nurse Draft Bill.

Objectives

1. Relate the history of nursing and nursing education from primitive times to the present day.
2. Describe the impact of factors and forces that have affected the emerging role of nursing practice to its current state.
3. Identify healthcare and nursing historical patterns and trends throughout the course of history.

PRIMITIVE TIMES TO THE LATE 18TH CENTURY: SORCERY TO SCIENCE AND HOUSEHOLDS TO HOSPITALS

Medicine was closely linked to religion, superstition, and magic during primitive times. Illness occurred when evil spirits entered the body of prehistoric man. Good spirits within the body maintained health and warded off illness; the supernatural caused illness. Thus, sorcery became the basis of cures. Medicine men within primitive tribes were endowed with special mystical powers. They cast spells and performed pagan rites and rituals to rid ill bodies of evil and illness. When success was not attained, female members of the tribe nurtured the stricken who became helpless and unable to care for themselves. These women by nature of their gender were particularly suited for prenatal, perinatal, and postnatal care—areas of care highly developed by these primitive cultures.

Sorcery diminished over the centuries as medicine became more scientifically based. Early civilizations in Egypt and Greece showed evidence of scientific development. Interest in health, hygiene, and medicine was apparent. The roles of priests and physicians were differentiated as scientific knowledge evolved. Medical manuscripts in ancient Egypt contained references to the causes of disease, anatomy, physiology, diagnostic procedures, pharmacy, and medical specialization. Ancient Greece, a major center of civilization, made monumental progress in education, philosophy, democracy, and science. Hippocrates, the father of medicine, was a key figure in this Hellenic civilization. He separated medicine from the supernatural and initiated its scientific foundation. He also developed a system of patient assessment and record keeping and established medicine's first ethical standards. Despite the fact that medicine received such attention in this pre-Christian era, there was no historical mention of nursing. This lack of credit may have been due to the fact that separate social spheres and related responsibilities existed for women and men. The status of women did not equal that of men. Women assumed the nurturing role according to their socially defined role. The need for nursing was apparent, especially during wartime, but recognition was not granted. This acknowledgement did not come until the Roman's contribution, shortly before the birth of Christ.

Prior to the birth of Christ, the Romans utilized slaves to provide health care. Soon, the advent of Christianity marked a rise in altruism. Appointed caregivers replaced the slaves who had previously staffed residential estates, hospitals, and battlezone shelters. Bishops designated female caregivers of superior moral character as deaconesses of the church. This prestigious and esteemed position was bestowed upon single and married women who gave succor to those in need. In their mission they often traveled distant lands. They were the first visiting nurses. In addition to rendering care, they spread the word and teachings of Jesus Christ. Their focus was upon the ill, the orphaned, and the traveler. Hospitals, formerly military in nature, came under the auspices of the church. A unification of church and state clearly existed.

Thus, the birth of Christianity brought forth major changes in health care and the provision of nursing services. The nurturing role, formerly reserved for married women, was made available to single women as well. The status of nursing was elevated to one of great acclaim and respect. Medicine, however, did not enjoy the same elevation. Its social status and respect were severely diminished. Many physicians were conquered Roman slaves and were forced to practice medicine. It was certainly a bright and fortunate time for our profession, and a period of darkness for medicine. This contrasted sharply with the fame medicine enjoyed in ancient Greece.

Subsequently, the Roman Empire and its glory collapsed. Our world entered into the Middle Ages (500-1500 A.D.). Isolation and protectiveness became the way of life for people during the early Middle Ages when barbarians plagued the countryside. Isolated monasteries sprung up. Strong alliances continued to grow and strengthen between the Catholic Church and those providing health care. Married and celibate Christians joined military, religious, and secular orders as providers of nursing care. These monastic orders provided basic nursing care to the populace who were unable to afford the services of household servants to fulfill their healthcare needs. Unfortunate orphans, travelers, and ill people sought refuge in monasteries' healthcare facilities. Some monastic orders provided limited training for their monks who cared for male patients and for their nuns who cared for female patients. As these orders flourished, the deaconesses became extinct. Travel became unsafe as the barbarians overran Europe. Great variations in care existed. At this time there was little distinction between medicine and nursing. The only unifying trend among these scattered and isolated units was their common goal and motivation which was to serve the Lord through corporal and spiritual care.

After the Crusades the isolation of the early Middle Ages ceased. Social mobility, population redistribution, and communication followed. An enthusiastic renewal of the arts and sciences ensued. Scholarship was reborn. The increased commitment and interest of this society gave rise to many universities for medieval scholars. Medicine became a branch of science that scholars pursued within universities. Medicine was recognized as a science. Physicians again became respected. The wholistic, undiffer-

entiated health care of the monasteries yielded to the differentiation of nursing and medicine. Hospitals secularized and began to spring up in cities. Male and female nurses staffed these metropolitan hospitals as they grew in size and number.

Medicine and surgery developed formalized and standardized educational programs. The same did not hold true for nursing. The increased respect and recognition that medicine received as a science was concurrent with a rapidly declining respect and acclaim for nursing. The monastic nurses of high character, morality, and intellect virtually disappeared with the Reformation, a period of revolt against papal supremacy. Nurses of inferior quality and character were recruited to staff overcrowded and understaffed secular hospitals. These lower class women of questionable character settled for hospital employment when they were unable to find employment elsewhere. Salaries were minimal, the work was menial, and conditions were horrifying. After the separation of church and state, nurses of superior quality and character became disenchanted and retreated from practice. It was a dark and dismal period for our profession. This trend was reversed only after the efforts of Florence Nightingale.

Thus, our profession's long initial preparatory period from primitive times until the Nightingale era evidenced many alterations in medicine, nursing, and the provision of health care. The passage of many centuries transformed medicine from supernatural sorcery and undifferentiation to a respected science taught in universities. Care of the ill, formerly provided within tribal households, became available to the multitudes within the hospitals. Hospitals became secularized after a long period of church domination and administration. The status of nursing, like medicine, fluctuated throughout. However, the period concluded with nursing at its trough in social respect and medicine at its pinnacle. Medicine and nursing had differentiated. Physicians had formalized and standardized their professional preparation; nurses had not. Nursing ranged from poorly defined menial tasks to no definition at all during this span of twenty centuries. Unlike medicine, nursing was not predicated on scientific knowledge. Scientific foundations did not develop until Florence Nightingale.

1860 TO 1985: PROSTITUTES TO PROFESSIONALS AND TRAINING TO EDUCATION

Nursing's dark period halted after social and educational reforms transpired. During the late eighteenth and early nineteenth centuries, hospitals were plagued with unsanitary and unsafe conditions. Epidemics spread rampantly. Nursing care was severely inadequate. Nurses were uneducated, lower class women of questionable morality and ill repute. Literary giants, like Charles Dickens, immortalized these abhorrent conditions in their writings. Social consciousness was raised. The stage was set for acutely needed healthcare and educational reform.

The nineteenth century brought great educational opportunity to the upper social classes as universities opened and tutors became more numerous. Since only a few universities admitted women, daughters of affluent families were very often educated by private tutors. After receiving their education, these women fulfilled their roles as wives and mothers. The family was very clearly the basic social unit. Women were not visible in public life. Women of means did not pursue careers outside the home. Instead, they lived a gracious life and carried on the traditions of the upper social circles.

Conditions in the hospitals demanded educated and committed women, but social expectations prohibited it. Solutions to the problem were difficult to generate. Finally, after much deliberation, a German protestant minister named Pastor Fliedner initiated one solution. He revitalized the deaconess movement seen in Rome shortly after the birth of Christ. He and his wife staffed a hospital in Kaiserswerth with deaconesses in order to provide the ill with quality nursing care. Kaiserswerth nurses received bedside instruction from pharmacists and physicians as they rotated from unit to unit. Pastor Fliedner believed that this method would provide the nurses with a well-rounded, comprehensive training program. No remuneration was given during the deaconesses' six month probationary period, but thereafter they received a small allowance. In exchange for their five-year commitment to service, deaconesses received this allowance, food, lodging, and training. It was at this hospital that Florence Nightingale received her formal training as a nurse. Although she was favorably impressed

with its purpose, she was disappointed with the inadequacies of training and nursing care. This disappointment deepened her commitment to the improvement of nursing and the nursing profession. She resolved to actualize reform.

Miss Nightingale was born in 1820 to a family of considerable wealth and affluence. As a member of the upper class society, she was well educated and widely traveled. The Nightingale family had numerous and longstanding friendships with members of the aristocracy. One of these friendships led her to Scutari. Despite her family's desire to see her married and with children, she zealously pursued her interest in nursing care and related reforms. Her life was one of selfless commitment, self-sacrifice, and dedication. She was an outspoken advocate and mobilizing force for nursing reform, health reform, and work reform. Her vision, foresight, and organizational skills laid the foundation for nursing as a profession. The courage of her convictions cemented her ideas. Nursing reform, she proclaimed, can only be realized subsequent to formal educational preparation. One hundred twenty five years ago Miss Nightingale envisioned nursing as we know it today—a profession based on a discrete body of scientific knowledge. This concept was completely contradictory to the *born nurse* sentiment that prevailed in this era. *Born nurses* were, of course, able to nurse without preparation. Nursing was viewed as a gender-related and naturally innate, maternal characteristic that women possessed. Nurturing was natural to women, according to the *born nurse* philosophy.

As a young adult, Miss Nightingale was interested in nursing and charitable institutions. However, this interest did not readily transmute into actualization since locating a suitable training program was a formidable task. Finally, she discovered Kaiserswerth under Pastor Fliedner. Her training here convinced her that educational improvement was vitally needed. It was her goal to develop planned nursing education programs for reliable and qualified women. Her huge success at Scutari during the Crimean War elicited the economic support needed to organize such a program.

Prior to her arrival at Scutari as the nurse in charge, poor conditions of health and sanitation existed. The wounded and ill received incompetent care. Supplies and equipment were sparse or nonexistent. Her efforts transformed the hospital at Scutari to a state of cleanliness with quality nursing care. Her professional skills, ability, and insight were apparent to those with whom she interacted. Expertise and commitment brought her worldwide respect and renown. She had become a heroine. Soldiers and private philanthropic Englishmen with a sense of social responsibility rewarded her efforts with the establishment of the Florence Nightingale Fund. This fund provided the monetary resources necessary to establish the educational program for nurses of which she had dreamed. Her dream came to fruition in 1860 when her school at St. Thomas Hospital opened. All, however, did not participate in this fund. Physicians were critical of endeavors to educate nurses. It was feared that "excessive" training would precipitate nurses' unwillingness to perform menial tasks. This group was probably the greatest advocate of the born nurse philosophy.

Despite the fears of a few, the school at St. Thomas Hospital opened as an endowed school. It was personally planned and organized by Miss Nightingale herself. Unfortunately, her fragile health prohibited her from becoming its first superintendent. Instead at her request her close associate, Mrs. Wardroper, accepted this position. Throughout her lifetime, nevertheless, Florence Nightingale remained intricately and actively involved in all aspects of the school. She communicated with both students and instructors on a regular basis. The Nightingale Fund enabled the school to be financially and organizationally independent of the hospital. The focus was upon nursing education. No conflict of interest existed between service and education.

The Nightingale school established rigid criteria for student admission. The upper classes as well as the less fortunate were admitted to the school if they fulfilled admission criteria and were of superior character. Upper class women were expected to pay tuition. Their less affluent classmates attended tuition free. A suitable residence was provided for the students' living quarters. Formal classroom instruction in theory was planned and interspersed with carefully selected clinical experiences according to identified learning needs. Nursing practice became theory based. Sporadic training was transformed into education.

After one year of superior educational preparation, student nurses took an exam for

certification. This certification distinguished Nightingale nurses from untrained nurses. After graduation many graduates remained at the school for an additional year or two to enhance their basic education. These nurses later served as superintendents and instructors in other Nightingale schools in England. Some served in American schools of nursing. The philosophy of Nightingale and the news of her success began to spread quickly throughout the world.

In the United States, healthcare conditions closely paralleled those seen in England prior to Nightingale's reforms. American hospitals were overcrowded, poorly staffed, and unsanitary. Untrained nurses of lowly social class and undesirable character rendered inadequate and unsafe nursing care. Respectable women avoided nursing as a career. They, instead, fulfilled societal role expectations within the family unit. Although many upper-class women were fortunate enough to pursue higher education, educational opportunities were limited. Many colleges and universities of superior quality admitted only men.

The Civil War, similar to other wars, amplified the need for trained nurses. The dearth of adequately prepared nurses did not meet the demand. Recruitment became a matter of utmost urgency both in the North and in the South. When the war ended, the long, gradual, and painful process toward the formalization of women's rights and elevated status began. Increasingly, more women sought employment outside the home, particularly in stores and factories. The suffrage movement was gaining momentum. More colleges and universities admitted women, and their recognition in public life commenced. Medicine, a male-dominated profession, was making great strides. The rapid advancement of the medical profession made discrepancies in nursing care more evident than ever. The Nightingale news stimulated American interest. Commitment to similar reforms rose.

In 1873 three schools based on Nightingale principles opened as a result of American concern. Bellevue Training School for Nurses, Connecticut Training School for Nurses, and Boston Training School for Nurses opened that year. Similar to their English counterparts, these schools actively recruited students of high character and potential. Graduates were referred to as trained nurses. This sharply contrasted them from the untrained nurses they began to replace in our hospitals. These schools hoped to reverse the trend by making nursing an attractive career for dedicated, high-caliber women. There was, however, one difference between these schools and the school at St. Thomas. They lacked sufficient and sustained endowments. This deficit created monumental effects—effects that are still felt to the present day. Consequently, they lacked organizational independence and autonomy. Many schools were consumed by the hospitals in which they existed. This consumption often created conflict between the need for nursing education and the need to provide nursing care to patients. Very often, it was the education that was sacrificed.

Despite the problems that these schools encountered, many notable contributions emerged. In New York City, Bellevue Hospital School of Nursing was opened under the direction of Sister Helen Bowden, an Englishwoman trained in London. Although she was not a Nightingale nurse, she applied her principles to Bellevue. The school published *A Manual of Nursing* in 1876 and graduated many future nursing leaders. Among its distinguished alumnae are Isabel Hampton Robb, Jane Delano, and Lavinia Dock. The Connecticut Training School for Nurses began with a slow and disappointing enrollment of only three students. It did not, however, take long for it to become a formidable leader and innovator in nursing education. Its success flourished, and it became an endowed school and later received university affiliation. In 1879 the school published the *New Haven Manual of Nursing*. The Boston school opened in 1873 under the supervision of Dr. Susan Dimock. This school was modeled somewhat after Kaiserswerth. One of its graduates, Linda Richards, became the night superintendent of Bellevue and an acquaintance of Florence Nightingale. Miss Richards wrote of her experiences as a student nurse. The students' hours were described as long and filled with little formalized teaching other than the practical bedside instruction provided by interns. Sadly, most American nursing students shared these same experiences.

In general, American schools of nursing lacked proper equipment, adequate housing, and qualified teachers. Their financial dependence upon the hospital, which operated as a business, and lack of autonomy were directly related to the lack of

endowments. Nonetheless, hospital schools flourished and opened at a rapid rate. In 1880 there were 15 such schools. This number increased to 432 by 1900. By 1910 there were 1129 hospital schools of nursing.[1] Formalized nursing education had begun.

As increasingly greater numbers of hospital schools opened, Nightingale's principles became progressively more comprised. Nursing students were usurped by hospitals as free sources of labor under the guise of education. Hospitals were most often guided by the principles of big business and profit making. Education's financial dependence gave rise to the conflict of interest that ensued when service and education were organizationally unified. Hours for students were inhumanely long; discipline was rigid. Admission standards were drastically reduced by hospitals for the purpose of increasing the number of entrants. Students decreased the financial burden of the hospital. Minimal concern was shown for nursing students. Physicians and hospital administrators were the masters of these male-dominated, authoritarian institutions. Loyalty, obedience, and devotion were instilled in young nursing students. They served for the welfare of the hospital. Subservience was positively reinforced. Education became inconsequential.[2]

Hospitals, by their very nature, had patient care as their goal. Training and classroom instruction were not priorities. It, therefore, became sporadic, cursory, and inadequate. Hospitals provided room, board, and training in exchange for nursing services—services vital to the economic viability of the hospital. Graduates were budgetary drains to hospitals and were, therefore, unable to find employment within hospitals after graduation. Although a very small number were hired as nursing directors or teachers within service institutions, most were forced to do private duty. Prepared teachers were so scant in hospital schools that second-year nursing students often trained lower classmen. Nevertheless, young women flocked to these schools. Families encouraged their young daughters to pursue these programs since few educational and career opportunities were available to women at this time. By the 1950s many students were paying tuition. Nursing, it was believed, prepared young women for marriage and motherhood. As seen throughout our past, socio-economic and political trends affected the status of women and nurses at this time. It was an era of dutiful servitude and subordination for America's nurses and women.

Economic and professional oppression continued for nurses until standardization and regulation developed within and around our profession. Even legal sanctions restricting work hours for women and students were nonexistent until California passed such a bill in 1911. Professional efforts began to unfold. In 1893, The American Society of Superintendents of Training Schools for Nurses was created within the nursing community. Its mission was to rectify unsuitable conditions in nursing education through a unified and collaborative standardization of nursing education. The superintendents, committed to a common goal, were instrumental in promoting change and advancing nursing education. This organization was originally headed by Miss Hampton as chairperson. Later, such illustrious and celebrated leaders as Miss Nutting and Miss Stewart headed the society. Its early goals included the improvement of student working and living conditions, the elevation of entrance criteria to attract higher quality students, and the development of postgraduate programs and educational programs for specialization. This organization, eventually to become the National League for Nursing (NLN), compiled *A Curriculum for Schools of Nursing* in 1917 and *A Curriculum Guide for Schools of Nursing* in 1937. These are among its many outstanding achievements. The collaboration, communication, and unity among nurses and nursing schools, initiated by The American Society of Superintendents, was a giant step forward toward the improvement and professionalization of nursing. The creation and acceptance of professional standards and controls within nursing was a stepping stone toward professionalization.[3]

Subsequently, nursing and nursing education became the focus of numerous and intensive studies. In 1923, the Rockefeller Foundation's Committee for the Study of Nursing Education presented the Goldmark Report. It urged the separation of nursing education from service institutions. Unification of education and service under a common governance, it contended, created conditions in which education was seriously compromised and nonautonomous. The preparation of nurses, therefore, was consis-

tently in conflict with the demands of the hospital whose primary focus was upon patient care. This landmark report advocated financial support to nursing education in order to facilitate conflict resolution and autonomous function. The Goldmark Report also recommended university associations for nursing schools and specialized training for teachers of nursing. Nursing licensure, previously opposed by Florence Nightingale, was advocated. It was evident that in this country at that point in time, conditions demanded such control to ensure quality, public safety, and professional status. The Goldmark Report became a turning point in our profession's educational and professional development. Unfortunately, many of its recommendations have not yet been fully implemented. Unification and collaboration within the profession were sorely absent in 1923. Had a unified voice spoken, perhaps the support required to implement these recommendations might have actualized.

Shortly after the Goldmark Report there emerged a second insightful study into nursing and nursing education. In 1934 the Committee on the Grading of Nursing Schools published its report, *Nursing Schools Today and Tomorrow*, as an outgrowth of three energetic projects—"Nurses, Patients and Pocketbooks," "Nurses – Production, Education, Distribution, and Pay," and "An Activity Analysis of Nursing." The committee agreed that patient care could improve only if nursing education was improved. "The need for highly qualified, well-trained nurses still remains one of the most urgent needs of the community." Again, eleven years after the Goldmark Report, it was urged that nursing education be provided in academia. It was acknowledged that hospitals had schools of nursing for the purpose of providing patient care, not to matriculate prepared nurses. Educational needs would perpetually conflict with service needs when education and service were organizationally unified within hospitals. Graduate nurses must supplant students within the hospitals. According to the committee, this change in staffing was intrinsic to the professionalization of nursing.

The Committee on the Grading of Nursing Schools again urged the registration of all graduates. They concluded that the unemployment crisis among graduate nurses was not a function of our nation's economic depression but, instead, the consequence of excessive numbers of hospital schools and their utilization of nursing students to fulfill their staffing needs. It was evident that many hospital schools were extremely inadequate. The committee established minimal criteria for nursing schools and recommended the closing of schools that could not meet those criteria. The NLN's present accreditation process is founded upon this 1934 endeavor.

Conditions essential to basic professional schools included many curriculum change proposals in order to facilitate emphasis on theory and theory-based practice. They also addressed the need for formal faculty preparation. The days for head nurses and students to function as teachers were drawing to a close. Nursing faculty had to be prepared comparably to other professions. Graduate education was advocated. This would enable graduates with deficient basic training to improve their practice as well as to permit those with sound training to augment their basic training. Proposals for teaching, administration, and clinical specialization programs were also made. The Committee on the Grading of Nursing Schools—comprised of representatives from nursing, medicine, public health, hospital, and education—further amplified the recommendations of the Goldmark Report. Although still partially unheeded, their landmark findings and suggestions raised consciousness and laid the foundation for many future reforms.

War again shook the world. The World War II nursing shortage shocked the nation. The United States government embarked upon an energetic recruitment campaign for nurses. So acute was the shortage that New York State, which had approved mandatory licensure of registered and licensed practical nurses in 1938, suspended its action until 1949 when the war ended. A Nurse Draft Bill passed in 1945 by the House of Representatives and reflected our national concern. The hospital schools, already short of qualified teachers, lost the few nurses they had to wartime service. Creativity and innovation in healthcare delivery developed. Practical nurses, nursing aides, volunteers, and other supportive personnel were utilized to allow the few qualified nurses to perform professional duties. World conflict, not a unified nursing effort, precipitated a differentiation of function among members of the

nursing team. Nurses were no longer scrubbing floors and performing menial tasks.

After the world was again at peace, the shortage of nurses remained paralyzing to our country's healthcare system. It appeared that nurses who had mobilized their energies for national patriotism were now war weary. After fulfilling their patriotic duty, they found few incentives to continue practice. Hospitals were old, neglected, and outmoded. Economic rewards and incentives were minimal. Women married and had children. Except for a few, nurses remained at home as their husbands provided financial support, thus fulfilling their role expectations. Concern grew. Out of this concern emerged several extensive research projects and federal assistance.

In 1943, the United States passed the *Nurse Training Act*, commonly called the *Bolton Act*. It provided economic support and stimulation for increased student enrollment in nursing programs and improvements of nursing education. Free education, uniforms, and a monthly stipend were granted to the 170,000 cadets who studied nursing at participating educational institutions under this *Act*. Enrollment peaked in 1946 when 129,000 students were enrolled in America's nursing schools as a result of this *Act*. The *Nurse Training Act* also stimulated improvement of school facilities, curriculum changes, and the upgrading of faculty preparation. This major federal assistance program was followed by a period of intensive examination and reflection upon our profession.

Esther Lucile Brown and the Russell Sage Foundation examined nursing and prepared its findings for publication in *Nursing For The Future*. This report insisted that nursing education be provided in academic institutions and that schools be strategically planned and distributed across our nation according to need. A massive recruitment of minorities and men was advocated as another solution to the shortage problem facing our country. It also recommended a differentiation of function among members of the health team in order to maximize limited nursing resources. In concurrence with *Nursing Schools Today and Tomorrow*, Dr. Brown urged specialized graduate nursing education.[4] This 1948 study received wide acclaim for its objectivity and thoroughness, and further augmented and validated the findings and recommendations of previous studies based on the current state of the art during that time.

During the same year *A Program For The Nursing Profession* appeared under the direction of Eli Ginzberg, a Columbia University economics professor. This study was undertaken with representation from nursing, medicine, and the social sciences. The goal of this group was to examine and explain the paucity of nurses. The shortage, they contended, was the consequence of insufficient and inadequate economic incentives for nurses, an increased need for adequate health care, and inefficient utilization of nursing's resources and potential. This study exhorted varying degrees of preparation for members of the nursing team and articulated the need for the public support for nursing education. It was advocated that professional nurses have four years of preparation and technical nurses have two years of preparation for entry into practice. Practical nurses, it contended, should have a one year educational preparation. Congruent with the economic orientation of Ginzberg, the report proclaimed the need to efficiently utilize the resources of auxiliary personnel in a cost effective manner. The committee also admonished the nursing profession to embark upon intensive research on nursing within the profession to resolve its internal problems.[5,6]

Intraprofessional efforts began. The American Nurses Association (ANA), our professional organization, instituted its Economic Security Program in 1946. The ANA maintained that standards of nursing care could only improve subsequent to the improvement of salaries and working conditions. It outlined minimal employment standards for adoption by state nursing associations. Salaries, hours of work, benefits, vacation, and sick time criteria were established. State associations began to contract with hospitals according to these standards to ensure adequate staffing and to upgrade nursing practice. Extraprofessional awareness and commitment continued to grow. Funds in the form of traineeships, scholarships, and fellowships materialized as the complexities of nursing care surpassed the capabilities of scarce and inadequately prepared nurses. It was time for our profession to reflect upon its current status amidst this rapid change and increased demand for quality care.

Nursing Schools At The Mid-Century, published in 1950 by the Committee for the Improvement of Nursing Services, reflected our current status. It was the result of an energetic nationwide survey of our nation's schools of nursing. The committee described our profession quite accurately. "It was a many-hued picture, composed of bright areas of progress and dark areas as well. According to the report, there were 87,700 student nurses in 1949; 76,000 attended hospital schools, and 11,700 attended collegiate schools of nursing. One hundred fifty one young, white women between the ages of 17 and 22 were nursing students out of every 10,000. This figure was far greater than the 39 young black women of the same age group out of each 10,000 who were enrolled in nursing schools. Young men were the least represented population in our schools. Only one in every 10,000 was enrolled in nursing programs at this time. This data indicated that the recommendation of the Brown Report to recruit men and minorities was not activated.

At mid-century only 27% of hospital schools had achieved separate budgets for education. Eighty-seven percent of collegiate schools had successfully achieved this goal of financial autonomy. Of the 1,193 state accredited schools, only 210 schools had academic affiliations or a place within academic institutions. Wide variations of practice and education existed. In view of the fact that only 55% of nursing instructors held academic degrees, it was surprising to note that 88% of students passed state board examinations. This survey and subsequent report were evidence that there was little actualization of the recommendations of Goldmark, Ginzberg, Brown, and others. It was apparent that many unresolved problems remained.

The Committee, convinced that "a sound educational foundation is basic to the improvement of nursing service," proposed criteria to describe a good school of nursing amidst the wide variations evidenced. An independent budget was essential. Nursing faculty should possess at least a B.S. and be required to teach no more than four subjects. The students should be required to attend no more than 40 hours per week in the classroom and clinic. The school library, according to the committee, should have at least 1000 professional books. The Committee For The Improvement of Nursing Services advocated a unified effort by nursing service and nursing education to improve conditions as well as to provide further study into curriculum changes and the optimal use of available clinical and educational facilities. It also contended that clearly stated, objective, and measurable standards of nursing education must be established. Although some improvements in nursing and nursing education had begun by 1950, it was disappointing that the profession had not advanced as much as it perhaps should have. A unified voice within the profession had not yet verbalized a collaborative solution.

The 1950s continued to be difficult times for women, particularly professional women. Nursing remained almost entirely comprised of women. Issues affecting women continued to affect nursing. Few women worked outside the home except when household needs necessitated their employment to supplement their husband's incomes. Limited professional and career opportunities were open to women except for teaching, nursing, and office work. These service careers have traditionally offered little recognition and sparse financial reward. During the middle of the twentieth century, few motivators were offered to attract women into professional careers.

During the 1960s, 1970s, and early 1980s our country's socio-economic and political complexion drastically changed. Equal rights for all, including women, received federal sanction. Organized protests, demonstrations, and labor actions became commonplace. Issues varied from war to racial and sexual oppression. Economic inflation created the need for women to seek employment in order to maintain a viable family unit. Colleges and universities began to increase enrollments of minority students through open admission policies. Many adults returned to school on a part-time basis to pursue professions. Career opportunities for women broadened. Restrictions were lifted from traditionally male-dominated jobs, careers, and professions. Educational opportunities to pursue new careers were facilitated by low interest student loans and other forms of tuition assistance. The number of two- and four-year college programs in nursing increased to accommodate the demand. In 1974, according to the NLN, there were 1,358 schools of nursing. Of these, 310 granted a baccalaureate degree and 588 granted an

associate degree. Hospital diploma schools numbered 460. By 1983, the number of nursing schools had increased to 1,466. Four-year and two-year programs had increased to 421 and 764, respectively. These rises were accompanied by a decreasing number of diploma schools. Only 281 such programs remained.

These statistics indicate that our profession's educational preparation has made the transition, although incomplete, to institutions of higher learning as so often recommended throughout our past. Although this transition is essential to our profession and perhaps long overdue, it has not been without its inherent problems. At times, it appears that there is a gap in many institutions between schools of higher education and the environments in which nursing care is rendered—a gap that may potentially dichotomize and divide our profession. This separation was not the case when schools of nursing existed in the same environment that care was rendered. As a profession skilled in the implementation of the nursing process for individuals, families, and groups, we must generate a diagnosis of our problems, develop goals, and propose alternatives for action.

Ineffective coping related to rapidly changing socio-economic and political conditions within and around our profession may be an appropriate diagnosis of our current condition. Goals for the profession must be defined and conducive to both long-term benefit and short-term acclimation. Alternatives for action must be developed through mutual cooperative effort within a collaborative relationship based on communication and trust. Collaboration must include all professionals—service, education, students, and staff nurses. It must be a continuous process in which all participate. Nursing has traveled a long road despite unfavorable conditions. We have responded to these conditions and survived. Our past can teach us many lessons. It provides insight into our present condition and suggests future direction. The demarcation between service and education is essential to our profession. The communication and cooperation gap is destructive. We must unite and progress proactively. Certain actions must be initiated by education. Some must be adopted by service. Most must be aggressively pursued by both. None will succeed without cooperation from all. "The strongest investment nursing can make in its future is to resolve the debate between nursing education and nursing practice.[7]"

CURRENT TRENDS

Although history never repeats itself with complete replication, some current trends are reflective of our past. The profession of nursing is perhaps more understood and appreciated than ever before. Our roles have expanded into virtually all areas of practice and specialty and in all healthcare settings. No longer are hospitals our only practice setting. Nurses today practice in schools, industry, government, and community healthcare settings. Virtually all basic nursing education is now in colleges and universities. The days of hospital schools of nursing are long gone.

Additionally, there have recently been many more areas of specialty from which to choose. For example, nurses can get advanced degrees in information technology, psychiatric mental health nursing, nursing administration, and others.

Some patterns, however, have repeated themselves. For example, we are now amidst what has been characterized as the greatest nursing shortage in history. Some predict that this shortage will take years to reverse and correct. It is believed that by 2020, the national nursing shortage will more than triple to 400,000 openings from 126,000 today, the Bureau of Labor Statistics forecasts. In New York State, the shortage is expected to reach 17,000 nurses by 2005 and double that by 2015, according to a study by the state's Education Department.[8]

The American Association of Colleges of Nursing states that:

- According to a July, 2002 report by the Health Resources and Services Administration, 30 states were estimated to have shortages of registered nurses (RNs) in the year 2000. The shortage is projected to intensify over the next two decades with 44 states plus the District of Columbia expected to have RN shortages by the year 2020. The report, *Projected Supply, Demand, and Shortages of Registered Nurses: 2000–2020*, is available online at <www.bhpr.hrsa.gov/healthworkforce/reports/rnproject/default.htm>.
- According to the latest projections from the U.S. Bureau of Labor Statistics pub-

lished in the November, 2001, *Monthly Labor Review*, more than 1 million new and replacement nurses will be needed by 2010. The U.S. Department of Labor projects a 21% increase in the need for nurses nationwide from 1998 to 2008, compared with a 14% increase for all other occupations. <www.bls.gov>.

- According to the National Council of State Boards of Nursing, the number of first-time, U.S. educated nursing school graduates who sat for the NCLEX-RN®, the national licensure examination for registered nurses, decreased by 28.7% from 1995-2001. A total of 27,679 fewer students in this category of test takers sat for the exam in 2001 as compared with 1995. <www.ncsbn.org>.

The current shortage is being addressed by professional community healthcare groups and business and governmental groups all over the country. Men, who now make up only 5.4% of the nation's 2.7 million registered nurses are being actively recruited to enter into nursing studies and the nursing profession. Johnson & Johnson, the pharmaceutical and medical-devices company, featured men in nursing with their $20 million public service campaign that aims to promote the profession of nursing.[9] Professional organizations, such as the American Nurses Association, are striving to promote the image of nursing and encourage young people to join the profession. Hospitals are offering incentives to nurses to join their staff.

NOTES

1. Jo Ann Ashley, *Hospitals, Paternalism and the Role of the Nurse*, (Teachers College Press, Teachers College, Columbia University, 1990).
2. Ibid.
3. Deborah MacLurg Jensen, *Principles and Practice of Ward Teaching in Nursing*, (St Louis, Mosby, 1942).
4. Lucie Young Kelly, *Dimensions of Professional Nursing*, (N.Y., Prentice Hall, 1968).
5. Vem Bullough and Bonnie Bullough, *The Emergence of Modern Nursing*, 2nd Edition, (New York, MacMillan Co., 1969).
6. Lucie Young Kelly, *Dimensions of Professional Nursing*, (N.Y., Prentice Hall, 1968).
7. National Commission on Nursing, 1981, p. 42.
8. Eve Tahmincioglu, "Men Are Much in the Sights of Recruiters in Nursing," *New York Times*, April 13, 2003.
9. Ibid.

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